COUNSELLING ASSOCIATION OF NIGERIA

CASSON

# THE COUNSELLOR

Volume 36 (1), 2017

*Supported by:*
TERTIARY EDUCATION TRUST FUND
Plot 433, Zambezi Crescent, Off Aguiyi Street, Maitama, Abuja.
Tel: 09-4139111, 4139112, 4139101

# ADDRESSING RURAL WOMEN'S HEALTH NEEDS IN NIGERIA THROUGH NON-FORMAL EDUCATION AND COUNSELLING

**By**
**Dr. Murtala Akanbi YUSUF,**
Department of Adult Education and Extension Services,
Faculty of Education and Extension Services,
Usmanu Danfodiyo University, Sokoto

**and**

**Dr. Halima Sa'adiya ABUBAKAR,**
Department of Educational Foundations,
Faculty of Education and Extension Services,
Usmanu Danfodiyo University, Sokoto

**Abstract**
*Rural women's health has long been a concern for governments, NGOS, scholars and researchers but today it has become an urgent priority. The paper argues that non-formal educators and counselors among scholars have potentials to address challenges revolving around provision of rural women's health needs in Nigeria. The paper therefore examines women health needs such as sexuality/reproductive health needs, immunization against childhood killer diseases, malaria, nutritional health and VVF. The paper also discuses challenges such as health system inadequacies, illiteracy, ignorance and poverty facing rural women in accessing available health services. The paper concludes that these challenges can be addressed if health information, community education, vocational skill acquisition, nutritional education, literacy education, maternity care education, preventive health education and counselling embedded in non-formal education and counselling are explored.*

## Introduction

Women in Nigeria constitute 49.12 percent of the national population and most of them live in the rural areas where they explore the resources of nature (National Population Commission (NPC), 2006). Yet, a significant proportion of women do not enjoy a level of health that will enable them to achieve socially and economically productive lives. Health is the main aspect of human life. Although a healthy life is the desire of everyone, the reality is that everyone is not healthy (Iyalomhe & Iyalomhe, 2012).

Women have unique health issues which are often magnified when they live in rural and remote locations. The rural women are often incapacitated by illness, disability and occupational hazards to mention a few. This reduces their efficiency for both agricultural and non-agricultural activities. High prevalence of

epidemic and endemic diseases in most rural areas further aggravates poor health and misery of rural women (ILO, 2000). Experience suggests that rural women have greater family and community responsibilities than urban women. They usually come from larger families, begin their own families earlier, have more children and play key roles in family and community. They often care for ill and disabled relatives without much support from the community, and with less access to respite care. The stresses imposed by this may cause poorer health conditions for rural women (Whittle & Williams, 2001).

However, the right to health is the most basic of all human rights. The World Health Organization (WHO) asserts that: the enjoyment of the highest attainable standard of health is a fundamental right of every human being without distinction of race, sex, religion, and political belief, economic or social condition. This means that every human being has the right to live in an environment with minimum health risk, have access to health services that can prevent or alleviate their suffering, treat diseases and help maintain and promote good health throughout the individual's life (WHO, 2004). Unfortunately, the health status of the rural women in Nigeria is very poor (Diso, 1994). This situation is unfortunate as the health of rural women is critical to the nation's food production and sustenance of families. It is in this unhealthy state of affairs that the paper examines the health needs of rural women in Nigeria with a view to suggesting how non-formal education programmes and counselling services can be explored to address the challenges of providing rural women's health needs in Nigeria.

**The Concept of Health**

As suggested by Balog (1978), three major views of health have emerged in more recent time: the traditional medical concept, the World Health Organization concept, and the ecological concept. The earliest notion of health as a disease-free state represents the traditional medical concept. This view of health was largely accepted during the first half of the twentieth century, mainly between physicians and medical personnel (Boruchovitch & Mednick, 2002). Rather than representing the presence of certain attributes, health was therefore defined solely in terms of the lack of disease, symptoms, signs or problems. The major pitfalls of this view of health were both that it conceptualized health emphasising illness, and that it neglected the individual as a whole by overemphasising specific diseases and parts of the body (Boruchovitch & Mednick, 1999).

In the late 1940's, the World Health Organization developed a more holistic concept of health as "a state of complete physical, mental and social well-being and not merely as the absence of disease or infirmity" (WHO, 1947). Rather than restricting health to an absence of illness, health was conceptualized more in terms of the presence of absolute and positive qualities. Along with that, social, psychological, physical, economic and political aspects were incorporated in the definition of health, and regarded as components of paramount importance for health and well-being (Boruchovitch & Mednick, 1999).

More ecological and relative notions of health emerged in the 1960s and1970s. These ecological and relative

definitions of health tended to be were heavily based on an evaluation of the person's level of functioning and adaptation to the environment. Within the more function-oriented perspectives, health has been defined either in terms of an adequate functional capacity which allows the individuals to carry out their duties and responsibilities (Oberteuffer, 1960), or in terms of a certain quality of life which enables individuals to live happily, successfully, fruitfully, and creatively (Hoyman, 1962).

**Women's Health**

Why focus on women and health? The issue here is that women and girls have particular health needs and that these needs must be provided. What are these needs? These are conditions that only women experience and that have negative health impacts that only women suffer. Some of these conditions, such as pregnancy and childbirth, are not in themselves diseases, but normal physiological and social processes that carry health risks and require health care. Some health challenges affect both women and men but, because they have a greater or different impact on women, they require responses that are tailored specifically to women's needs. Other conditions affect men and women more or less equally, but women face greater difficulties in getting the health care they need. Women's health matters not only to women themselves. It is also crucial to the health of the children they will bear (WHO, 2009). This underlines an important point: paying due attention to the health of girls and women today is an investment not just for the present but also for future generations. This implies addressing the health needs of women is important for the survival, growth and development of their children.

**Non-formal Education**

Non-formal education (NFE) refers to structured education that take place outside of an organized school setting (UNESCO, 2006). Non-formal education gives people the possibility to develop their values, skills and competencies others than the ones developed in the framework of formal education. Those skills (also called 'soft skills') include a wide range of competencies such as interpersonal, team, organizational and conflict management, intercultural awareness, leadership, planning, organizing, co-ordination and practical problem solving skills, teamwork, self-confidence, discipline and responsibility. What is special about non-formal education is that individuals, participants are the actors actively involved in the education/learning process. The methods that are being used aim at giving young people the tools to further develop their skills and attitudes. Learning is the ongoing process, one of its crucial features is learning by doing. Non-formal education programmes are appropriate for promoting health programmes, as they cover all out-of-school settings, such as nutrition education, public health, family planning and environmental education.

**Counselling**

Counselling denotes a professional relationship between a trained counselor and a client. This relationship is usually person-to-person, although it may sometimes involve more than two people.

It is designed to help clients to understand and clarify their views of their life space, and to learn to reach their self-determined goals through meaningful, well-informed choices and through resolution of problems of an emotional or interpersonal nature (Burks & Stefflre 1979). The term 'counselling' includes work with individuals and with relationships which may be developmental, crisis support, psychotherapeutic, guiding or problem solving. The task of counselling is to give the 'client' an opportunity to explore, discover and clarify ways of living more satisfyingly and resourcefully (BAC 1984). To Feltham and Dryden (1993) counselling is a service sought by people in distress or in some degree of confusion who wish to discuss and resolve these in a relationship which is more disciplined and confidential than friendship, and perhaps less stigmatizing than helping relationships offered in traditional medical or psychiatric settings. The import from the above definitions is that counselling services can be used to help people in addressing their problems through their active participation.

**Women's Health Needs in Rural Communities in Nigeria**

There are conditions that only women experience and whose potentially have negative impact on their health and health of their children. In this connection, Adam (2010) study's presented a picture about the health needs of rural women in Borno State, Nigeria. The study showed that the paramount health needs required by rural women were ante-natal and postnatal care; immunizations especially on the six childhood killer diseases, how to prevent and mange Vescio Virginal Fistula; how to secure safe child delivery; how to prevent and control epidemics especially cholera and meningitis which are rampant in the area. The common health needs of rural women can be summarized as follow:

**Sexuality and Reproductive Health Needs**

Women's health during the reproductive or fertile years (between the ages of 15 and 49 years) is relevant not only to women themselves, but also has an impact on the health and development of the next generation. Many of the health challenges during this period are ones that only young girls and women face. For example, complications of pregnancy and childbirth are the leading cause of death in young women aged between 15 and 19 years old in developing countries including Nigeria (WHO, 2009). The most important risk factors for death and disability in this age group in low and middle-income countries like Nigeria are lack of contraception and unsafe sex. These result in unwanted pregnancies, unsafe abortions, complications of pregnancy and childbirth, and sexually transmitted infections including HIV. Pregnancy and childbearing are particularly risky for women who suffer from malnutrition – and especially anaemia which is very common among rural populace (UNICEF, 2008). Other risk factors of growing importance include high blood pressure, high cholesterol levels, tobacco use, obesity and violence (WHO, 2009). These factors contribute to poor reproductive outcomes for both mother and infant and are direct causes of other health problems for women. The combination of biological and

social factors (including humanitarian crises) that makes women more vulnerable to HIV infection also makes them far more likely than men to have sexually transmitted infections – particularly Chlamydia and trichomonas (Glasier, 2006).

Treatable infections – such as gonorrhoea, Chlamydia, syphilis and trichomoniasis – not only give rise to acute symptoms but also provoke chronic infection. The longer-term consequences of sexually transmitted infections include infertility, ectopic pregnancy and cancers, as well as increased vulnerability to HIV infection. Sexually transmitted infections increase the risk of adverse pregnancy outcomes, including stillbirths, low-birth-weight infants, neonatal deaths and congenital syphilis (Glasier, 2006). In addition, women bear much of the stigma associated with these infections.

**Six Childhood Killer Diseases**

Immunization against six childhood killer diseases have been identified by Adam (2010) as parts of common health needs of rural women in Nigeria. This is because the health of families according to Nwagwu and Ajama (2011) is tied to the health of the women. Traditionally, women are expected to care for the health of their family members especially their children. The six childhood killer diseases are measles, tuberculosis, polimyelities, pertussis (whooping cough), diphtheria and tetanus. Immunization against these diseases has been one of the priorities of Nigerian government. Over the years women, community members, religious learners and traditional leaders have been mobilized by government and NGOs to ensure cooperation and support of households for participation in immunization against childhood killer diseases rural and urban communities in Nigeria. This further justifies the stake rural women have in caring for the health of their children. This situation no doubt shows why rural women health needs could be tied to their children. The health needs here therefore, are creating opportunities for rural women to buy the idea of immunizing children against these diseases conveniently and easily.

**Malaria**

Malaria has been identified as one of the common health issues of rural women in developing countries, Nigeria inclusive (Odeleye, 2015). Malaria is estimated to kill more than 1 million people annually, the majority of whom are young children and pregnant women. Ninety per cent of malaria cases in the world occur in Africa south of the Sahara including Nigeria. Children under 5 years of age and pregnant women are the worst affected by malaria. Malaria during pregnancy causes severe maternal illness and anaemia, and is also associated with low birth weight among newborn infants, a leading risk factor for infant mortality (UNICEF, 2000). In areas where malaria is endemic, 30 to 40 percent of women may be incapacitated by it at any time during the year (Adejare, 2001). Hence, rural women require malaria preventive and control measures to enable them get protected against malaria parasites.

**Nutritional Health Related Diseases**

Malnutrition and nutrition related diseases continue to be problems of public

health importance in Nigeria with the under-five mortality rate unacceptably high at 158 per 1,000 live births. Malnutrition is the underlying cause of 53% of these deaths (UNICEF, 2011). The 2013 Nigeria Demographic and Health Survey (NDHS) reported 37% of children under five as being stunted, 29% as underweight, and 18% as wasted. In addition to a lack of basic protein and energy, the immediate causes of undernutrition are a lack of micronutrients such as vitamin A, iodine, iron, and zinc. Almost 63% of women are anaemic and 31% are iodine deficient, while close to 30% of under-fives are vitamin A deficient (VAD) and 20% are zinc deficient. The consequences of inadequate body reserves and deficient dietary intake result in low pregnancy weight gain for birth outcome and birth weight that are well-known problems of maternal depletion. Nutritional deficiencies among pregnant rural women also make them to suffer from anemia that creates complications during childbirth and increase the risk of maternal mortality (UNICEF, 2011).

**Vesico Virginal Fistula**

Vesico Virginal Fistula (VVF) is an abnormal opening between the bladder and the virginal that results in continuous and unremitting urinary incontinence. Although the incidence of VVFs has become rare in the industrialized world, they still commonly occur in developing countries (Waaldijk, 1995). Estimates suggest that at least three million women in poor countries Nigeria inclusive have unrepaired VVFs, and that 30,000–130,000 new cases develop each year in Africa alone (Wall, 2006). Probably the most important factors contributing to the high incidence and prevalence of obstetric fistulas in Africa are socioeconomic (Thaddeus & Maine, 1994).

Early marriage, low social status for women, malnutrition, and inadequately developed social and economic infrastructures are all more common in the poor areas. Most importantly, lack of access to emergency obstetric services is ubiquitous in the rural areas where the incidence of VVF is endemic. In parts of the world where obstructed labor is a major contributor to maternal mortality, the rate of VVF might even approach the maternal death rate (Cron, 2003). This situation makes rural women vulnerable to the pain and stigma of VVF in the community.

**Challenges Facing Rural Women in Accessing Health Services in Nigeria**

Various Nigerian governments have made numerous great efforts toward the provision of healthcare facilities to its populace. Notable among these efforts were the expansion of medical education, improvement of public health care systems, provision of primary health care (PHC) in many rural areas. However, many low income countries, Nigeria inclusive, have not been able to meet the basic healthcare needs of their people, especially those in the rural areas. In Nigeria, there has been a growing recognition of the challenge of rural women's health issues and the need for it to be addressed (Hamid, Sadique, Ahmed & Molla, 2005). However, there is a huge shortage of qualified practitioners in the rural areas. Accessing health care in rural areas is confounded by problems such as

insufficient health infrastructure, the presence of chronic diseases and disabilities, socioeconomic, physical barriers, ignorance and adult illiteracy (Ricketts, 2009).

Lack of education among women undoubtedly contributes to the widespread self-neglect characteristic of many African women. They tend to be inattentive to their own illness and health needs and fail to seek care. It is for lack of education and its corollary ignorance among other factors that often make women passively accepts the conditions of life that are meted to them in the name of culture and tradition. It was on this note that Njikam (1994) concluded that the low level of education together with the fact that over 60% of the population are rural based in Nigeria that cultural norms and practices still exert a strong influence on reproductive health care especially in relation to pregnancy, delivery and child rearing. For instance, local beliefs on causation of illness, subsequent treatment and prevention often prevent timely medical intervention. Local beliefs indicate that prolonged labour is hereditary or may be just retribution for infidelity or adultery that will only abate with confession. Other issues border on ignorance or lack of education.

Economic and financial status is an important consideration in the use of health services. Most hospitals and clinics have a basic, registration and consultation fee in addition to which may be added laboratory and prescription charges. Financial considerations pose real obstacles among the low–income groups. In the traditional setting especially, a rural area, this condition may be very challenging. Sometimes, even the availability of financial power may not change the healthcare behaviour of people due to their culture of poverty (Ugal, Ushie, Ushie & Ingwu, 2012).

Poverty has been identified as one of the major causes of maternal mortality, as it prevents many women from getting proper and adequate medical attention due to their inability to afford good antenatal care (Ugal, Ushie, Ushie & Ingwu, 2012). Reproductive ill health is both a cause and consequence of poverty (Family Care International, 2005). Sexual and reproductive health problems account for approximately 20 percent of the ill-health of women globally, and 14 percent of men due to lack of appropriate sexual and reproductive health services (World Bank, 2004). These conditions have further prevented rural women to access health services where these facilities are available. The importance of women's health underscores the need to remove the barriers women face in accessing health services especially in the rural communities. This is the reason for exploring non-formal education and counselling services for meeting health needs of rural women in Nigeria.

**Non-formal Education and Counselling for Meeting Health Needs of Rural Women in Nigeria**

The ability of Non-Formal Education (NFE) and counselling to address women issues and especially in tackling rural poverty among women has been the subject of much research on NFE as a tool for social, economic and cultural development (Amedzro, 2005). Labelle (1976) as cited in Thompson (1995) avouches for viable NFE's ability to

change people and the constraining social structures while Duke (1979:8) sees NFE as the new paradigm and argues that the concept has not only come of age but that it has assumed a "central continuing strategy for development and is neither a stop gap nor a temporal second best expedient." He argues that its strategy reaches those least served by the formal system and contributes significantly to the economic, health and social advancement of the poorest of the poor.

In the same vein Jayaweera (1979) views NFE programmes as imperative for satisfying basic needs of people in developing nations especially with respect to socio-economic development. She contends, rather forcefully, that NFE is currently considered a panacea for all socio-economic problems. UNESCO (2006) contends that non-formal education programmes are appropriate for promoting health programmes, as they cover all out-of-school settings, such as nutrition education, public health, family planning and environmental education. Counselling as helping profession has potentials to give succor to women patients. Some of these programmes are examined as follows.

**Health Information**

Achieving better health of women in Nigerian rural areas must be given priority. There is need to create an enabling environment and educate rural women through regular information and communication on improved health related practices that will enhance their well-being and productivity. This can be done through health information. Health information is an important adult and non-formal education programmes. Health information according to Odeleye (2015) is a panacea for dealing with health problems, hence, information must be organized and presented so that it will motivate and encourage the rural women to use them.

**Community Education**

Community education is a form of non-formal education. It is defined by Ezimah (2004) as a process aimed at raising consciousness, spreading understanding and providing the necessary skills, including the human and material resources, for the social, economic, political and cultural development of the community. The philosophy of community education lies in the recognition of the fact that emphasis is on the immediacy of coping with the problems inhibiting community progress. This is done through citizen participation, sharing of decision making and utilization of community problems to meet the needs of community members. For example community education could be geared towards preventing locally endemic diseases and in particular for the improvement of the welfare of women so as to be conscious of what to do in health emergency cases.

**Maternity Care Education**

Maternity care is one of the women health categories and encompasses a wide range of services that span the pre-conception, pregnancy, labour and delivery, postpartum, and inter-conception periods. In addition, a wide range of maternity-related services such as prenatal care, several screening tests, alcohol and tobacco counseling, and breast feeding supports are covered in maternity care

services. The education component of these services is to encourage pregnant and nursing mothers to attend maternity clinic at regular interval and apply information, knowledge and skills gained. This can be done inform of public enlightenment on the importance of attending and accessing maternity care services to the women and their children.

**Adult Literacy Education**

Among the women health characteristics, education of women has been found to have the strongest association with regards to access and utilization of health care services. Education serves as a proxy for information, cognitive skills and values. It exerts effects on health seeking behaviours through a number of path ways. These pathways include higher level of health awareness and greater knowledge of available health services among educated women, improved ability of educated women to afford the cost of medical healthcare and their enhanced level of autonomy that results in improved ability and freedom to make health related decisions, including choice of maternal service to use (Hotchkiss, Krasovec, El-Idrissi, Eckert & Karim 2003). Creating adult literacy opportunities will afford rural women to make informed decisions on their health matters.

**Vocational Skills Acquisition**

Poverty is linked to health of women. Women who do not have enough food, poor diet, enough money to feed their children, are likely to suffer from severe consequences of their own well being ( Deaton, 2003). However, if rural women are equipped with relevant occupational skills in the vocational skills acquisition they will be economically self-dependent. This economic power will afford them opportunities to care for their health needs.

**Preventive Health Education**

Since sanitation and hygiene behaviour have significant effect on women health status, effort must be made improve the sanitation and hygiene of rural women in Nigeria. Preventive health education should be geared towards encouraging women to take proper care of their surroundings and imbibe good personal hygiene. Preventive measures like cutting down bushes around houses, washing of plates regularly, washing of hands before and after meal, taking bath regularly, avoiding self-medication and use of mosquito net will go a long way to keep women in good health condition.

**Counselling**

The pain and stigma attached to fistula patient requires that victim should be given pre and post-operative counseling in order to provide valuable help for the fistula patient. Counselling as a helping profession can help fistula patients to take rational control over feelings and actions and a positive attitude towards self, marked by an ability to acknowledge areas of experience that had been the subject of self-criticism and rejection. Counselling service of this type can help the patient to regain self-confidence she has lost as a result of stigmatization.

**Conclusion**

This paper reviews evidences on the health issues that particularly affect

women in rural areas in Nigeria which have prevented many rural women to reach their full potential. The major health needs of women in rural areas include sexuality/reproductive health, immunization against six childhood killer diseases, malaria, VVF, nutritional health among others. Unfortunately, rural women are unable to access the available health services to meet these needs due to social and gender inequalities and health system inadequacies, illiteracy, ignorance and poverty among others. These challenges must be addressed in order to provide rural women with their health needs. It is hope that exploration of non-formal education programmes and counselling will go a long way to address the health needs of rural women in Nigeria.

**References**


Adejare, T. G. (2001). *Health problems of women cassava processors in Oluyole Local Government area.*" M.sc Thesis, Department of Agricultural Extension and Rural Department. University of Ibadan, Ibadan.

British Association for Counselling (BAC) (1984). *Code of ethics and practice for counselors*. Kugby: BAC

Burks, H.M. & Stefflre, B. (1979). *Theories of counseling*. New York: McGraw Hill.

Adam, G.S. (2009). Information needs and information seeking behavior of rural women in Borno State, Nigeria. *Nigeria Library Philosophy and Practice*, 1(2), 23-30

Amedzro, A.D.K. (2005). *Globalization, non-formal education and rural development*. Accra: Ghana Universities Press.

Balog, J. E. (1978). *An historical review and philosophical analysis of alternative concepts of health and their relationship to health education* (Unpublished dissertation). Maryland: University of Maryland.

Boruchovitch, E. & Mednick, B. R. (1999). Causal attributions in Brazilian children reasoning about health and illness. *Revista de Saúde Pública*, 35 (5), 484-90.

Cron, J. (2003). Lessons from the developing world: Obstructed labor and the vesico-vaginal fistula. *Medscape Gen Med* 5(3), 56-67

Deaton, A.S. (2003). Inequalities in income, *A Health NBER Working Paper* No. 7141, Chicago: University of Chicago Press, 285-313.

Disco, L.I. (1994). Information policies and government guidance in Nigeria: What hope for communities? *Resource Sharing and Information Networks*, 9(2)141-151.

Duke, C. (1979). Non-formal education conference. Coordination at local, national and international levels. *Convergence, 8 (*3), 8-20.

Ezimah, M.O.A. (2004). *Knowing adult education: Its nature, scope and processes*. Owerri: Springfield Publishers Ltd.

Family Care International (2005). Millennium development goals and sexual and reproductive health. New York: Briefing Cards.

Federal Ministry of Health (FMOH) Nigeria. (1988).The national health policy and strategy to achieve health for all.

Feltham, C., & Dryden, W. (1993). Dictionary of counselling. London: Whurr Publishers Ltd.

Glasier, A. (2006). Sexual and reproductive health: a matter of life and death. *Lancet*, 368,1595–1607

Hamid, S.A., Sadique, Z., Ahmed, S. & Molla, A.A. (2005). Determinants of choice of healthcare providers: Evidence from selected rural areas of Bangladesh. *Pakistan Journal Social. Science*, 3(3), 437-444

Hotchkiss, D. R, Krasovec, K., El-Idrissi M. D. Z., Eckert, E., Karim, A. M. (2003). *The role of user charges and structural attributes of quality on the use of maternal health services in Morocco*. Chapel Hill: Measure Evaluation

Hoyman, H. (1962). Our modern concept of health. *Journal of School Health*, 32, 253.

ILO (International Labor Organization). 2000. Safety and health in agriculture. Retrieved July 26, 2016 (http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/safework/documents/publication/wcms_110193.pdf)

Iyalomhe, G.B.S. &. Iyalomhe, S.I. (2012). Health-seeking behavior of rural dwellers in Southern Nigeria: Implications for healthcare professionals. *International Journal of Tropical Disease & Healt,. 2(2): 62-71*

Jaraweera, S. (1979). Programmes of non-formal education for women. *Convergence 12 (3)* 21-31

Njikam, M. (1994). The management of maternal services in Africa: The socio economic and cultural environment in contemporary issues, maternal health care in Africa, B. T. Nasah, J. K. Mate, J. M. Kasonde (eds), Harwood: Academic Publishers

NPC. (2006). *Legal notice of publication of 2006 census final result*. Federal Capital Territory Abuja: Federal Republic of Nigeria

Nwgwu, W.E. & Ajama, M. (2011). Women's health information needs and information sources: A study of a rural oilpalm business community in South-Western Nigeria. *Annals of Library and Information Studies*, 58, 270-281

Oberteuffer, D. (1960). *School health education*. 3rd Ed. New York: Harper and Brothers.

Odeleye, T.G. (2015). An overview of health and occupational hazards of rural women in Nigeria. *Journal of Rural Social Sciences*, 30(1), 51–61.

Onokerhoraye, A.G. (1999). Access and utilization of modern health care facilities in the petroleum producing region of Nigeria: The case of Bayelsa State. Research Paper No. 162. Takemi Program in International Health Harvard School of Public Health.

Ricketts, T.C. (2009). *Rural health in the United States*. New York: Oxford University Press.

Thaddeus, S. & Maine, D. (1994). Too far to walk: maternal mortality in context. *Social Science Medical*, 38, 1091–1110.

Thompson, J. D. E. (1995). Curriculum development in NFE. Nairobi, Kenya: *African Association for Literacy and Adult Education*

Ugal, DB., Ushie, BA., Ushie, M.A. and Ingwu, JA. (2012). Utilisation of facilities and maternal health outcome among urban dwellers of Obudu and Ogoja Local Government Areas of Cross River State, Nigeria. *Afro Asian Journal of Social Sciences*, 3(3).

UNICEF (2000). *The global malaria burden*. New York: UNICEF

Waaldijk, K. (1995). Surgical classification of obstetric fistulas. *International Journal Gynecology Obstetrics*, 49, 161–163

Wall L. L. (2006). Obstetric vesicovaginal fistula as an international public-health problem. *Lancet*. 368:1201–1209

WHO (1947). *Chronical of WHO*, 1, 1-2.

WHO (2004). Communicable and maternal diseases. *The World Health Report*. Retrieved July 4, 2016 (www.who.int/whr/2004/.../annex_2_en.p...)

WHO (2009). *Women and health: Today's evidence tomorrow's agenda*. Geneva: WHO

World Bank ( 2004). *The global burden of diseases: 2004 Update*. Retrieved July 4, 2016 (www.who.int/.../global_burden_diseases/2004_report)