Kebbi's Silent Crisis: The Devastating Toll of High Maternal and Child Mortality and a Call to Action for Sustainable Healthcare Interventions

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INTRODUCTION

Despite Nigeria's national maternal health strategies and commitments to the Sustainable Development Goals (SDGs), Kebbi State continues to exhibit alarmingly high maternal and infant mortality indicators—1,077 maternal deaths per 100,000 live births and 112 infant deaths per 1,000 live births (NPC & ICF, 2019; NBS & DHS Program, 2020). These figures underscore systemic deficiencies in healthcare infrastructure, service delivery, financing, and social determinants of health. This paper utilizes the **Three Delays Model**—delays in seeking, reaching, and receiving adequate care—to structure an analysis of key drivers of poor maternal and child health outcomes in Kebbi.

The analysis integrates secondary data with primary findings from fieldwork conducted between 2015 and 2025, including focus group discussions (FGDs), stakeholder interviews, and baseline facility assessments. These multi-source insights allow for both statistical analysis and community-grounded narratives.

Delay in Seeking Care: Sociocultural and Financial Barriers

Cultural Norms and Gender Inequality

Patriarchal family structures and low female autonomy continue to restrict timely access to maternal healthcare. In FGDs conducted in Maiyama and Fakai LGAs (2024), women reported needing permission from male family members to seek care. Misconceptions about Caesarean sections and immunization further deter utilization. Low literacy rates among women exacerbate misinformation and health illiteracy.

Financial Barriers and Weak Health Insurance Coverage

Out-of-pocket expenses remain a significant barrier. Although policies exist to offer free maternal and child health services, implementation is inconsistent. Hidden costs—including medications, diagnostics, and informal fees—persist. The National Health Insurance Scheme (NHIS) and the Kebbi State Health Insurance Program (KEBSHIP) are not effectively scaled to reach informal workers in rural communities.

Delay in Reaching Care: Geographic and Security Constraints

Insecurity and Infrastructure Limitations

Insecurity in areas such as Danko-Wasagu and Zuru LGAs has hindered service accessibility. In addition, poor road conditions and lack of emergency transport infrastructure have delayed critical referrals. One woman from Sakaba LGA stated, “It took over six hours to reach the general hospital after labor pains started—we had to use a motorcycle for most of the journey.”

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Delay in Receiving Adequate Care: Health System Deficits

Inadequate Access to Skilled Care

Many PHCs and MCH facilities lack qualified physicians and are instead staffed primarily by Community Health Extension Workers (CHEWs) and nurses without adequate supervision. Only 6 of 225 PHCs in 2023 reported routine physician support (State Health Bulletin, 2024), limiting their capacity to handle obstetric and neonatal emergencies.

Decline in Preventive and Essential Services

With the 2023 withdrawal of donor funding for Intermittent Preventive Treatment (IPT) for malaria, maternal exposure to malaria has increased. Malaria during pregnancy remains a leading cause of anemia, stillbirths, and low birth weight. The state has yet to adequately compensate for this funding gap.

Donor Dependency in Nutrition and Supplies

Essential maternal and child nutrition interventions—including micronutrient powders, Vitamin A supplementation, and Ready-to-Use Therapeutic Foods (RUTF)—remain largely donor-dependent. Stockouts have become frequent due to inconsistent international support, posing sustainability risks.

Low Utilization of Skilled Delivery Services

Facility-based deliveries remain low at 21%, with only 18% attended by skilled birth professionals. Preference for Traditional Birth Attendants (TBAs) is driven by cultural trust and dissatisfaction with public health facilities. FGDs in Argungu and Arewa LGAs revealed women's perceptions of government clinics as under-resourced and disrespectful.

Governance and Coordination Failures

Kebbi's primary healthcare governance remains fragmented. Health financing is under-resourced, and reliance on vertical donor programs has delayed the integration of critical services into state systems. The 2023–2025 donor phase-out has further exposed the fragility of maternal and child health services.

Voice of the People

From May 2015 to May 2025, focus group discussions across communities and a baseline assessment of selected PHCs conducted by Royal Impact Healthcare Society (ROYAL) confirmed these systemic weaknesses. These participatory findings validate the community's lived experiences and offer a people-centered dimension to the analysis.

Comparative Indicators of Maternal and Infant Mortality

Indicator	Kebbi State	National Average	Sokoto State	Zamfara State
Infant Mortality Rate (IMR)	112 per 1,000 live births	67 per 1,000 live births	89 per 1,000	94 per 1,000
Maternal Mortality Ratio	1,077 per 100,000	512 per 100,000	1,014 per 100,000	957 per 100,000
Skilled Birth Attendance	~18%	43%	~20%	~19%
Health Facility Deliveries	~21%	39%	~22%	~20%

Sources: NDHS 2018; NPC & ICF (2019); State Health Bulletins (2023–2024); Stakeholder Interviews (2024–2025).

Global Lessons and Best Practices

Several low- and middle-income countries have successfully reduced maternal mortality by addressing delays systematically. Rwanda's national community health worker program integrates trained health agents into rural

areas, improving early referrals. India's implementation of maternal waiting homes near tertiary centers in tribal states has reduced intrapartum travel delays. Kebbi State could adapt similar innovations to its own context.

Limitations

This analysis is based on a mix of qualitative and cross-sectional quantitative data. While triangulation enhances validity, findings from selected LGAs may not fully represent statewide heterogeneity. Longitudinal research is needed to measure policy impact over time.

CONCLUSION

Kebbi's maternal and child health crisis reflects deep-rooted systemic vulnerabilities that have been exacerbated by donor withdrawal, governance fragmentation, and socio-cultural barriers. Effective response requires addressing all three delays through integrated policy, sustained investment, and community engagement.

POLICY RECOMMENDATIONS

1. **Human Resource Investment**: Scale up the training and equitable deployment of midwives and medical officers to rural PHCs.
2. **Domestic Health Financing**: Incorporate essential maternal and child health services (IPT, MNPs, RUTF) into state-funded health budgets.
3. **Insurance Expansion**: Strengthen KEBSHIP/NHIS enrolment using community-based and digital models.
4. **Women's Empowerment**: Implement large-scale girl-child education and health literacy campaigns.
5. **Infrastructure Development**: Build maternity waiting homes and rehabilitate rural access roads.
6. **Supply Chain Reform**: Establish state-led supply chains for drugs, vaccines, and nutrition commodities.
7. **Health Governance**: Create an inter-ministerial coordination platform for maternal and child health, with performance monitoring.

Appendix A: Methodology

Data were collected from multiple sources including NDHS 2018, NPC & ICF (2019), Kebbi State Health Bulletins (2023–2024), and primary fieldwork. Key informant interviews (n=24) with state health officials and providers, and FGDs (n=8 groups across the 3 Senatorial districts of Kebbi state) with women of reproductive age were conducted using semi-structured tools. Thematic analysis was performed using grounded theory principles. Ethical approval was granted by all relevant authorities.

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