APPROACHES FOR EFFECTIVE TEACHING AND LEARNING OF ANTENATAL HEALTH LITERACY EDUCATION FOR SAFE MOTHERHOOD IN ALAGBAAGBA MATERNITY CENTREIN IGBOORA, OYO STATE, NIGERIA

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Abstract

Antenatal health literacy education has the potential of boosting the health knowledge and development of rural pregnant mothers particularly at Alagbaagba area of Igboorain Ibarapa Central Local Government Area of Oyo State, Nigeria. It can also boost other forms of societal development including the health grow and economic development of a nation like Nigeria. This paper filtered and refined the problems from literatures for experimental verifications so as to provide adequate and connect approaches and relevant discussions that can boost the health growth, safe the mothers, during pregnancy and combat maternal mortality and morbidity. A meaningful and applied ante-natal health literacy education programme was recommended to assist and the wellness of rural pregnancy mothers in all the rural areas of developing nations, Nigeria inclusive.

Introduction

It is highly conspicuous in the development plan of many developed and developing nations across the Earth planet in the pursuit of vital ante-natal health literacy education as an imperative effect for achieving prosperity and advancement particularly in the rural areas of Nigeria. The advancement and prosperity of the rural pregnant mothers gives serious concerns. Thus, antenatal health literacy education programmes have now became so popular that the wealth and popularity of a nation rests permanently on its level of health development (UNICEF, 2016).

Gracefully, it has now been clearly observed and recognised that without ante-natal health literacy education programme among the sizeable portion of the rural pregnant mothers in our society, the introduction of modern health literacy education which is behind to be one major innovation for achieving modern day health literacy in all ramifications is made exceedingly rough, bad and difficult particularly in the third world countries, Nigeria inclusive (Abdulrahman, 2021).

In order to produce a healthy literate rural pregnant mothers and societiesthe new moves, trends, needs and collective endeavours in the contemporary world is to integrate teaching and learning process of ante-natal health education at all levels of educational programmes in Nigeria, be it formal, informal and non-formal education.

The Making of Safe Motherhood

Around the world, people celebrate the birth of a new baby. Societies expect women to bear children and honour women for their role as mothers. Yet in most of the world's pregnancy and childbirth, is in perilous journey. In developing nations of the Earth planet, more than 500,000 mothers die from causes related to this life-giving event each year (procreation). For many women,

motherhood spans several decades. The period when mothers are most at risk of death, however, is during pregnancy, delivery and the 42 day period following childbirth.

Evidence in every ramification shows that motherhood can be safer to all women (Ajuwon, 2007). Over the past decades, experts have largely come to agree on a set of lifesaving strategies that can work even in low-resource settings like Nigeria (Abonzahar, 2016). Governments across the world have signed international Conventions that advocate significant reductions in material mortality and morbidity (Jerker, 2010). In 2000 however, the United Nations General Assembly, acknowledged that despite progress in some countries, rates of maternal mortality and morbidity remain unacceptably high in most countries (Safe Motherhood, 2010).

Maternity mortality is a major problem in developing countries where it essentially represents a developmental issue. It is a multi-system failure and a major occupational hazard for women in developing nations of the World. The number of death is considered a tip of the iceberg, as 25 women are believed to suffer various forms of reproductive ill- health for every one that dies.

Integration of Ante-natal Education

Integration of ante-natal health education to all forms of education is not anew affair. In fact, it is the bedrock on which ante-natal care and education as an adult component is based. Attempts to integrate this component in Nigeria in 1994 majorly at the Cairo consensus of September 13, 1994of the International Conference in Population and Development (ICPD), 184 governments reached anunprecedented consensus on a new 20 year programme of action to achieve a balance between the world's people and its resources.

This remarkable plan broadens our understanding of population by integrating population related and development policies. This transformation in the meaning of population was done in large part to the significant influence exerted by non-governmental organization (NGOs) especially women group fromall over the world.

The Goals and Objectives of Antenatal Health Literacy Education in Nigeria include

1. Stressing the fundamental unity of ante-natal health literacy education.
2. Producing ante-natal health literacy education course relevant to the pregnant mothers' needs and experiences.
3. Laying adequate foundations for ante-natal health literacy education.
4. Stressing the use of ante-natal health literacy education method as a common approach in solving the problem of maternal mortality and morbidity.
5. Providing cultural dimension to ante-natal health literacy education.
6. Stressing the functions of ante-natal health literacy education in everyday task of the rural pregnant mothers.
7. Preparing the pregnant mothers for useful living during the pregnancy, (ante-natal) and self-reliance of the pregnant mothers within the rural society).

Analysis of the stated seven cardinal goals and objectives and indeed beautiful and robust national or societal ideals for healthful living, growth and development as well as for national development.

The goals and objectives are not and cannot be actualised so easily with mere mentioning. Lot of efforts is needed by all and sundry to make them a reality. These efforts

are not being offered by majority of our rural pregnant mothers. This is because ante-natal health literacy education is not adequately contributing to the health development of the rural pregnant mothers in our various localities in Nigeria.

Inhibitors are:

1. Poor implementations of ante-natal health literacy education goals and objectives.
2. Lack/low of awareness of ante-natal health literacy education at ourvarious rural villages concerning ante natal health literacy education
3. Under-rating of ante-natal health literacy education by rural pregnant mothers.
4. Failures of health literacy education workers to relate ante-natal-healthliteracy education to real-life situation of the pregnant mothers.
5. Numerous theoretical experts to the detriment of very few practical professionals.

These aforementioned inhibitors are cog in the wheel of attaining healthfulgrowth, ante-natal health and development of the rural pregnant mothers in Nigeria. The rural areas of Nigeria of today are characterized by numerous vices like poverty, diseases, superstition, intolerance and host of other areas that inhibit rural pregnant mothers.

Truthfully, most Nigerian women of reproductive age (pregnant mothers) are illiterates despite the laudable goals and objectives of ante-natal health literacy education. Hence Nigeria's poor health and complications during pregnancy is great.

With all these attempts to clarify the terms, concepts and adequate background information, this paper now relates in order to identify and discuss full approaches that can possibly ameliorate the impediments facing the integration of ante-natal health literacy education to boost the potentials of the rural pregnant mothers at Alagbaagba area of Igboora in Ibarapa Central Local Government area of Oyo State, Nigeria.

Hypotheses

The following four hypotheses were generated in connection with the study.

1. Policies, goals and objectives of ante-natal health literacy education courses are not being implemented to attain the desired safety of the ruralpregnant mothers.
2. Ante-natal health literacy education teaching and learning are not integrated but disintegrated.
3. There is isolation or underrating of ante-natal health literacy education by rural pregnant mother.
4. Failure of health literacy educators and Service providers to relate it to practical ante-natal literacy to real life structures (ICPD, 2015).

Population, Sample and Sampling Techniques

The target population for this paper is made up of the health service providers doctors, Community Health Extension Workers (CHEWS) and the learner (the rural pregnant mothers) of maternity centres and hospitals at Alagbaagba area of Oke-Iserin Igbo ora in Ibarapa Central Local of Oyo State, Nigeria. In all a total of (800) eight hundred respondents were used. This comprises of five hundred pregnant mothers and 300 health service providers.

Instrument

A simple, self-designed four point Likert Scale was designed by the researcher and validated by five experienced health literacy; ante-natal health service provides at our various maternity centres and hospitals in general hospital, Igbo- ora. Respondents were

requested to pick the appropriate responses. The first item was trial-tested by administering it to ten health literacyservice providers (the nurses, the mid-wivery medical doctors and community health extension workers (CHEWS) and twenty five rural pregnant mother in Alagbaagba area of Oke-Iserin, Igboora in Ibarapa Central Local Government of Oyo State. It was re-administered thrice at two weeks interval. A correlation co- efficient of 0.68 was obtained when the data obtained from test-trial was subjected to Pearson Product Correlation Coefficient formula statistics. This conforms the validity of the instrument.

Data Analysis

To test the hypothesis raised in this paper, the responses in the questionnaire Strongly Agree (SA); Agreed (A); Disagreed (D) and Strongly Disagreed (SD) were assigned 4,3,2,1 points respectively. Degree of responses was determined by the value of means as follows: mean less than 2.00 (1.0 < x 1.99), disagreed mean between 2.00 and 4(2.00 < x 4.00), agreed. To determine whether level of status of the respondents influenced their responses, the data was subjected to t-test statistics.

Result: The analysis data was presented in Table 1 and 2

Table 1: Responses on approaches for teaching and learning of integrated ante-natal health literacy education for safe-motherhood development

S/N	Options	SA	A	D	SD	x	P
1.	Non-implementation of ante-natal health literacy educationpolicies and objectives	520	155	80	45	3.00	Agreed
2.	Non-integration of ante-natalhealth literacy education at maternity centres and hospitals	680	120	00	00	3.70	Agreed
3.	Isolator/underrating of ante- natal health literacy educationprogramme	325	455	15	05	2.90	Agreed
4.	Failures to relate practical ante-natal health literacy educationto real life	390	350	40	20	2.96	Agreed

Table 2: T-test showing influence of level of status in responses to approaches for teaching and learning of ante-natal health literacy education for safe motherhood

Variable	N	x	SD	S2	Df	t-cal	t.table	P
Learners	500	2.97	2.03	412	398	2.57	1.96	Agreed
Experts	300	3.15	1.65	2.72				

Findings

Table 1 showed that will the respondents agreed that the inhibitors raised are really affecting the teaching and learning of ante-natal health literacy education for safe motherhood. The table also showed that non-integration of ante-natal health literacy education at maternity centres and hospitals has the highest means (3.70) value while isolation/underrating of ante-natal health literacy, education has the lowest mean (2.90). Thus all the four generatedhypotheses were accepted (i.e. agreed).

Table 2 Revealed that the mean value recorded be the (learners) the rural pregnant mothers (2.97) is lower than that of the health service providers (3.15). This means that experts of health service providers (the medical doctors, nurses, midwives and community health extension workers (CHEWS) are all versed in the content components and curriculum of the ante-natal health literacy education programme than the pregnant mothers. The table also showed that level or status of the rural pregnant mothers has little influence on the responses since t-calculate 2.57 are greater than t-table (1.96) at 0.05 level of significance. This also verifies the acceptance of all the generated hypotheses. Hence, ante-natal health literacy education policies (Alma Ata Declarations) and stated objectives must be properly implemented, efforts should be made to integrate some components of ante-natal health literacy education must be properly organised and implemented, efforts should be geared to integrate some components (nutrition or maternal diet, hygiene immunization exercises, environmental sanitation etc).

Discussion and Strategy

With references to the results received from the findings of the study, the encouraging policies and objectives of integrated ante-natal health literacy education are not being implemented to attain the high standard and desire safe motherhood practices of the mothers during procreation. All forms of education – formal, informal and non-formal education should prepare rural pregnant mothers particularly during pregnancy, childbirth and after (ante-natal and post-natal education).

Thus, if the policies and objectives of ante-natal health literacy education are properly followed closely monitored and fully implemented, mothers will be prevented from the needless death.

Apart from this policy implementation, ante-natal health literacy education must be integrated to all forms of education. The need to integrate ante-natal health literacy education and learning to other areas of learning should be in new task for the ante-natal health literacy education curriculum developers. On analysis, forms of education (formal, informal and non-formal education). Also, at this level, pregnant mothers should imbibe the culture of learning particularly at this period of pregnancy.

Moreover, ante-natal health literacy education which h is isolated in private maternity centres and hospitals should not be isolated. There should be a general consensus on the ways and manner of teaching all the seven areas of ante-natal health literacy education (maternal diet, or nutrition, the teaching of immunisation, personal hygiene, environmental sanitation, exercises, and education in basic medicines among others. With this area, learning will be able to appreciate that their success of giving birth in life and ability to transform theirknowledge into practical values will dictate their rate of survival and safe delivery.

Emphasis should therefore be shifted away from theoretical to practical teaching. The use of audio-visual must be encouraged.

Conclusion and Recommendation

For the ante-natal health literacy education to remain viable, virile for the safety of the mothers during pregnancy and at childbirth, it must meet thechallenges of changing environments (Okedeji, 2010). The health conditions of the present day environment does not depend only in one form of education. Therural pregnant women in general and ante-natal health literacy education specifically must earnest all the practical possibilities with the intent to acquire necessary skills to create a subtle learning to supplement for better delivery afternine months.

It is when all the components of education and the seven cardinal areas such as maternal diet or nutrition, personal hygiene, sanitation immunization, exercise, medications and so on are harnessed and practiced by the health service providers for more earnings that one relevant and proper safemotherhood will be attained in Nigeria rural areas. Therefore, to achieve safe motherhood among the rural pregnant mothers health literacy education must be compulsory for all women of reproductive age to avoid the complications during and after delivery and to combat the maternal and mortality in Nigeria.

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