Counselling Implication of Women Reproductive Health Needs in Minna, Niger State Nigeria

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Abstract: - This study focuses on women reproductive health needs in Minna, Niger state with implications for counselling. This paper conceptualizes women reproductive health needs and counselling. It discusses Reproductive health needs, such as family planning, sexually transmitted diseases, and infertility. It also look into challenges of women reproductive health needs, like resources, burden of disease, impact on reproductive system and human right dimension. The paper listed some remedies to women reproductive health needs such as: women should be given access to appropriate safe, effective, affordable, accepted methods of family planning and satisfying safe sexual life as well as eliminating violence against women. Counselling implications include: provision of counselling services at public hospitals in Niger state. Such services should address issues such as negotiation with husbands in terms of improving health related behaviours of women reproductive health needs.

Keywords: Women, Reproductive Health, Needs, Counselling

I. INTRODUCTION

High rates of maternal and infant mortality, preterm births, as well as continuing disparities in pregnancy outcomes in Nigeria, have prompted a number of states Medicaid agencies to focus on improving the quality and continuity of care provided to women of childbearing age, Niger state inclusive. Many of these efforts have focused on implementing the national recommendations of the Centers for Disease Control and Prevention (CDC) and the Institute of Medicine, which call for expanding people’s awareness of pregnancy-related health risks, the expanded use of preconception care to reduce those risks, and the extension of public and private health needs coverage to low-income women. Such efforts are particularly important for state Medicaid programmes, which finance at least half of births in each Local Government Area of the state and bear the financial burden of addressing adverse birth outcomes, including neonatal care for premature children. Design features of Medicaid programmes have complicated efforts to improve the quality of women’s health needs, as more than half of women whose maternity needs is financed by Medicaid lose coverage 60 days after giving birth.

When that happens, Medicaid agencies lose a critical opportunity to address health risks, such as hypertension, obesity, and gynecological problems that can lead to high-cost and adverse birth outcomes. In view of the fact that these risks pose challenges for individuals, families, care providers, and states, many Medicaid agencies are exploring opportunities to finance primary care that includes the use of evidence-based prevention services for low-income women. To boost these efforts, the Medicaid agencies of 25 Local Government Areas of Niger State participated in a peer-to-peer learning project jointly funded by the CDC and the Commonwealth Fund. The project identified four principal strategies that states can use to improve women reproductive health. These include the use of family planning waivers and state plan amendments (SPAs). Other strategies include: the use of inter-conception care waivers, managed care approaches to improve the quality and continuity of care, and data to identify unmet needs and monitor performance. The project also identified five core strategies that state public health agencies can use to improve women’s health needs prior to pregnancy. These strategies include: Plans to improve the health of women of childbearing age and birth outcome, assignments to preconception health of public health agency staff whose roles typically include convening public and private stakeholders, planning, interagency collaboration, and data analysis, using measures from a core state of pre-natal health indicator set to monitor preconception health on a population basis, engaging health resources and services administration’s for first time motherhood, new parent initiatives for an advance knowledge and awareness, establishing an entity to guide a cross-sector collaboration in every part of Niger State. The project also produced a checklist designed to help the state identify improvement opportunities that fit within their approach to Medicaid coverage for women of childbearing age, their delivery models, ongoing quality improvement efforts, and public health resources. The checklist will also benefit the state as they look ahead to 2020 when the state will be free from any reproductive health related issues (WHO, 2012).

The concept of women reproductive health needs received great attention and was endorsed by Niger State government in 2013. The definition of reproductive health adopted at the conference reads as follows: “Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes”. Reproductive health needs therefore implies that people are able to have a satisfying and safe sex life, they have the capability to reproduce and the freedom to decide if, when and how to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable
methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care service that will enable women to go safely through pregnancy and childbirth and also provide women with the best chance of having a healthy infant (World Bank Report, 2013).

Women reproductive health needs in Minna, Niger state, is a crucial part of general health and a central feature for human development. It is a reflection of health during childhood, and crucial during adolescence and adulthood, sets the stage for health beyond the reproductive years for both women and men, and affects the health of the next generation. The health of the newborn is largely a function of the mother's health and nutrition status and of her access to health care. Reproductive health needs is a universal concern, but is of special importance for women particularly during the reproductive years. Although most reproductive health problems arise during the reproductive years, in old age, general health continues to reflect earlier reproductive life events. Men too have reproductive health concerns and needs though their general health is affected by reproductive health to a lesser extent than in the case of women.

However, men have particular roles and responsibilities in terms of women's reproductive health needs because of their decision-making powers in reproductive health matters. At each stage of life an individual’s needs differ. However, there is a cumulative effect across the life course and events at each phase having important implications for future well-being. Failure to deal with reproductive health problems at any stage in life sets the scene for later health and developmental problems. Reproductive health needs is such an important component of general health, it is a prerequisite for social, economic and human development. The highest attainable level of health is not only a fundamental human right for all, it is also a social and economic imperative because human energy and creativity are the driving forces of development. Sick and tired people cannot generate such energy and creativity, and consequently a healthy and active population becomes a prerequisite of social and economic development.

II. REPRODUCTIVE HEALTH SERVICES

The precise configuration of reproductive health needs concerns, and the programmes and policies to address them, will vary from country to country and from state to state. However, in Niger state the situation depends on an assessment of each local government’s situation and the availability of appropriate interventions. Globally, both the epidemiological data and the expressed wishes of diverse constituencies indicate that reproductive health needs interventions are most likely to include attention to the issues of family planning, STD prevention and management and prevention of maternal and child mortality and morbidity. Reproductive health needs should also address issues such as harmful practices, unwanted pregnancy, unsafe abortion, reproductive tract infections, including sexually transmitted diseases and HIV/AIDS, gender-based violence, infertility, malnutrition and anaemia, and reproductive tract cancers (World Bank Report, 2013).

Sexually-transmitted diseases: According to a World Bank study quantifying the burden of disease, sexually-transmitted diseases (STDs) rank as the second major cause of the disease burden in women reproductive health in developing countries, accounting for 8.9% of the total disease burden in that young girls age group (World Bank, 1993). Among males of the same age group, STDs are not among the first ten causes and account only for 1.5% of the disease burden. For a mix of biological and social reasons, women are more likely to be infected, are less likely to seek care, are more difficult to diagnose, are at more risk for severe disease, and are more subject to social discrimination and consequences. Men control the most effective method available for protection against STDs, the condom. A simple and effective method of protection, which a woman can use without the need or necessity of her partner’s cooperation, does not yet exist.

The unfair burden of fertility regulation: The modern contraceptive technology revolution provided women with reliable methods of birth control, which they can use independent of the necessity of cooperation of the male partner. This was at a price. They had to assume the inconveniences and risks involved. The role and responsibility of the male partner have receded when contraception was considered a woman's business. The percentage of current contraceptive use worldwide, among couples in reproductive age in 2012 was estimated as follows (United Nations, 2012):

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female sterilization</td>
<td>17 percent</td>
</tr>
<tr>
<td>Intrauterine device</td>
<td>12</td>
</tr>
<tr>
<td>Pill</td>
<td>8</td>
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<tr>
<td>Male sterilization</td>
<td>5</td>
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<tr>
<td>Condom</td>
<td>5</td>
</tr>
<tr>
<td>Other supply methods</td>
<td>2</td>
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<tr>
<td>Non-supply methods</td>
<td>8</td>
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Other supply methods include; injectables, diaphragms, cervical caps and spermicidal. Non-supply methods include; periodic abstinence or rhythm, withdrawal, douches, total sexual abstinence if practiced for contraceptive reasons, folk methods and other methods not separately reported. Women, therefore, assume a disproportionate responsibility for contraception in comparison to men. Not only do women have an undue burden of responsibility in fertility regulation, but also the methods which women have available for use are those associated with potential health hazards. The importance of male participation and responsibility has become much

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more with the emergence of the Acquired Immune-Deficiency Syndrome (AIDS) pandemic and the increasing prevalence of sexually-transmitted infections, where the use of the condom is the only effective strategy for protection other than abstinence.

**Infertility:** infertility is the inability for a woman to conceive or carry pregnancy to full time of nine months after having continuous relationship for one year. The couples commonly share responsibility for infertility. Analysis of data compiled in a large WHO multinational study showed that a major factor in the female with no demonstrable cause in the male was diagnosed in only 12.8% of cases, and a major factor in the male with no demonstrable cause in the female was diagnosed in only 7.5% of cases (World Health Organization, 1987). The burden of infertility, however, for biological and social reasons, is unequally shared. The infertility investigation of the female partner is much more elaborate and is associated with more inconvenience and risk. The burden of treatment also falls mostly on the female partner. Even for male infertility, the promise of successful management is now shifting to assisted conception technologies, where the female assumes the major burden. The psychological and social burden of infertility in most societies is much heavier on the woman. A woman's status is often identified with her fertility, and failure to have children can be seen as a social disgrace or a cause for divorce. The suffering of the fertile women can be very real.

III. THE CHALLENGES FOR WOMEN REPRODUCTIVE HEALTH NEEDS

The challenge to make reproductive health needs universally available, as demanded by the Niger state government, has implications for resource allocation by state and the international community, for organization of health services and for the health care profession.

1. **The case for resources:** Reproductive health needs for women, has to compete with other health needs for scarce resources. There is a need to make priorities in the allocation of investments in health. Criteria for setting priorities include the magnitude of the health problem, its impact, as well as the availability of cost-effective interventions.

2. **The burden of disease:** In a joint major exercise of the World Health Organization and the World Bank, quantitative assessments were made of the global burden of different diseases, and the results were expressed in the terms of women reproductive health needs (WRHN) lost because of the disease (World Bank, 1993). Although in infancy and early childhood, girls and boys suffer from broadly similar health problems, striking sex differences emerge in adults. Women suffer disproportionately from their reproductive role. Although the burden of reproductive ill health is almost entirely confined to the developing regions, it is so great that even worldwide, reproductive conditions make up three out of the ten leading causes of disease burden in women aged between 15 and 44 (Murray and Lopez, 1996). In developing countries, five out of the ten leading causes of WRHNs are related to reproductive ill health, including the consequences of unsafe abortion and Chlamydia infection. Almost all of this loss of healthy life is avoidable.

3. **The impact of reproductive health:** The burden of a disease is primarily a function of its prevalence and its seriousness to the individual concerned. In the case of reproductive health, the impact is not limited to the individual directly concerned. Inability of individuals and couples in Minna, to regulate and control their fertility because of lack of information and inadequacy of services, is not only affecting the health of the people immediately concerned and their families, but has implications for their societies and the state at large, for global stability and for the balance between population and natural resources between the human species and the environment (Mohamod, 2012)

The health of the women will surely have an impact on the health of the child. Investment in reproductive health is an investment in our future.

4. **Inequity in reproductive health:** The Alma Ata: Declaration in 1978 stated that: "The existing gross inequality in the health status of the people particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable, and is, therefore, of common concern to all countries." (World Health Organization, 1978)

There is no area of health in which inequity is as striking as in women reproductive health needs. If we look at mortality differentials in Minna, Niger state, we find out that the crude death rate for the population is about ten percent more in the less developed local government than in the more developed ones, the infant mortality rate is almost six times higher, the child mortality rate is seven times higher, and the maternal mortality rate is fifteen times higher. In no area of public health are mortality differentials more marked than in the area of maternal mortality (Adegbenga, Adegbenga, Morenike, Sunday, & Adebayo, 2002).

5. **The availability of cost-effective interventions:** The magnitude of the burden of disease, its impact and the glaring inequity are not enough to provide a rational basis for allocation of resources. The availability of cost-effective interventions has also to be considered. While the total women reproductive health life years lost for the age group between 15-44 years old was nearly for the women, the percentage that can be substantially controlled with cost-effective interventions was estimated to be 43.9 percent for diseases of women, compared to 17.5 percent for diseases of men (World Bank, 1993). It is for reasons of burden of disease, an impact that transcends national boundaries, as well as a deep concern about social injustice and inequity, together with the availability of cost-effective interventions that a major investment is justified in the field of reproductive health care.
6. A human rights dimension: The tragedy of maternal mortality in Minna, Niger state is not just a health problem; it should be recognized also as a human rights issue. The theme for World Health Day in 1998 was: "Pregnancy is Special; let's make it safe". When the World Health Assembly adopted this theme, it was setting a principle in health policy. Pregnancy is not a disease. Pregnancy is special. Pregnancy, a woman's privilege, is the means for survival of our species. Women have a right to safe motherhood, when they risk their life and health in order to give us life. Pregnancy should not compete for resources with disease conditions. Pregnancy is special.

7. The case for integration of services: The Oxford dictionary defines the word "integrate" as "complete (imperfect thing) by addition of parts; combine (parts) into a whole". Reproductive health needs should be an integrated package. There are, however, two levels for integration. Services can be integrated at the level of policy, management and administration and/or at the level of service delivery. A strong case can be made for integration of all reproductive health services at the level of policy, management and administration, to ensure that all these reproductive health needs receive attention and a relatively adequate allocation of resources.

At the level of service delivery, the approach should be pragmatic. Services should be integrated if integration makes their delivery more cost-effective. Different situations in Niger state should be judged on their own, taking into consideration some basic principles.

Service delivery will be more cost-effective either through better utilization, resulting in an increase of output, or cost savings, resulting in a decrease of inputs.

Better utilization of services can result when integration makes services more convenient and accessible to women’s. It can also result when the demand on one service can increase or create demand for the other, e.g. the demand for childcare may increase the demand for family planning.

Cost savings will be made when fixed costs are shared between different services. This will result if the same infrastructure can be used for the different services to be integrated, if the same providers can provide the services, and if enough excess capacity is available to meet the demands of the new service to be added.

Integration should be distinguished from "bundling" of services. The verb "bundle " (a common computer software jargon) is defined as "tie in, make up into, a bundle; throw confusedly in to any receptacle". When services are simply combined or joined together in one way or another, this is not necessarily integration. In such cases it may be more appropriately labelled as bundling. When services are combined or joined together as a strategy to provide a more complete package for services needed, this is integration.

The need for comprehensive health care should not translate to an all or none situation. Providing people with some elements of the service is better than providing no services. The best should not be made the enemy of the good. Services could be built up as resources become available and according to level of need and demand. Nor should integration result in dilution of available resources. Rather, it should result in more effective utilization of resources that are put together.

IV. REMEDY TO WOMEN REPRODUCTIVE HEALTH NEEDS

Improving reproductive health, a number of strategies need to be developed to address issues related to women’s reproductive health. One of the key strategies at the national level is to ensure that the breadth of issues covered is consistent with the elements agreed to at the International Conference on Population and Development (Nigeria, 2012), which encompass a state of complete physical, mental, social well-being, including:

1. Access to appropriate, safe, effective, affordable, acceptable methods of family planning based on informed choice and dignity;
2. Services for safe pregnancy and childbirth;
3. Prevention, diagnosis and treatment of reproductive tract infections and sexually transmitted infections, including HIV/AIDS;
4. A satisfying, safe sexual life; and
5. Elimination of violence against women and girls, including female genital mutilation/cutting, domestic violence and trafficking.

V. COUNSELLING IMPLICATIONS & WOMEN HEALTH REPRODUCTIVE NEEDS

Guidance services are provided at all the government-owned hospitals in Minna, and the 25 Local Government Areas of Niger state, but tend to focus mainly on ensuring that clients understand the different contraceptive methods and side effects and ensures that their specific needs are met. The opportunity to use these services to address issues such as negotiation with husbands, management of violence, and healthy related behaviours in term of women reproductive health needs will go a long way in assisting them to be more informed and also will reduce the high rates of maternal and child mortality. Guidance services to be provided in all the government owned hospitals and communities across the state are:

Orientation Service: Here the counsellor can take advantage of this service by helping women of productive age on how to access and make use of the healthcenters to cater for their needs. Such needs include safe pregnancy and delivery, prevention and treatments of sexually transmitted diseases, and also prevention of transmission of mother to child diseases like HIV/AIDS. Also counsellors can make use of marital counselling to educate or inform newly wedded couples on ways to go about planning their family and where to access or seek for the assistance. Posters and other relevant information can be placed on strategic areas for the benefit of
the general public. Also, women attending anti-natal and post-natal can be well informed on the issue of family and child-spacing for the wellbeing of both child, community health workers can also play a vital role here.

**Appraisal:** The appraisal of individuals can be done through diagnostic interview to know their level of awareness and convey these awareness to them so as to improve where necessary. Though some women are aware of family planning issue but are not clear about them. Here, they can be appraised on their awareness or sometimes being directed to health workers on where and how find out their status on sexually transmitted diseases STD including HIV/AIDS which if detected earlier could be managed and treated appropriately and will also be controlled from being transmitted from mother to child.

**Counselling Services:** Counselling is the person to person relationship that is between a counsellor and the counselee with the hope of assisting him/her to solve his/her problems. The counsellor can engage on one on one or group intervention approach by bringing together women with related issues to assist and direct them on available options for family planning and child spacing issues, while they are allowed to take decision on their own. These enable them to explore and understand better their needs and try to work towards achieving it.

**Follow-Up Services:** Here the counselor in collaboration should try and find whether those are really making use of the information acquired and are really accessing the reproductive health needs to see where they will need improvement. The follow up can be done during anti-natal/post-natal days and also in community meeting days. Their reproductive health but affect their entire wellbeing. Able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide, when and how regular to do it without any problem. They should be informed of and also to access safe, effective, affordable and acceptable methods of birth control, also access to appropriate health care centres of sexual reproduction, medicine and to emphasize on teaching of health education program to enable women go to through a free and safe pregnancy and delivery and this will not only the women but also the husband of having a health child.

All clinics provide some information education and communication (IEC) materials, but to a variable extent, and none are specifically designed for young people. Most had posters on the wall, with topics including vaccination, child health, family planning and contraceptives, medications and treatments. Some were hand written, presumably by clinic staff. Some posters showed doctors of the clinic at work or advertised its services. However, many posters depicted Western women and/or African peasant women, all as mothers with babies. No posters were youth oriented, to cater for the needs of reproductive age. Very few men were depicted in the materials, and none showed matters of gender responsibilities in reproductive health needs and some of the posters were written in Hausa for better understanding of the clients. Materials were available in counselling rooms, mainly illustrating various contraceptive methods, but these were almost exclusively for the use of the staff. Literature has shown that Niger state government with collaboration with NGO provides much pamphlets and other IEC materials are handed out to clients. However, counsellors can render the following services to their clients.

1. Family planning counselling, information, education, communication and counselling services;
2. Education and services for prenatal care, safe delivery and postnatal care, especially breastfeeding and infants’ and women’s health needs;
3. Prevention and appropriate treatment of infertility;
4. Prevention of unsafe abortion and the management of complications;
5. Treatment of reproductive tract infections, STIs and other reproductive health conditions;
6. Information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood;
7. Active discouragement of harmful practices, for example, female genital mutilation.

**VI. CONCLUSION**

Investing in women’s reproductive health does not only advance human life, improves the health and wellbeing of individual women and their families, it also benefits societies and national economies. According to the United Nation Population Fund, countries that have made special investments in health, family planning and education have slower population growth and faster economic growth than countries that have not made such investments. However, there have been significant improvements in women’s reproductive health in Minna and across the 25 Local Government Areas of Niger state.

Addressing women’s reproductive health needs, particularly in Minna and its local communities, requires strong commitments on the part of government as well as non-governmental health organizations and human right advocates. Although reproductive health issues are sensitive topics for many people in Niger state and Nigeria at large, it is important that culturally appropriate discussions of public policy. Failure to pay attention to and invest in improving health today will only result on greater health and social costs in the nearest future.

**REFERENCES**


