# Currents and perspectives in Sociology

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*Chapter Thirteen*

# The political economy of maternal and child health in Africa

– *Bernard E. Owumi*

## Background

Generally, the African culture puts premium value on the existence of children in the family. The absence of one tends to threaten the stability of marital life. Onwuejeogwu (1981), writing on the Nyer people of the Sudan, observed that bride gifts are never distributed until the birth of the first child. Among the Hausa-Fulani of Nigeria, marriages are stable only after the birth of the first child. In the same vein, women who are childless are socially stigmatized and called various derogatory names such as witch, outcast, and barren (Kigozi, 1992). Imamura (1986), writing on international marriages between Nigerian men and foreigners, noted that motherhood in Nigeria involves children – especially sons-while voluntary childlessness is not understood and foreign women who are childless face the daily problem of traditional greeting which stresses the significance of children. Even women who have children have to contend with local belief that a man should have many children and marry more than one wife. Added to the above is the fact that the "mere" ability to procreate is not enough to earn a woman the necessary status and prestige in the family and society. In other words, the number of children and the sex is very crucial to the social status of the African woman (Imamura 1986). Onwuejeogwu (1981) noted among the Ibos of Nigeria that the number of children a woman bears and their sex enhances her social status. This is also true of the Mbeere of Central Kenya (Brokensh, 1973). In this wise the African woman as noted by Kigozi (1992) and Njeru *et al.* (1992) may produce almost a dozen children by the time she is 45 years of age and if all are 'unfortunately' female she would continue to have children till death comes in pursuit of cultural value related to motherhood and male child preference.

What the preceding suggests is that Africa and other parts of the developing world (Berer, 1994; Paolisso & Leslie, 1995) treasure motherhood and attach such a high premium to children to the extent that women have little control over their reproductive and maternal health. This has consequently led to high fertility rate within the continent, thus endangering the health of mothers and children because the

higher the number of births per woman the higher the maternal mortality rate and by extension child mortality rate (Turmen, 1993) especially in a developing nation where the health facilities and nutritional requirement are poor. For instance, the 1995 world development report indicates that maternal mortality rate in Nigeria is 800 per 100,000 live birth while in Ghana it is 1000 per 100,000 live birth. Bender *et al.* (1995) also observed that in Bolivia the mortality rate is 600 per 100,000 live birth. This is also true for infant mortality. The World Health Organization (WHO 1996) put it at 85 per 1,000 live birth, while in countries such as Malawi it could be as high as 136 per 1,000 live births. The picture presented above is best depicted by Berer's (1970) observation that we glorify motherhood on the one hand and still we let half a million women die each year world-wide in pregnancy, childbirth and dangerous abortion. The World Health Organization also states that 12.9 million under five children die yearly (Ching–Li, 1993) world-wide.

According to the WHO, UNICEF, UNDP and demographers, maternal mortality and infant cum child mortality rates are indicators of the level of health care and general economic development in a country. Given the high level of maternal mortality and under-five mortality rate in Africa what can we say of the level of health care development and, by extension, maternal and child care in sub-Saharan Africa? What has accounted for their dismal state of health care? Put differently to what extent can the political economy model account for the nature of health care development in Sub-Sahara Africa? These are some of the pertinent questions which this chapter attempts to address.

## Political economy as a tool

Political economy is essentially an approach as well as a realistic methodology with a holistic perspective to the analysis of societal development (Onimode, 1985; Aina,1986; Ake,1990; Alubo,1995).Within this school of thought two basic variants are identifiable, viz the liberal, and the radical, comprising the world systems and the Marxist approaches.

While the liberal school of thought stresses the role of market forces in the distribution and the allocation of resources, including those of health care, the radical school upholds production and production relations. For instance, Marx insisted that the theory of value relates to the historically specific (capitalist) method of resources and recognises that there are laws regulating the allocation of scarce resources in all societies, but goes on to add that the nature, purpose and *modus operandi* of these laws are shaped by social relations determined in turn by prevailing modes of production of particular epochs (Onimode, 1990). Since the purpose in this paper is not to engage in long disputation on political economy, it is enough at this stage to highlight its usage in this paper and to stress that the political economy approach brings us closer to and sensitizes us to the intricacies of the linkages between and

within politics and economics and how both interplay to dampen or disrupt existing practices at the socio-cultural level.

## Development of health care in sub-Saharan Africa

Maternal and child care/health (MCH) is a component of the health care system. Consequently it would be pertinent to examine its overall structure to enable us comprehend the nature and structure of MCH in Africa. This section examines the evolution of the structure in a broad and historical manner.

A number of scholars (Maclean, 1971; Unschuld, 1976; Oke,1982; Ataudo 1985) have shown that Africa had its own system of health care before the advent of colonialism and the introduction of western medicine. Unschuld (1976) observed that "where-ever western medicine was introduced and no matter how urgent the need for its immediate application was felt to be, it was never a question of its filling a medical vacuum". In other words, the various cultures had developed their medical system in line with their needs. There were various categories of practitioners of the art within these cultures. These traditional practitioners maintained the health needs of the population and included specialists like Traditional Birth Attendants (TBAs), bone setters, oraclemen, herbalists, massagers and psychiatrists (Read, 1966; Maclean, 1971; Mbiti, 1975; Oyebola, 1980; Oke, 1982; Owumi, 1989; 1994). These practitioners were culturally compatible with their client (patients). In other words, they (practitioners and patients) shared the same values and cultures. For instance, Bender et al 1995; Bender Kwera and Madonna (1993) noted that women of rural origin appear more likely to continue the traditional practice of seeking assistance from Traditional Birth Attendants (TBAs) at the time of birth while Donahue and Mcguire (1995) observed that folk healer is available day and night and the people have different opinion about the social and cultural authority of the healer over the western physician. These observations support the fact that the traditional practitioners were highly ubiquitous and the services rendered were in consonance with the socio-economic conditions of the African as it is with other parts of the developing world: services were rendered without resort to economic benefits and were community oriented (Owumi,1989). The beliefs and conception of health were shared by both practitioners and patients and the entire community. The utility of the African traditional health care system is better appreciated by taking into cognisance the World Health Organization (WHO,1975) recognition of the place of traditional medicine in the attainment of health for all by the year 2000.

The Christian missionaries and the colonial masters imported into African societies, the western model of health care delivery. This system was meant to cater for the health problems of the missionaries and the colonial masters (Stock and Anyinam, 1992) and much later the civil servants in the service of the colonial government. The services which were eventually extended to the public were not available due to cost and cultural constraints (Ityavyar, 1987). Most African states

that were under the tutelage of the colonial government therefore had this system super-imposed on their societies. The minimal infrastructures, financed by the missionaries and proceeds from local taxes, were to serve the interest of the colonial government and further missionary activities. Given the exploitative tendencies of the colonial government, it is understandable why the services undermined the need and interest of the natives and workers on the plantation farms because the workers were even classified as dispensable. The hospitals that were established were localized in the urban centres while other public health measures which were disease specific programmes were executed wherever the need arose (epidemic situation). The rural Africans were not considered vital in health care development until the latter days of the colonial government and, in areas where there were some economic goods of interest to the colonial masters (Banerji, 1984; Ityavyar, 1987). This self-centred development made health care services inadequate and thus left the citizenry with no choice other than to rely on traditional medicine.

At the demise of colonialism, the nature and character of the emerging elite class thus dictated the pattern of health care development. Though the pattern and nature of the structures established by the colonial government were relatively unaltered, the political orientation of the emergent class was significant in the pattern of policies that were enunciated. While some of the elite were pseudo capitalist and thus market oriented and neocolonialist, others were populist and "need driven" in health policy design and implementation.

In Nigeria, for instance, the development was essentially guided by the structures put in place by the colonial government. While all efforts were concentrated on building teaching hospitals, training of health professionals, establishment of private hospitals and clinics, the over-bearing presence of the military and their allied business and technocratic elite did not enhance the decentralization and democratization of health care delivery for a number of reasons. First, the new political elite still needed and relied on the support of the former colonial master and bilateral and multilateral agencies for supply of aids and thus dictated development pattern surreptitiously. Secondly, the new leaders of states also relied on the urban dwellers who were the opinion leaders and the core of pressure groups (Donahue and Mcquire 1995; Banerji 1984). Emphasis was concentrated in urban health care with only scanty or half-hearted attention being paid to rural health care and by extension maternal and child health. This lopsided development strategy is still evident in the Nigerian health care delivery. Even where the primary health care system has been fully adopted, many outposts are non-functional due to lack of manpower, economic crisis and lack of commitment. The same pattern can be said of Ghana's health care development. While Nigeria, and to some extent Ghana, have been capitalist, Tanzania and Zambia have been populist in orientation. The urban bias development strategy put in place by the colonialist was repudiated to a large extent after the attainment of political independence. In Zambia, for instance, the number of government hospitals and rural health centres doubled in the first decade after independence. Similarly between 1972 and 1976 the total health care facilities in

Tanzania grew from 1,754 to 2,892 health facilities. This was within a period of four years and the development was not only in the underserved regions but was primarily in ethos thus accentuating the reorientation of the national government vis-à-vis the colonial government's policy which was urban centred (Arusha Declaration, 1967).

The nature of the health care development was due to the commitment of the government which invariably led to the success of Primary Health Care (PHC) strategy for health care development (Benerji, 1984). Significant as the above development would appear, the existing lopsided development of health care in favour of urban dwellers remains largely unchecked (Stock and Anyinam, 1992). The picture presented above is better depicted in table 1 below.

## Maternal and Child Health (MCH)

Given the discussion thus far, it would be imperative to pose the following questions. What is maternal and child health (MCH)? Why do we have to talk about maternal and child health? What is the situation today and what is it tending towards, or what does it portend for future generations? Before we proceed with the examination of the preceding questions, let us refer to Table 1 which presents a vivid account of the overall health care situation and the possible inference which can be extrapolated for MCH in Sub-Sahara Africa.

**Table 1: Percentage of the population with access to health services in selected African countries**

| Selected Countries | Urban | Rural | Total |
|---|---|---|---|
| Mozambique | 100 | 30 | 39 |
| Nigeria | 85 | 62 | 66 |
| Tanzania | 94 | 73 | 80 |
| Ghana | 92 | 45 | 60 |
| Zambia | 100 | 50 | 75 |
| Zimbabwe | 96 | 80 | 85 |
| Zaire | 40 | 17 | 26 |
| Benin | - | - | 18 |
| Niger | 99 | 30 | 32 |

*Source: The State of the World's children UNICEF 1996.*

Going by the above table and the question of accessibility which it poses in terms of distance and taking into consideration *that maternal and child health problem are emergency related matters,* the state of MCH appears gloomy given the general over all development which the sub-Saharan African health care has witnessed. Again, if there are countries in Sub-Saharan Africa with only 18% (Benin) of the total population and the best being 85% (Zimbabwe) with access to health care and given that most of the population are rural based (70%) yet undeserved while women are

generally disadvantaged socially in terms of accessibility, the state of maternal and child health in sub-Sahara Africa can not be better understood than as graphically illustrated above. To further illuminate the above discussion, data on under-five and maternal mortality rate for selected African countries are presented in Table 2 below to demonstrate the state of MCH in sub-Sahara Africa.

**Table 2: Under-five mortality and maternal mortality rates for selected African countries**

| Selected Countries | [a]Under Five Mortality rate (000) | [b]Maternal Mortality Rate per 100,000 Live births) |
|---|---|---|
| Niger | 280 | - |
| Mozambique | 206 | - |
| Nigeria | 187 | 800 |
| Tanzania | 142 | - |
| Ghana | 105 | 1000 |
| Zambia | 202 | - |
| Zimbabwe | 89 | 80 |
| Benin | 165 | - |
| Uganda | - | 550 |
| South Africa | 83 | - |

*Sources: a) The State of the World's Children, UNICEF 2000*
*b) World Development Report,1995.*

Generally, there is no clear-cut demarcation between maternal health and child health because both are connected and one dove-tails into the other. In other words, it is a dyad (Turmen, 1993; WHO, 1994; Castle, 1995). Maternal and child health refers to health problems that occur during pregnancy, child birth, the immediate *post partum* period/lactation and the health problems associated with the management of the new-born until the child is five years of age (Paolisso & Leslie, 1995; WHO, 1994; 1996). It is generally believed that (Turmen, 1993; Winter *et al.*, 1993; WHO, 1994) whatever affects the health of the mother affects the child and in the same token the health status of adult (Lundberg, 1993). So a chain of events is set in motion if the health of mothers and children are not met. This is the more reason why maternal and child health should be a primary concern of all. It is against this background that we attempt to examine the state of MCH in Africa.

As stated earlier, health care in Africa is urban biased and highly elitist and cure centred as against the preventive, primary, rural and participatory approach which makes the services unavailable and consequently inaccessible and unaffordable. The above picture thus makes it imperative for MCH in sub-Saharan Africa to be examined within the umbrella of the initiatives of the world organs. In addition to the above, is the fact that high infant and childhood mortality rate in sub-Saharan Africa

is due to infectious and parasitic diseases (Fosu, 1994), which have been mainly tackled by these agencies due mainly to the nature of their activities.

Since 1974 till the moment, a number of programmes aimed at improving the health of mothers and children in the world and Africa in particular have been established. In 1974 the Expanded Programme on Immunization (EPI) was put in place to immunize children against six preventable childhood killer diseases and later extended to pregnant women. This was closely followed by the Primary Health Care (WHO, 1978) strategy for the development of health care. This scheme has as one of its focus maternal and child health which is to be executed at the local (primary) level. The MCH focus under this scheme is due to the realization of the enormous health implication which child bearing entails and the death toll attendant in an environment where little or no facilities are available for the maintenance of mothers and their newborns (Turmen, 1993; Ching-li, 1993). Other programmes worthy of mention are the Safe Motherhood Baby package (1987) and the Baby-Friendly Hospital initiative (1991).

While it is germane to affirm that these programmes have been beneficial to African countries though initiated by international organizations their implementation have been affected by the level of resources at the disposal of African countries (Banerji, 1984; Fosu, 1994; Donahue and Mcquire, 1995). Table 3 below shows the level of immunization attained in selected African countries.

**Table 3: Percentage of infants fully immunized 1990-94**

| *Selected Countries* | *TB* | *DPT* | *POLIO* | *MEASLES* |
|---|---|---|---|---|
| Niger | 46 | 22 | 21 | 27 |
| Mozambique | 99 | 77 | 78 | 87 |
| Nigeria | 27 | 21 | 22 | 26 |
| Tanzania | 83 | 74 | 75 | 72 |
| Ghana | 81 | 68 | 68 | 62 |
| Zambia | 81 | 70 | 70 | 69 |
| Zimbabwe | 73 | 70 | 70 | 62 |
| Zaire | | | | |
| Benin | 94 | 86 | 85 | 82 |
| South Africa | 95 | 73 | 73 | 76 |

*Source: The State of the World's Children UNICEF, 2000*

Countries like Zambia and Tanzania for instance that have high political commitment to health care and with high level of democratization have experienced high percentage coverage of infants fully immunized while in countries like Nigeria and Ghana with less populist, democratized and market oriented health care development approach, the coverage appears poor. This poor state of things does not imply in real terms that these countries have not embraced these programmes (for instance EPI). In Nigeria, efforts are currently on to ensure that the health of mothers

and children is significantly improved. The National Immunization Programme (NPI) is being vigorously pursued under the Family Support Programme (FSP) of the Federal Military Government. While it is true that these efforts are noble the spirit or the governing ethos is shrouded by health development. The structure and the development pattern initiated under the colonial masters have largely remained while the obvious fact of the inevitable utility of the traditional structures is becoming manifest. This can be buttressed by the fact that traditional health care practices that were discredited previously are now being adopted and is playing a significant role in maternal and child health in Africa. The Mozambican instance is a case (Cliff and Noormahomed, 1996). The WHO (1976) has recognized and promoted the idea of the training of traditional medicine men as an effective means of extending the frontiers of health care and the cornerstone of PHC in the developing world. The Baby friendly hospital initiative is also another case in point which suggests the African dependency syndrome. Not until any subject is promoted by the developed world African elite and government do not take it seriously due largely to the fact that these programmes have foreign aids tied to them which are of interest to African elite and government (Donahue and Mcquire, 1995).

On the average, the international agencies have contributed tremendously to the improvement and the quality of MCH in sub-Saharan Africa. Most of the activities have been partly or wholly directed at improving the health and life conditions of women and children. A fact which the *South Letter* (1996) acknowledged when it observed that in sub-Saharan Africa most public health programmes since late 1960s have been directed towards reducing maternal, infant and childhood mortality thus neglecting adult mortality. Today, the under five mortality has been reduced from 256 per 1000 in 1960 to 177 per 1000 in 1994. Similarly maternal mortality rate is currently put at 597 per 100,000 live births (UNICEF, 1996). Significant as these improvements may appear, they are still a long way from what obtains in the industrialized world, where under five mortality rate is put at 9 per 1000 while maternal mortality is 7 per 100,000 (UNICEF, 1996).

## Constraints analysis

While it is true that given the substantial national and international efforts that have been made towards the development of MCH in sub-Saharan Africa in reducing maternal and child mortality, there are a number of impediments that have and would mitigate the pace and the gains made in the reduction of mortality and morbidity among mothers and children.

One of the greatest threats to the crusade is the Acquired Immune Deficiency Syndrome (AIDS), which has cast a dark shadow over the achievement already made. WHO (1992) estimates that there are at least 10-12 million adults and 1 million children with HIV infections, and about 1.7 million cumulative adults and more than 500,000 childhood AIDS cases. It would thus be a futile effort if so much has been

put in place by way of reducing maternal and child mortality in Africa while AIDS is robbing us of all that have been gained. Efforts should therefore be made alongside the existing ones to ensure that AIDS does not rob us of the gains.

The level of women's health education and the political awareness of the citizenry should be developed. As it is today the level of educational (table 5 shows the proportion of females who are illiterates) and political-awareness of the masses and government commitment is low (Arkutu, 1995). Similarly, the percentage of citizens with access to safe water is low. In an environment where some of the health problems are associated with water, the mortality rate could not be better than it appears. If this is improved, maternal and child health care will also be affected positively. An educated woman is more likely to use maternal services than an illiterate one (Gouldan *et al.*, 1993; Harrison *et al.*, 1993; Stanton, 1994) in the same way as a politically emancipated woman is more likely to agitate for equity in health care than an apolitical woman.

Wars also constitute another serious threat to the achievements made in MCH. Many hospitals and maternal/primary health care centres and health programmes have been disrupted or ravaged by wars while millions of children and mothers have either been maimed or orphaned or sent to their untimely graves (UNICEF 1996; Noormahomed 1996). These are disasters which are caused by adult actions and with enormous resources that could have been invested on health development. Research in fact reveals that the greater the amount on the military the greater the under five mortality rate (Stanton, 1994).

**Table 4: Percent Adult illiteracy (female), and population with access to safe water**

| *Selected Countries* | *Adult illiteracy* | *Population with access to safe water* |
|---|---|---|
| Niger | 83 | 59 |
| Mozambique | 79 | 22 |
| Nigeria | 61 | 42 |
| Tanzania | - | - |
| Ghana | 49 | 56 |
| Zambia | 35 | 59 |
| Zimbabwe | 40 | 36 |
| Benin | 84 | 50 |

*Source: World Development Report 1995.*

The influence of cultural constraints (Fosu, 1994; Owumi, 1994) cannot be under estimated. There are some impediments to the utilization of healthcare services. Traditional people (women) are more at home with TBAs (Bender *et al.*, 1993; Balsey, 1993; Bhantia and Cleland, 1995) and prefer to use their services even when modern health care facilities are available. This is due partly to what Banerji (1984) called the complex of western medicine in the Third World societies and what Poalisso & Leslie 1995 tagged the violation of women's concern for privacy. The

public setting for hospitals, clinic and the nature of medical examination are threatening in both physical and emotional sense to African women. Similarly, the high premium placed on children and consequently the high fertility rate in Africa also affects the health of the women and the children due largely to birth frequency and birth spacing (WHO 1996). Closely related to the cultural factor is the degree of perception of the need and the benefit associated with utilization of these facilities (Rosenstock, 1974). This has made women to truncate the issue of immunization services and other facilities meant to reduce the level of maternal and child mortality in sub-Sahara Africa.

Finally it should be stated that the nutritional and economic status of women and children is a serious impediment to the improvement of maternal and child health in sub-Sahara Africa. Due to poor economic situation of women, nutritional level is poor/low while poverty is pervasive which further induces a lot of stress (hard labour) on the women (Watson and Kemper, 1995, Paolisso and leslie 1995; Winter *et al*, 1993; Sharma and Vaniani, 1993; Stanton, 1994).

## Conclusion

Turmen's observation about child health is very incisive in drawing a concludin remark for this paper. He noted:

> ensuring quality of life means providing quality care before, at and after birth. This is not an impossible task. The knowledge exists, the skills are known, the resources are not attainable. *What is lacking is the wisdom to bring needed knowledge, skills and resources together.* (emphasis mine)

The above situation is also true of maternal health and the observation appe correct and precise. This point may be substantiated by the fact that Reunion, African country, has an infant mortality rate of 7 per 1000 (WHO 1996). So, why other African countries? It is therefore my opinion that it is not the wisdom galvanize the technical know-how but that the wisdom is "skewed" by the politi economy of the African states. What is thus necessary is the restructuring of socio-economic basis which would enhance the political will necessary for mobilization of all facets of society for the attainment of the common goal.

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