

ACCESS TO SAFE AND EQUITABLE REPRODUCTIVE HEALTHCARE FOR COMMUNITY WOMEN OF REPRODUCTIVE AGE IN NIGERIA

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Abstract

Safe and equitable reproductive healthcare is essential for the health, autonomy, and well-being of women of reproductive age. Reproductive health services such as family planning, antenatal and postnatal care, prevention and treatment of sexually transmitted infections, safe abortion services where legal, and reproductive health education play a vital role in reducing maternal morbidity and mortality and promoting gender equality. Despite global and national commitments to improving reproductive health outcomes, many women at the community level continue to experience unequal access to these essential services. This study critically examines access to reproductive healthcare by exploring the range of available services, the determinants that influence access, the barriers that persist, and possible strategies to improve service utilisation. Access to reproductive healthcare is influenced by several factors, including socioeconomic status, level of education, place of residence (rural or urban), health system capacity, cultural norms, gender relations, and policy environments. Major barriers include financial costs, long distances to health facilities, inadequate infrastructure, stigma and concerns about confidentiality, limited decision-making power among women, and negative attitudes from healthcare providers. These challenges often cause women to delay or avoid seeking necessary care. The Health Belief Model (HBM) provides the theoretical framework for this study by explaining how individual beliefs and perceptions influence healthcare-seeking behaviour. Key components of the model are perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy help explain differences in the use or non-use of reproductive health services. These beliefs are shaped by broader social and health system contexts. Overall, improving access to safe and equitable reproductive healthcare requires a comprehensive and multi-level approach. Governments and health authorities should strengthen primary healthcare systems by providing adequate human resources, essential reproductive health commodities, and quality services, particularly in underserved communities, to enhance women's health outcomes and well-being.

Keywords: Reproductive Health Services, Access to Healthcare, Reproductive Health Equity and Women of Reproductive Age, Nigeria

Introduction

Reproductive health (RH) is an essential component of human health and well-being and is contextualised within human rights. The right to make decisions about one's own body and reproductive health is vital for individuals to live healthy, full lives, and people across the world are subjected to trivial access to safe and fair reproductive healthcare services, such as contraception, safe abortion, and maternal healthcare. Traditionally, RH is an underappreciated driver of women's economic agency (Mishra & Sahoo, 2025). Access to quality reproductive health care (RHC) not only promotes a woman's physical and mental well-being, but also improves her ability to make informed decisions about life, access to education, and economic participation. RH is thus foregrounded not simply as a health concern but as a development and empowerment imperative (Mishra & Sahoo, 2025). Enhancing access for women RHC acts across subjective, economic, intergenerational layers. First, it improves the health and well-being of women themselves through declines in adolescent fertility and maternal mortality (Canning & Schultz, 2012). Use of contraception has also been associated with increased agency among women, delaying age at marriage, and avoiding unwanted pregnancies and sexually transmitted infections (STIs) (Finlay & Lee, 2018), and investing in women's RH has big payoffs for the economy. It reduces gender inequality and may increase world Gross Domestic Product (GDP) by as much as \$1 trillion by 2040 (Perez *et al.*, 2024). Better RH enables women to finish their education (Goldin & Katz, 2002), increases their labour market participation and productivity (Onarheim *et al.*, 2016) and helps to reduce poverty (Canning & Schultz, 2012).

According to Ajakaiye and Mwabu (2010), the labour and product market are affected by RH, economic growth and poverty reduction. The advantages of RHC are multigenerational. Postpartum family planning (PPFP) is effective in reducing unintended pregnancies after childbirth, promoting healthy birth spacing, and decreasing unmet need for family planning. Right to reproductive health services (RHS) is a human right. The high maternal mortality ratio (MMR) in Africa would be reduced by improving access to RHS for women of reproductive age (World Health Organisation (WHO), 2024). Research revealed that RHC in many African countries is inaccessible, contributing significantly to certain maternal deaths of 69 % world-wide in Africa (Dahab, & Sakellariou 2020; Ogundele, Pavlova & Groot, 2020). Furthermore, the reproductive healthcare-seeking behaviour of women in fertility age was also influenced by the distance of health facility (Kifley *et al.*, 2017). Improving access to reproductive health care could potentially play a pivotal role in the global pursuit of the 2030 Sustainable Development Goals (SDG) maternal mortality ratio (MMR) target of 70 per 100,000 live births in developing nations (WHO, 2024). Women's rights, their well-being and socio-economic development are dependent on their reproductive health. Yet despite the advantages, access to reproductive health services is still very uneven in the world. Women from developing countries are 33 times more likely to die from maternal causes than their counterparts in developed countries (WHO, 2015), and 218 million women in low- and middle-income countries continue to have an unmet need for modern contraception (Sully *et al.*, 2020). Even with worldwide progress in RHC, the women in many communities continue to experience systemic barriers related to social and economic determinants of health that limit their ability to access safe and equitable services for RH, access to safe and equitable RHC remains the exception rather than the rule, particularly for rural women in their childbearing years. Ongoing challenges such as poor healthcare infrastructure, socioeconomic disparities, and scarcity of vital RHS are leading to adverse health results including elevated maternal mortality as well as limited involvement in the economy. Since RH, women's empowerment, economic growth, and intergenerational well-being are so closely interrelated, it is

a public health and development imperative that these gaps be addressed. Given the enduring difficulties in reproductive health services (RHS) particularly for community women of reproductive age, it is paramount to assess the availability of safe and fair RHS. Global pledges to enhance maternal and reproductive health outcomes often did not consider the widening inequities in access, quality of care, cost-effectiveness of services, and awareness among the women, particularly in under-served regions. It is against this backdrop that the study is based on the need to interrogate access to RHC as a means of showing that promoting fair, accessible and quality RHS delivery will change the lives of women and their communities. Thus, this study aims to: (1) analyse the extent of access to reproductive healthcare among community women of reproductive age, (2) explore the socio-economic and structural barriers that impede such access, and (3) review the possible solutions for a greater access to reproductive healthcare. In essence, the study attempts to demonstrate that strengthening reproductive healthcare systems would enhance maternal health and contribute to the realisation of the global health and development agenda.

Literature Review

Reproductive Health: Concept

Development lies in the promotion of women's health and life especially reproductive life (Omokhabi, 2016). In contemporary article, scholars testified that it is the United Nations traditional position that reproductive health is an integral part of general health and well-being and that it is an enabling condition for social, economic and human development and that FP, sex and maternal health are all parts of reproductive health (Akanbi *et al*, 2024). Women's engagement in these health-oriented processes, and their very activity, depends on them being physically and mentally well. Infertility and sexual dysfunction prevention and treatment in both men and women, safe motherhood (prenatal care), safe delivery, essential obstetric and newborn care, postpartum care, breastfeeding, and prevention and treatment of reproductive tract infections, with a special focus on Sexually Transmitted Infections including Human Immunodeficiency /Virus) (HIV) Infections and Acquired Immune Deficiency Syndrome (AIDS) are the elements of reproductive health (Omokhabi,2014). Menstruation, menarche, fertility, pregnancy, childbirth, gynaecological problems, cancer, STDs, sex, sexuality and sexual health and performance are all important components of women and girls' reproductive health (Omokhabi,2024). There has been progress in safeguarding and enhancing women's health, particularly RH, Omokhabi (2016) stated that women need to be physically and mentally healthy in order to perform such health-related activities.

Overview of Reproductive Health Services

Services related to RH care are among the most frequently utilised health care services by women of reproductive age, and the availability of such services is essential for public health. Postponing or not obtaining RHC can lead to illness and, in cases like untreated STIs, an elevated risk for severe complications, including infertility and pelvic inflammatory disease. More generally, access to desired RHC, such as provision of contraception and abortion, enables people to exercise their bodily autonomy and decide if, when, and/or how to have children, and this can contribute to better well-being and quality of life (Okorafor *et al*, 2024)

Family Planning: Contraception and Fertility Management.

Access to contraception is an essential component of the right to decide the number and spacing of children, free of discrimination, coercion or violence. It also offers significant health advantages by avoiding unplanned pregnancies and the associated risks to health. There are many options for contraception to help prevent unintended pregnancy, including short-term (reversible) and long-term options. Condoms are the only method of contraception that can also protect against

pregnancy and sexually transmitted infections (STIs), such as Human immunodeficiency virus (HIV) (WHO,2025) .Worldwide, among the 1.9 billion women of reproductive age (15–49 years) in 2021, 1.1 billion of them have family planning needs; 874 million of them are using modern contraceptive methods and 164 million have unmet need for contraception (United Nations Department of Economic and Social Affairs, Population Division,2022).Family planning is an essential service that has the potential to avert 90% of abortions, 32% of maternal deaths, 20% of pregnancy-related illness, and can reduce maternal mortality by 44% in developing countries (Lovita *et al.*, 2018).The Federal Ministry of Health (FMOH) (2011) has introduced a myriad of interventions to curb maternal mortality, among which has been the abandonment of the practice of family planning services at all levels of the health care. FP methods may be classified into two types: modern and traditional (Maria Paz, Maria Midea and Elma, 2017 in Omokhabi,2020). Traditional contraceptive methods are withdrawal, rhythm and cycle methods (Mosha, Mгимwa and Msuya 2017), and modern contraceptives are the oral contraceptives, intrauterine devices (IUDs), female and male sterilisation, injections, condoms and the diaphragm (United Nations, Department of Economic and Social Affairs, Population Division; 2015).

Access to FP is part of the right to benefit from science, which enables people to make well-informed decisions relating to sexual and reproductive health (SRH).It makes important contributions to broader development objectives by advancing health, gender equality and access to education and economic opportunity, and these are contributions that map directly on to SDG 3.7, which includes a target on universal access to SRH care, including FP (WHO, 2026). RH and FP have long been two of the most prominent themes in mainstream media advertisements particularly in the third world countries (Omokhabi, & Egunyomi,2016). Usage of contraception among women in the world has increased substantially. The number of female users of these methods has increased from 663 million to 851 million over the past 20 years. (United Nations Contraceptive Use by Method, 2019) and it is estimated that 70 million more women will use contraception by 2030 with the expansion of access. In a study in 2024, female workers tend to have positive reproductive health practices, especially with regard to adoption of family planning measures to avoid unintended pregnancies at present use FP methods, have discussions with their spouse on family planning issues, decide on family planning as a couple, use family planning while breastfeeding as a means of not becoming pregnant again immediately, space pregnancies, ensure safe sex with spouse and have conception time. (Olunubi *et al.*, 2024). The right for women to choose if and when to reproduce, have access to full, accurate information, and select their method of contraception are essential to the life and health of women and their families (Ogedegbe *et al.*, 2025)

Maternal Healthcare: Antenatal, Delivery and Postnatal Care.

Maternal health, a crucial element of global health, is defined as the physical, emotional, and social well-being in all aspects of the reproductive system during pregnancy, childbirth and postpartum (WHO,2016). Maternal health is one of the service components under the PHC (primary health care) services that offers needed services information through the continuum of care in the prepartum/antenatal, intrapartum/delivery and postpartum/postnatal stages that includes delivering mother and baby friendly good quality care. Premarital services focus on identifying and avoiding possible pregnancy and childbirth issues. Women's healthcare services which are curative as well as preventive play a critical role in their survival during the reproductive age, lack of it coupled with poor utilisation due to low consciousness about their rights, lack of infrastructure and skilled provider, are major factors contributing to high maternal mortality ratio in developing countries (Oluwole *et al.*,2025). Maternal health services (MHS) comprising of maternal health

care are antenatal care, care during labour and delivery, and postnatal care which provide essential health services to women from the time they become mothers to approximately 42 days postpartum in an effort to save the lives of mothers and their babies (Okpala *et al.*,2019). MHS consists of antenatal care (ANC), delivery care (DC) and postnatal care (PNC) services (Onuh *et al.*, 2024).

Care in the prenatal period also called antenatal or prenatal care, is the healthcare rendered to pregnant women during their pregnancy period. In the best-case scenario, quality prenatal care includes tests that enable providers to detect the risks of pregnancy and complications of birth. It is the provision of general information on health to pregnant women, on proper nutrition during pregnancy, post pregnancy hygiene, and to identify any pre-existing diseases that may possibly cause complications (WHO, 2019). Prenatal talks also inform women to quit smoking or abusing alcohol, both of which are harmful to unborn children and can limit their growth both before and after delivery (Martinson & Reichman, 2016).ANC is the monitoring of a normal, healthy pregnancy and the care of early stage pregnant women, who have no medical or obstetric complications, aimed at detecting maternal and fetal distress (WHO,2020; Bolarinwa *et al.*, 2021).The ingredients include nutritional advice and multiple micronutrient supplement, usual scheduled visit for regular provider, laboratory testing of blood and urine, administration of tetanus toxoid and antimalarial prophylaxis, health education for pregnant women and family members on pregnancy and birth risk signs (WHO,2018) It is now universally recognised that pregnant women should begin ANC no later than the first trimesters of pregnancy and attend almost 8 total ANC contacts (Ajegbile,2023) .This means that women who are considered to be at risk have been screened and are being watched over during their pregnancy. The pregnant women are also informed on various issues relating to pregnancy that they be able to have a healthier pregnancy and outcome (Ademuyiwa *et al.*, 2020). Therefore, those women who do not receive the above services during pregnancy are highly vulnerable to severe obstetric and medical sequelae for both themselves and their infants.

Intrapartum care (or delivery) care, the second component of MHS, is the health service given to a woman during labour. This care has a strong focus on the woman delivering her child in the presence of skilled birth attendants in a safe and clean environment, following safe and clean delivery practices, considering umbilical cord care (clean cut and cloth tied to the cord), and adhering to the best practices of sterile materials used for tools and instruments. Good DC is respectful care; there is effective communication between the women and health workers; a companion is allowed during labour and birth; birth in a health facility attended to by skilled personnel; appropriate pain relief is provided; women are encouraged to be mobile in labour where possible and to select their birth position; uterotonics are used and cord clamping is delayed (for a minute); immediate care and breastfeeding are promoted; bathing of the newborn is delayed (for 24 hours); and mothers and their newborns receive care in a health facility for at least 24 hours following birth (National Institute for Health and Care Excellence (NICE), 2023).Thus laying the groundwork of safe puerperium for the mothers and an excellent neonatal encounter by the newborn.

Postnatal care is the third module of MHS. Postnatal Care is the care given to the mother and her newborn within less than 24 hours of birth, followed by at least three additional post-natal contacts for home- or facility-based care within six weeks (42 days) of birth, to the mother and the newborn, including home visits during the first week after birth, optimal breastfeeding, cord care, mother's use of prophylactic antibiotics, and health education on maternal and newborn health danger signs (WHO,2013). Postnatal care is the care provided to a mother for the first six weeks after delivery.

This advice is important for the new mother because of the mood alteration and psychological changes immediately following delivery (Ataguba, 2018). PNC is also important for the mother and infant, since it helps some of the physiological changes that happened to the mother during pregnancy and delivery to reverse and it aids in the identification of any other abnormalities which may have developed in this time. The proper PNC care is the priority to successfully decreasing maternal and neonatal mortality. This service gives the mother the possibility to access on the one side education in healthy behaviours that are important for the survival of the mother and child (instructions regarding hygienic delivery practices, care of the umbilical cord, early and exclusive breastfeeding practices, thermal care, special attention to low birth weight or preterm delivery, immunisation, use of family planning) (McNellan *et al.*, 2019) and, with regard to treatment, mothers may receive care for health problems (postpartum haemorrhage, infection/genital tract sepsis and pre-eclampsia/eclampsia) that are detectable during the postnatal period and babies may be treated for jaundice, thrush, and sepsis (Ilesanmi *et al.*, 2023).

Sexual Health Services: STI Prevention, Treatment, and Education.

Infections transmitted via sexual contact are known as the STIs or Sexually transmitted diseases. The contact is mainly vaginal, oral, and anal sex (Allen, Sherrod, & Williams, 2017). Sexual activity was known to transfer more than 30 types of bacteria, viruses, and parasites. Eight of these are correlated with the highest rates of STIs. Among these eight infections, four are curable today: syphilis, gonorrhoea, chlamydia and trichomoniasis, 4 others cause chronic, incurable diseases: hepatitis B, herpes simplex virus (HSV or herpes), HIV, and human papillomavirus (HPV) (WHO, 2025). Diseases or symptoms resulting from an incurable infection may be alleviated or reversed by treatment (WHO, 2016). STIs have been considered a major public health concern since their origin especially in the developing countries (Amin *et al.*, 2021). Upwards of 1 million people are afflicted with STIs every day (WHO, 2021). Contributing reasons for unknown fact that epidemiology of STIs was not known in the developing world include poverty, cultural and social (discrimination) and lack of diagnostic facilities (Abebe, Eshetie & Tessema, 2021). Apart from the impact of the infection itself, STIs may have harmful consequences. For example, transmission of STIs from mother to infant can cause stillbirth, preterm birth, sepsis, pneumonia, neonatal conjunctivitis, and neonatal tetanus (Van Gerwen, Muzny & Marrazzo, 2022). The second biggest cause of stillbirth worldwide is syphilis (WHO, 2019).

Evidence suggests that genital ulcers caused by STIs are an important clinical manifestation contributing to increased susceptibility to acquisition and reproduction of human immunodeficiency virus (Tu *et al.*, 2022). In 2009, the WHO highlighted the importance of an integrated approach to managing STIs including the generation and implementation of preventive strategies, community-level interventions, reliable evidence-based information, and accessible clinical services to persons with STIs. In addition, the WHO highlights the importance of education and raising awareness as these resulted in a slow decline in incidence and prevalence of STIs (Albarghali & Othman, 2020). Abstinence and monogamy also prevent STIs by limiting the number of potential contacts who can be infected with an organism and are largely emphasised in STI prevention programmes focused on young people from religious or other conservative viewpoints (Breunig, 2017). Abstinence and limitations of sexual intercourse are, nevertheless, idealistic or undesirable to a lot of youth (Visser, 2017), and practical prevention of STIs includes the so-called ABC-principle which emphasises abstinence, faithfulness and condom use (Rukundo *et al.*, 2016). Condoms have been used for centuries to prevent STIs (Amy & Thiery, 2015), and have resurged as a leading measure to prevent HIV (Beksinska *et al.*, 2020). Male condoms, when used consistently and correctly, are an effective method for preventing STIs (WHO, 2019).

Although female condoms protect against pregnancy and STIs that acceptability among women and their sex partners is a challenge (Peters *et al.*, 2014).

Preventive and Screening Services: Cervical and Breast Cancer Screening, HPV Vaccination.

Cervical cancer ranks as the second most common cancer among Nigerian women between 15 and 44 years with a fatality rate of 20 or more death every day (Ferlay *et al.*, 2020). Nigeria is burdened with the highest rates of human papillomavirus (HPV)-related diseases in Sub-Saharan Africa (Bruni *et al.*, 2023) with evidence from studies indicating that HPV is common amongst Nigerian women. Prevalence of Immunoglobulin G (IgG) against HPV had been more than 40% among northern Nigerian women (Aminu *et al.*, 2014). The prevalence of HPV infection among female outpatients in Southwest Nigeria has also been recorded to be between 30.4 and 36.5% (Okunade, *et al.*, 2017). Persistent infection with the sexually transmitted human papillomavirus (HPV) is a leading cause of cervical cancer (Golfetto *et al.*, 2018). In fact, HPV accounts for 90 – 100% of the cases of cervical cancer in women, particularly those who are younger than 35 years of age (Bruni *et al.*, 2010 in Ogundipe *et al.*, 2023). HPV is the commonest viral infection of the female reproductive system and majority of sexually active women and men will acquire the infection at least once in their life time and there are some who will be infected more than one time (WHO, 2020).

Complete cervical cancer prevention and control strategies were outlined by the WHO in 2020. The strategies ranged from primary, secondary and tertiary prevention interventions such as community education, social mobilisation, vaccination, screening, treatment and palliative care. Vaccination against HPV, screening for and treatment of pre-cancerous lesions, early detection and prompt treatment of invasive cancers, and palliative care represent proven cost-effective interventions for the prevention of cervical cancer throughout the continuum of care (Abraham *et al.*, 2013). It is anticipated that extended coverage of HPV vaccination will prevent about 70% of cervical cancers worldwide, and cervical cancer screening can lower the risk of developing cervical cancer by 25-30% when performed in women in their 30s or 40s (WHO, 2014).

HPV infection vaccination among adolescents prior to their first sexual contact is one of the biggest cervical cancer prevention interventions (The American College of Obstetricians and Gynaecologists Committee Opinion, 2014). The delivery of HPV vaccines in low and middle-income countries is a critical part of the global action plan to decrease the burden of cervical cancer (Perlman *et al.*, 2014). WHO recommends administering the HPV vaccine to girls aged 9–13 years prior to sexual initiation because the vaccine is more effective if the girls have not yet been exposed to HPV (WHO, 2009). Girls aged 9-13: 2 doses of the HPV vaccine should be given (0, 6 months), and for women 16 to 26 years of age, a three-dose schedule (0, 1, and 6 months or 0, 2, and 6 months) is available and cervical cancer screening is still needed after HPV vaccination (Akinola *et al.*, 2019). There are three types of tests for cervical screening that are now available and widely used: HPV DNA testing, cytology-based Papanicolaou test (Pap test), and with the naked eye in visual inspection with acetic acid (VIA) but awareness of these tests is limited, especially in developing countries (Jassim, Obeid & Al Nasheet, 2018).

Safe Abortion Services: Where Legal, as Part of Reproductive Rights.

Abortion legislation is a set of rules and regulations which determine under what condition a pregnancy can be legally ended (Center for Reproductive Rights, 2023). Historically, abortion laws were introduced as abortion was considered a sin and these laws were designed to punish and discourage people from receiving and providing abortion services. Abortion laws were designed to safeguard women and fetal life as abortion was risky and many women were dying at

the hands of abortionists (Berer, 2017). But as now procedures and medications for legal abortions are significantly safer, the purpose of current abortion laws can only be punitive or protect fetal life over that of a woman's life. Though on rare occasions an unsafe abortion that result in complications is still prosecuted, abortion laws are now primarily used to criminalise those who perform and/or receive safe abortions (Berer, 2017). The worldwide regulation of abortion, legal or otherwise, is usually very liberal (allowing abortion at the woman's request or for social or economic reasons) or very strict (allowing abortion only to save a woman's life or banning abortion altogether) (Center for Reproductive Rights, 2023). In a number of countries, abortion regulations also include gestational limits and specific conditions such as rape, incest, and fetal anomaly (Center for Reproductive Rights, 2023). The abortion legislation in Sub-Saharan Africa (SSA) was largely borrowed from the colonial era. While many of the European holdouts of these laws have now transformed to more permissive laws, most SSA countries retain the old strict laws (Berer, 2017). In 2019, more than 90% of women aged 15–49 years in SSA resided in countries where abortion legislation was extremely restrictive, allowing abortion access solely when the woman's life was in danger (Bankole *et al.*, 2020).

The impact of restrictive abortion policies on women's reproductive health is significant, such laws have been linked with an increased rate of unsafe abortions (Ganatra *et al.*, 2017), while the legality of abortion has a strong impact on its safety, it does not impact how often abortion is used (Ganatra *et al.*, 2017). For example, the worldwide abortion rate stays steady at 40 for every 1,000 women of reproductive age each year irrespective of whether abortion laws are permissive or restrictive (Bearak *et al.*, 2020). Nevertheless, the safety of these procedures differ widely around 1% of abortions are unsafe in countries with liberal laws, in contrast to 31% in those with restrictive laws (Ganatra *et al.*, 2017). In SSA, Guttmacher Institute projects approximately 33 unsafe abortions per 1,000 women of childbearing age annually (Bankole *et al.*, 2020). It is one of the leading causes of maternal morbidity and mortality within the region (Ganatra *et al.*, 2017). Another body of evidence indicates that restrictive abortion laws relates to the worse mental health of women (Rajkumar *et al.*, 2022), negative infant and child health outcomes (Bascieri *et al.*, 2017; Pabayo *et al.*, 2020) and long term financial strain on families (Foster *et al.*, 2019; Hajdu & Hajdu, 2021).

Access to Safe and Equitable Reproductive Healthcare

Access is a spatial and a spatial construct (Wood *et al.*, 2023). A spatial access refers to non-geographic determinants of accessing services (for example cost, cultural compatibility), while spatial access refers to geographic-related factors playing a role in access (for example presence and proximity) (Versace *et al.*, 2019). Access to care is a complex measure of health system performance and fairness in care delivery (Wood *et al.*, 2023). Good access is positive for individual and population health, while bad access is linked to health inequalities and a greater burden of disease (Baum & Friel, 2017). Access to sexual and reproductive health (SRH) services for all has been a long-standing global ambition, given that barriers have a disproportionate effect on women and lead to health inequities through the life course (Bateson, Black & Sawleshwarkar, 2019). Family planning, maternity care, treatment for infertility, care related to abortion, and the prevention, identification and management of STIs are all essential components of SRH services that should be available at the primary care level (Guttmacher Institute, 2015). The consequences of sexual and reproductive ill-health are more than a burden of disease; they impact the social and economic well-being of individuals, families, communities, and the society at large (Starrs *et al.*, 2018). A good way to contribute to this improvement in maternal health, child mortality, and

communicable disease prevention is provision of SRH services (United Nations Population Fund,1994).

Access is one of the universal health coverage (UHC) building blocks (access, need and effective coverage) (Rodney & Hill, 2014). The World Health Assembly has stated that UHC means All people can use the quality health services they require, when and where they need them, without financial hardship, (Rodney & Hill, 2014) to that end. It is said that access has four elements, which are geographic accessibility, availability, financial accessibility and acceptability (Rammutla & Mtapuri, 2014 in Shatilwe, Kuupiel, & Mashamba-Thompson, 2021). Women in the reproductive age group are able to make best use of maternal and child health care information (MCHI) if they are enabled to avail health care services (Abera Abaerei, Ncayiyana & Levin, 2017). The public or private use of the healthcare information can be affected by socio-economic factors, and cultural traditions and practices. Prompt, reliable, and quality healthcare services Healthcare-seeking practices are influenced by the prevailing factors like the healthcare system itself, distance to health facilities, availability, cost, and quality of healthcare information, among others (Abera Abaerei, Ncayiyana & Levin, 2017).

Determinants of Access to Reproductive Healthcare Services

Individuals everywhere experience barriers that hinder their ability to access reproductive health services and care. Akintayo (2022) report for instance, that women's reproductive health demands, in particular contraception, maternal health and abortion services, are for the most part marginalised and discriminated in a variety of nations. Women in Nigeria and the rest of the world were discriminated against on the basis that they could not own opinions concerning issues about their lives and which made them feel helpless (Olajide, & Omokhabi, 2014). This implies every household's reproductive behaviour matter in so far as it affects their reproductive anatomy. What makes reproductive behaviour important to every household is that it affects the reproductive anatomy of every household and so development agents are often confronted with difficulties like those who are developing such as inadequate accessibility to credit, healthcare and education. (Omokhabi, & Fajimi, 2023). A number of studies have found that barriers to seeking health care services include maternal age, occupation, wealth status, education level, education level of husband, media exposure, area of living, health insurance coverage, and number of children (Minyihun & Tessema , 2020 ; Tamirat ,Tessema & Kebede ,2020; Seidu , 2020; Seidu *et al.*, 2020; Tessema *et al.*, 2022; Tsegaw, Mulat & Shitu , 2023).

There is a large population living under poverty line people who cannot bear the cost of these services even if provided (Vallières *et al.*,2016).Poor knowledge of health problems and services available can prevent people from going for treatment (Schwarz, Schmidt, Bobek & Ladurner ,2022).Traditional beliefs and practices may also deter people from consulting modern medical practitioners (Kunnuji *et al.*,2022).There is often a lack of healthcare facilities in rural areas, and where facilities are present, they may be a significant distance away, so that travel time and cost are barriers (Evans *et al.*,2022).Access to public transit may be sporadic or costly in rural communities, compounding the difficulty of reaching distant facilities (Varela *et al.*,2019). Qualified healthcare providers, such as doctors and nurses, tend to be more numerous in urban areas, and rural health facilities are often understaffed (Wurie, Samai & Witter,2016). Rural residents also tend to have lower mean incomes, which makes it more difficult to pay user fees or transportation costs for health care (Varela *et al.*,2019). Health illiteracy may contribute to low awareness about health and service options among rural residents (Shahid *et al.*,2022).Some previous reports have offered limited information on factors related to access to healthcare, such as social, demographic, and economic factors including marital status (Pandey *et al.*,2019), place

of residence, (Yang *et al.*,2015), wealth index, (Minyihun & Tessema ,2020), birth order,(Pruckner *et al.*,2019),wanted pregnancy (Tamirat,Tessema & Kebede 2020) and women empowerment (Htun, Hnin & Khaing ,2021). Nigeria is a multi-ethnic and multi-linguistic country with over 250 ethnic groups, each possessing unique cultural (implicit and explicit) norms, values, rituals, and practices, these significantly affect women's utilisation of MHS (Ogunlana *et al.*, 2023).

Disparities in access to and utilisation of care within rural areas have been ascribed to a number of factors including higher rates of poverty and uninsurance, greater dependence on Medicaid, less robust provider availability, and longer distances traveled to reach health care facilities, decreasing rural obstetric service availability, and increasing rural hospital closure rates. There are four main reasons that combined to influence women's access to health services including not wanting to travel alone, distance to health services, acquisition of money for treatment, and obtaining consent for medical care. Literature review has shown that the access to MHS is affected by distance to a health facility (long distance) and the geographical location of health facilities(Alamneh *et al.*,2022), poverty, low monthly income and having no job which makes women to have no enough money for medical care, (Tesfaye *et al.*,2017), poor knowledge and low risk awareness among women, laziness and severity of illness which prevents women from attending health care alone (Banda, 2013), in addition there is a strong culture of male and family member decision making for women access to health services (Baffour-Awuah *et al.*,2015; Alkema *et al.*,2016), these are also factors that make maternal and child health services turn access into a challenge for women. Several studies indicate that the restriction of abortion could be related with less use of contraception, particularly in nations having very restrictive abortion legislations where access obstacles might hinder people to acquire contraceptives (Felkey & Lybecker,2018). On the other hand, other reports show that in response to very restrictive abortion laws there have been increasing use of contraceptives in an effort to avoid unintended pregnancy (Jacobs & Stanfors,2015). This divergence of results is indicative of broader structural, cultural and socioeconomic issues that influence contraceptive use regardless of abortion law (Apanga *et al.*, 2020; Patel *et al.*,2020).

Barriers to Safe and Equitable Access to Reproductive Health Services

Women and girls are confronted with a multitude of barriers when seeking SRH services. Among the demand side barriers are lack of knowledge on SRH, socio cultural and religious beliefs practices, poverty, stigmatisation and negative attitude of HCPs (Silumbwe *et al.*,2018; Mutea *et al.*,2020). On the supply side, barriers include non-availability and non-affordability of the commodities and services, stock out, distance to health facilities, human resource challenges such as high HCWs attrition and shortage of skilled HCWs, among other (Hasselback *et al.*,2017). Yet, it is not known how these barriers differ among the three service delivery sectors that offer SRH. The prior investigations focused only one sector (Mchome *et al.*,2015) or multiple sectors but failed to disaggregate findings by sector (Mutea *et al.*,2020), or failed to indicate the sector(s) involved (Silumbwe *et al.*,2018), which does not allow for cross-sector analysis. One study, which did address availability, affordability, and stock out rates of sexual and reproductive health commodities (SRHCs) in all three sectors, found that availability was comparable across sectors, and that affordability of a number of products was not a problem in the private and, if the creditworthy were included the paragraph the private not-for-profit (PNFP) sectors (Ooms *et al.*,2020).

Rural women had higher likelihoods of barriers to healthcare access as compared with their counterparts. Similarly, studies in sub Saharan Africa (Alamneh *et al.*,2022) and East Africa (Minyihun & Tessema,2020) revealed that rural women had higher likelihoods of barriers to

healthcare access as compared to urban women. The possible reason for this might be physical accessibility of health infrastructures (Tamirat, Tessema & Kebede, 2020) limited education, and high transportation costs for rural resided population (Alamneh *et al.*, 2022). According to studies conducted in northern Nigeria and other areas, women's reproductive autonomy and healthcare use are restricted by the intersection of patriarchal norms with systemic, cultural, and economic restrictions (Al-Mujtaba *et al.*, 2020; Nmadu *et al.*, 2020). According to earlier research, patriarchal systems affect pregnant women's psychological health and health behaviours in addition to restricting their access to healthcare facilities, which exacerbates adverse health outcomes (Agbo & Esmailzadeh, 2024; Opara *et al.*, 2025). For instance, it has been demonstrated that war exposure and patriarchal rule in Northern Nigeria impact women's decision-making around family planning and condom use, leading to a rise in unmet reproductive health requirements (Vilier & Groot, 2025).

In a similar vein, patriarchal cultural norms have also been linked with decreased utilisation of maternal health services as seen among Igala women whose cultural norms and beliefs hinder them from seeking formal health care (Opara *et al.*, 2025). These findings exemplify the far-reaching influence of patriarchal attitudes on access to and outcomes of reproductive health in both Nigerian contexts. Contrarily, the place of residence is surprisingly the most dramatic factor which determines one's right to enjoy health care services, especially in the rural community and small town that are considered as remoted areas (Lara, Decker & Brindis, 2016; Petrie, 2022). Barriers to access SRH service in SSA are respectively cited to be cost, information and knowledge of available services, religious and cultural SRH norms influencing service utilisation, negative attitudes of service providers, poor quality of services and lack of privacy and confidentiality (Jonas, Crutzen, Van Den Borne & Reddy, 2017; Kyilleh, Tabong & Konlaan, 2018; Mekonnen, Dune & Perz, 2019; Mugore, 2019; Engelbert Bain, Amu & Enowbeyang, 2021).

Strategies to Improve Access to Reproductive Health Services

It is pertinent to tackle the barriers to the utilisation of reproductive and maternity services not only for improving the maternal and child health status (Konje *et al.*, 2018), but for contributing to economic, social, and community development and gender empowerment and equality (Sully *et al.*, 2020). Several policies have been introduced to combat the low utilisation of reproductive and maternal health services in Nigeria including the Free Maternal and Child Health Services (which is not being implemented in all the states) (Ozumba *et al.*, 2019), the Mothercare Nigeria Project (Moeteke, 2021), Integrated Maternal, Neonatal and Child Health (Etiaba *et al.*, 2023), and the National Reproductive Health Policy and Strategic (Uneke *et al.*, 2017). These and other similar policy matter impacted positively on reducing maternal morbidities and mortalities in Nigeria (Uneke *et al.*, 2017; Ozumba *et al.*, 2019) but continuous high maternal and child morbidities and mortalities indicates inadequacies of the policy or policy gaps in tackling the issue (Kana *et al.*, 2015). Hence, interventions should target community participation and awareness tradition, active advocacy through local leaders and community influencers such as religious leaders, chiefs, traditional birth attendants (TBA) (WHO, 2017) amongst others. In the same manner, training the capacity of healthcare providers particularly on culturally and religious sensitive services provision in reproductive and maternal health services can improve utilisation (Arousell & Carlbom, 2016). Policies need to be focused on the removal of the main socio-demographic barriers to facilitate access and use. For example, WHO (2019) suggests the use of mobile health clinics to serve populations living in remote areas or at risk (in such areas). Therefore, a mobile clinic for delivery of reproductive and maternity services in the rural areas may also contribute to increased service utilisation. In addition, the improved health literacy and peer education using indigenous language

may help to increase usage of reproductive and maternity services among women in the low education category or no education (Udenigwe *et al.*,2023). Moreover, the free maternal health care policy should be implemented in all the states of the country to improve on service utilisation and increase maternal health outcomes (Ajayi & Akpan, 2020). World Bank policy is to encourage financial incentives, such as vouchers and cash transfer to increase utilisation of reproductive and maternity services especially for poor women, while it states that raising the income of women through jobs and other means of income generation including women led small, medium scale enterprises and vocational training for girls and women can better increase utilisation and improves outcomes of health (Neelsen *et al.*,2021). The policymakers ought to champion and encourage the adoption of digital healthcare platforms like artificial intelligence (AI) among the women of reproductive health age to avoid some of the physical access barriers to make utilisation easier and to strengthen the health system in the country (Bolarinwa, Mohammed & Igharo ,2024). Rwanda, for example, has seen a dramatic increase in the use of healthcare services with the incorporation of AI in its digital healthcare system (Hoffmann Institute,2021). Similar programmes in Nigeria, focused on reproductive and maternal healthcare, will go a long way to improving utilisation in the country and hence mitigating poor maternal and child health outcomes.

Theoretical Lens for Analysing Access to Reproductive Healthcare

Health Belief Model (HBM)

The Health Belief Model (HBM) is a commonly applied theoretical model for understanding health behaviours and developing interventions to change them. The HBM suggests that the individual decisions toward specific health behaviours are primarily influenced by perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy (Becker,1974). The Health Belief Model (HBM) is an established psychological model employed to explain and facilitate positive health-related behaviours, including the use of reproductive health care services (contraception, prenatal care, and screenings). This model asserts that a person's choice to access services is dependent on his or her perceptions of a threat (for example., an unintended pregnancy) and the perceived costs and benefits of taking the recommended course of action.

Primary Constructs of the HBM Concerning Reproductive Care

- **Perceived susceptibility:** is women's evaluation of their chances of getting a reproductive health issue, including an unintended pregnancy or STIs and how likely individuals think they are to get an unintended pregnancy (Anyatonwu *et al.*,2023). High perception of susceptibility for example knowledge of ovulation cycle or perception of the risk of unprotected sex is related to higher contraceptive use.
- **Perceived severity:** is concerned with the negative outcomes of such pregnancies, including risks to health, economic strain, and potential effects on mother and child well-being (Anyatonwu *et al.*,2023). How serious women believes the implications of a condition are (for example the health, social, or economic consequences of a high-risk pregnancy).
- **Perceived benefits:** encompass the advantages associated with contraception such as effective pregnancy prevention, birth spacing, and improved maternal and child health outcomes. (Anyatonwu *et al.*,2023). The perceived advantages of taking action, such as the effectiveness of contraception for birth spacing or the protective benefits of prenatal care for both mother and child.
- **Perceived Barriers:** are the tangible and psychological costs of seeking care to obtaining care for example fear of side effects, financial limitations, lack of transportation, or

cultural/religious opposition). Barriers may include cultural, religious, financial, or logistical obstacles or worries that people have about using contraception. A community-based contraception and sexual health clinic study in Southeast Wales aiming to identify the predictive value of health behaviour models on the intention to use long-acting reversible contraception found that proximity barriers had a strong impact on the use of long-acting reversible contraception (Roderique-Davies *et al.*, 2016).

- **Cues to action:** include advice from others, reminders about contraceptive use, or the beginning of menopause.). These cues can be provided by health care providers, through educational programs, social networks, personal experience and more). Behaviours are initiated by cues to action, which could be a recommendation from a healthcare professional or participation in an educational intervention or symptoms (such as a missed menses).
- **Self-efficacy** :is a person's belief in their capacity to initiate and continuously engage in contraceptive behaviours, and to negotiate challenges and barriers to contraceptive utilisation (Hall, 2012). For example, belief in one's ability to successfully perform a behaviour, for example, use a method of contraception or attend a health facility.

Applicability of HBM in Understanding Barriers to Reproductive Health Services

HBM is among the most commonly used behavioral theories and it offers a useful conceptual framework to guide understanding of health-seeking behaviours through assessing the influence of individual beliefs in utilizing services. In reproductive health care, as well as in other medical disciplines, access is not simply a matter of availability of services, but is also shaped by attitudes, perceptions and social factors influencing individuals' motivation and capacity to look for services. Thus, the HBM is equally pertinent for examining supply-side and psychosocial constraints to accessing reproductive healthcare. HBM identifies important constructs (perceived susceptibility, perceived severity, perceived benefits and barriers, cues to action, and self-efficacy) that are closely related to decision making in the area of reproductive health. Individuals may, for instance, minimize their risk of unintended pregnancy or STIs, thereby reducing their impetus for utilising preventive services. In the same vein, symptoms of reproductive health conditions may be perceived as not serious or with inaccurate beliefs about consequences resulting in delays in seeking care. While awareness of the benefits associated with contraception, antenatal care, or screening for STIs may also motivate use of services. Among these, perceived barriers, including cost of service, travel distance, stigma, confidentiality, attitude of providers, and gender norms, are reproductive healthcare-specific and are well accounted for in the HBM model. The model also draws attention to the role of cues to action (for example health education, peer influence, media campaigns, and provider interactions), which can prompt utilisation. Self-efficacy also sheds light on aspects of health care navigation, such as an individual's confidence in their ability to manage their care, communicate with providers, and make reproductive health decisions independently. Through the use of HBM, one can identify belief-based barriers and facilitators for accessing reproductive healthcare in a systematic manner. This supports the development of integrated, culturally appropriate interventions and policies that address structural and behavioural issues to increase equitable access to reproductive healthcare services.

Conclusion

Safe, fair and dignified access to reproductive services is essential to the health, dignity, and life of women with reproductive capacity. This is not a question of health system capacity, it is a question of human rights and social justice. When reproductive health services are available, acceptable and responsive to women's needs, they can lead to better health, gender equality and

social and economic development. Access to reproductive health services is, however, still hindered by many obstacles, and its importance is underestimated. These are financial and cultural barriers, limited access due to distance and inadequate health infrastructure, stigma and discriminatory treatment of patients, restrictive gender norms, misinformation, and concerns about confidentiality and quality of care. To address these challenges will require approaches that not only increase the availability of services, but also address behavioral, cultural and systemic barriers to accessing care.

Multi-level interventions are needed to achieve meaningful and sustained change. At the policy level, governments need to make reproductive health a priority through comprehensive laws, sufficient funding, and by incorporating it into the national health system. At the community level, activities should be directed towards education, stigmatization and empowerment to increase knowledge, self-efficacy, and potential for community support. To build trust and increase utilisation, it is also important that adolescent- and woman-centered services, a cadre of trained providers, and respectful, non-discriminatory care exist within the health system. A concerted, multisectoral strategy that harmonises policy, community mobilisation, and health systems fortification is crucial to guarantee that every woman of reproductive age receives safe, affordable, and high-quality reproductive health care. This kind of action is critical to promoting health equity and empowering women to make informed decisions about their reproductive lives.

Recommendations:

1. Government and Policy Makers

Who: Ministries of Health, Women's Affairs, Finance, and Local Government

How:

- Pass and enforce policies that will ensure the right of every woman to have access to safe reproductive health services including family planning, antenatal care, safe abortion where legal and postnatal services.
- Designate specific funds for reproductive health programmes at the community and primary health care level.
- Reproductive health services should also be included in national health insurance and social protection programmes to mitigate costs to individuals.
- Formulate and monitor pro-equity policies that address the needs of marginalised women, such as those in rural, low income or informal areas.

2. Healthcare System and Providers

Who: Public, private and mission hospitals, clinics, healthcare professionals, professional councils

How:

- Improve primary health care facilities for delivery of high quality, comprehensive reproductive health services.
- Educate providers about respectful, non-discriminatory and confidential care.
- Create woman-centered and culturally sensitive delivery models.
- Build additional mobile clinics and outreach programmes to serve isolated and marginalised populations of people.

3. Community Leaders and Local Institutions

Who is it for: The Traditional leaders, religious leaders, women's groups, community-based organisations

Means of Implementation:

- Facilitate community discussions to confront stigma, harmful practices and misinformation about reproductive health.
- Backing initiatives for women's empowerment that increase knowledge, making of decision and self-efficacy.
- Bring male partners and family members into the conversation to create supportive atmospheres for access to women's health care.

4. Civil Society and Non-Governmental Organisations

Actors: NGOs, advocacy groups, women's rights organisation

How to go about it:

- Conduct community-based reproductive health education and sensitisation activities.
- Promote policy change and accountability at the community and national levels.
- Offer support services, referrals and legal assistance to women obstructed from receiving care.
- Inform programmes design and policy advocacy with data and evidence.

5. Communities and Women Themselves

Who: Women of reproductive age, peer educators, community volunteers

Means of execution:

- Join agreed health promotion programmes and peer-support groups.
- Be involved in making decisions about their reproductive health care.
- Inform health facilities about the need to improve quality and access to services.
- They can wave flags loudly for safe, respectful, and just healthcare.

6. Development Partners and Researchers

Who: Donors, academic institutions, research organisations

How To:

- Development partners and researchers need to contribute to enhancing access to reproductive health services through research that focuses on the barriers to service utilisation among women of reproductive age.
- They should also facilitate the process for availability, uptake and scale up of successful community-based interventions that enhance knowledge and demand for services.
- Universities and research institutions are encouraged to undertake routine monitoring and evaluation of reproductive health programmes to achieve equitability, effectiveness, and sustainability. Findings from such studies can help inform the development of strategies by policy makers and health systems to increase access to safe and equitable reproductive healthcare.

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