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ORIGINAL RESEARCH ARTICLE

Widowers' accounts of maternal mortality among women of low socioeconomic status in Nigeria

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Abstract

The research is based on information collected on 50 deceased Nigerian women of low socioeconomic status in different locations of the country including Lagos, Ibadan, Kaduna, Zaria, Minna, Enugu, and Port-Harcourt among others. They had some common characteristics such as low levels of education, involvement in petty trading and were clients of a microfinance bank as small loan receivers. Primary data were generated mainly through verbal autopsy with widowers employing In-depth Interviews and Key Informant Interviews. In addition, unobtrusive observation was carried out in these locations to ascertain in some instances the distance between the deceased homes and health facilities patronised by the women. Secondary data were specific to death certificates of the deceased supplied by the widowers. Both ethnographic summaries and content analysis were employed in data analysis to account for contextual differences, especially in a multicultural society like Nigeria. The findings implicated several issues that are taken for granted at the micro-family and macro-society levels. It specifically revealed that small loans alone are not sufficient to empower poor women to make meaningful contributions to their own reproductive health in a patriarchal society like Nigeria. Results also indicated that cultural differences as well as rural-urban dichotomy were not proximate determinants of maternal behaviour; the latter rather finds expression in low socioeconomic status. Consequently, policy relevant recommendations that could contribute to significant maternal mortality reduction were proffered. (*Afr J Reprod Health 2012; 16[3]: 101-117*).

Résumé

La recherche est basée sur des informations recueillies sur les 50 femmes nigérianes décédées venant d'un milieu socioéconomique faible dans différents endroits du pays tels que Lagos, Ibadan, Kaduna, Zaria, Minna, Enugu et Port-Harcourt, entre autres. Ils avaient des caractéristiques communes telles que de niveaux bas d'éducation, la participation dans le petit commerce et elles étaient des clients d'une banque de micro finance en tant que récepteurs de petits prêts. Les données primaires ont été générées principalement par le biais d'autopsie verbale avec les veufs qui emploient des interviews en profondeur et des interviews avec des informateurs clé. En outre, l'observation discrète a été réalisée dans ces endroits afin de déterminer dans certains cas, la distance entre les domiciles des décédés et les établissements de santé fréquentés par les femmes. Les données secondaires sont spécifiques à des certificats de décès de la personne décédée fournies par les veufs. Les deux résumés ethnographiques et l'analyse de contenu ont été employés dans l'analyse des données pour tenir compte des différences contextuelles, surtout dans une société multiculturelle comme le Nigéria. Les résultats ont mis en cause plusieurs problèmes qui sont pris pour acquis aux niveaux micro-et macro-famille de la société. Il a surtout révélé que de petits prêts à eux seuls ne suffisent pas à renforcer la capacité des femmes pauvres, de faire des contributions significatives à leur propre santé de la reproduction dans une société patriarcale comme le Nigéria. Les résultats indiquent également que les différences culturelles ainsi que la dichotomie rurale-urbaine ne sont pas des déterminants immédiats du comportement maternel; celui-ci trouve plutôt son expression dans une situation socioéconomique faible. Par conséquent, les recommandations politiques pertinentes qui pourraient contribuer de manière significative à la réduction de la mortalité maternelle ont été proposées (*Afr J Reprod Health 2012; 16[3]: 101-117*).

Keywords: verbal autopsy, health facilities, multicultural society, mortality reduction

Introduction

Studies have consistently shown that women of low Socioeconomic Status (SES) are more at risk of maternal mortality and morbidity due to poor

nutrient intake, lack of health related awareness, strenuous activities among others^{1,2,3,4}. In addition, these women, a large majority of whom are found in less developed societies, contribute substantially to the global annual estimate of

529,000 maternal deaths due to lack of access to functional health systems including poorly skilled providers⁵. It has been noted that attempts to reduce mortality from complications of pregnancy and childbirth have been less successful than other aspects of human endeavour⁶. As such, having a child is classified among the most serious health risks for mothers. This is particularly the case in less developed regions of the world.

Data indicate that the lifetime chances of dying from maternal causes are 1 in 3,600 and 1 in 90 in the more developed and less developed societies respectively⁷. A large majority of these deaths could be prevented with access to essential maternal and basic health care services^{8,6}. Because several women in less industrialised communities have poor access, attention is placed on providing emergency obstetric care to deal with potential severe complications⁹. Yet, in some sub-Saharan African communities, already notorious for inadequate health facilities, such emergency care is not at all emphasized and most severe cases result in death.

Access to maternal health services is dependent of several factors related to awareness, socioeconomic status, cultural beliefs and practices among others¹⁰. As has been observed, maternal education is strongly associated with fertility and maternal health¹¹. The impingement of family-relationship quality on women's use of maternal health care services in non-western contexts cannot be overemphasized. Allendorf for instance hypothesized that 'when bonded by high-quality relationship, family members will more likely encourage or even compel women to obtain maternal health care services... paying health care fees, accompanying women to health facilities, and communicating health related information'¹².

These issues are more visible in sub-Saharan Africa than other regions; therefore the essence of understanding maternal events among different groups cannot be overstated. The main objective of this study is to examine issues related to child-spacing intervals, antenatal care, place of delivery, and socioeconomic background and their individual and collective impingement on maternal morbidity and mortality among a cohort of women that received small-loans from a micro-finance bank. More profound, the study aims at

interrogating the extent to which these loans empowered the women, while they were alive, in partaking in family decision making processes including those that relate to reproductive health.

Theoretical Perspectives

This study is anchored on three theoretical perspectives – the Health Belief Model (HBM), Rational Choice and Systems theories. The adoption of HBM, in this research, is strictly speaking outside the domain of health seeking given that pregnancy is not equated with illness¹. However, its application here indicates its penetrating and multifaceted feature particularly for a discourse on maternal morbidity and mortality which in themselves are, ordinarily, preceded by some form of complications that translate to illness and illness behaviour. Conceptualized on the basis of four main constructs, the model is embedded in the perception of the actors as the driver of health seeking behaviour^{13,14}.

The model supposes that perceived susceptibility to maternal related morbidity and mortality would likely motivate a pregnant woman or her significant others to undertake maternal health services related to antenatal, delivery and postnatal care with zeal. Such perception will engender early and sustained care seeking in facilities with requisite competencies. This would not be the case for those who perceive pregnancy as a normal condition that does not require special care. The latter scenario may explain why some families allow expectant women to continue their laborious activities late into pregnancy, hardly get them registered early and/or in tested medical facilities, and do not support these women to improve their nutritional status. Research shows that diets with sufficient calories and micronutrients are essential for pregnancies to be successfully carried to term^{4, 15}.

In Vitamin-A-deficient populations, doses of Vitamin-A of about 10,000 IU per day or 25,000 IU or week are beneficial to pregnant women¹⁶. Poor nutrient intake is associated with anaemia and serious maternal illness¹⁷. Anaemia among pregnant women may be a function of several factors such as nutritional ignorance, beliefs, practices and poverty. Indeed women represent a

disproportionate share of the poor and are largely unable to independently provide themselves with necessary maternal requirements²; a condition that has implications for their health status and pregnancy outcomes.

The model views perceived severity in relations to already established illness conditions, in this case maternal complications. Ordinarily, perception of seriousness of a given maternal situation would not only make for recourse to early emergency obstetric care but also patronage of perceived adequate facilities. Yet due to ignorance about symptoms of life-threatening conditions, requiring urgent attention, some situations are never perceived as serious. As studies have indicated, maternal deaths are strongly associated with delays in seeking care, sub-standard health services and lack of medical supplies at the time of labour, delivery and immediately after birth^{18, 19, 3}.

Perceived benefits emphasize calculations, among potential actors, pertaining to the merits and costs of either taking or avoiding a specific health related action within a given illness scenario. This construct assumes that individuals will take actions considered appropriate for handling threatening situations, in this case maternal related complications. The appropriateness of a given action will be to the extent that other alternatives are less desirable or even inimical to successful maternal outcomes; unnecessary delays in transferring emergency cases to medical facilities, patronizing inadequate facilities and engaging in dangerous activities individually and collectively undermine the health status of expectant mothers.

The model conceives perceived barriers in terms of assumed and practical limitations to health seeking. For instance, an actor may conclude that some facility is inadequate to offer minimal obstetric care either due to poor state of equipment or personnel bereft of current knowledge in medical practice or both. It could also be that treatment charges are exorbitant or that staff are rude and hardly consider the feelings of patrons. A study among the Ibani of River State, Nigeria found that the people avoided facilities that do not readily release placentas (afterbirth) to families for blessings and burial²⁰. These among

other reasons may serve as disincentives for not patronizing a facility even if the latter is reputed for competence.

Similar to some HBM constructs the Rational Choice Theory conceives individuals as able to weigh the advantages and demerits of an intended action before taking such action which ought to be directed at ends or goals²¹. As such, actors have the capacity to make choices among alternatives within the context of available resources and prevailing conditions. However, such ability must be considered relative to a prospective actor's level of awareness about the efficacy of these alternatives in dealing with a particular illness condition. Consequently, the theory makes meaning only when it is established that an actor understands the nitty-gritty of available medical systems and therefore possesses the capacity to genuinely assess the options. For instance, an illiterate family in some remote location may not be aware of the essence of patronizing an orthodox facility during obstetric emergency; therefore the issue of choice does not arise.

Systems theory explains maternal outcomes as the cumulative effects of the stages that characterize pregnancy-postnatal processes. This theory posits that the activity of any part of a whole affects all other parts and the whole in general²². As a corollary, the impact of any stage of pregnancy affects in varying degrees every other stage and maternal outcomes eventually. Thus, a system is an entity composed of interrelated and connected parts²³. Rather than dealing separately with the various stages of pregnancy as unrelated entities, the systems approach views pregnancy as comprising interrelated stages. Thus, analysing each stage of the pregnancy-postnatal processes in isolation of others will only produce results related to these stages as separate subsystems. It has been argued, in line with this concept of integration, that literature on maternal outcomes is scanty because individual scholars only focus on one or some aspects of the system and not all¹.

Indeed, family planning as an integral part of reproductive health has received significant attention among scholars in various contexts. Its analysis, for the most part, terminates at the point where conception is prevented or allowed to occur.

The closure of analysis of a subsystem from others presents just a partial view of reality. The challenge confronted by researchers as a result of such sub-systemic insulation is that knowledge is disarticulated and conclusions are extremely difficult to reach. The connections among family planning, pregnancy, antenatal activities, child delivery and postnatal have received negligible attention. For instance, the likelihood is higher for couples that space births at two years interval to readily defray the cost of prenatal care than couples that bear children at shorter intervals, especially in a harsh economic environment. In addition, the extent to which child delivery is successful depends largely on the quality of care undertaken during the antenatal period.

Conceptual Framework

In this section, we present a synthesis of the three theoretical perspectives adopted for explaining the relationship between socioeconomic status and maternal outcomes in relevant Nigerian contexts. Figure 1 shows that between socioeconomic status and pregnancy outcomes lie several intervening variables such as perception, choice of care options and the role of significant others among others. Socioeconomic status of women is conceived in terms of education and awareness, occupation, income and extent of participation in decision making processes. Indeed, women's SES could be classified as low, moderate or high depending on the parameters adopted and the context under review.

For our purpose, low status shall be emphasized considering that the fifty women on which the study is based were illiterates, petty-traders, generated poor incomes and depended on their spouses for decisions, virtually, on all matters including their reproductive health. Low SES among pregnant women has implications for their perception of a particular situation. For instance, poorly educated women will not likely perceive their pregnancy status as prone to complications even when their activities or otherwise such as poor nutrient intake, strenuous engagements and bad sanitary behaviour among others suggest likelihood of susceptibility. In addition, the inability to identify common danger signs in pregnancy undermines perception

of severity including at critical moments of emergency. Avoidable delays have been implicated in increased complications and deaths among pregnant women in relevant contexts¹. Low SES women are less likely to perceive the benefits of timely and sustained access to adequate maternal health care services but may rather view the cost of services, attitude of medical personnel to beliefs and practices and bureaucratic medical procedures as barriers to health seeking. To be sure, a woman's SES has implications for the latter's worldview and by extension her capacity and disposition towards making rational choice amidst competing alternatives. A woman of low SES, for instance, may perceive late registration, access and use of maternal health services as a rational strategy towards saving money that may be needed more during postnatal period than antenatal, without necessarily considering the risks associated with the latter period especially in Nigeria and sub-Saharan Africa.

Figure 1 shows the link between women's SES and the role of significant others during the entire maternity period, ending on the forty-second day after delivery. It is more likely for women of low status to be neglected during critical period of pregnancy probably due to general family and household poverty situation. Such neglect may range from non-financial support to defray the cost of maternal health services, routine activities including drugs and for improved nutrient intake necessary to forestall anaemia which is one of the leading causes of maternal morbidity and mortality in impoverished settings¹⁰. The framework indicates that women's perception, choice of care options and the role of significant others separately and collectively influence pregnancy-postnatal continuum represented by subsystems.

To a large extent, maternal outcomes depend directly on activities related to each aspect of maternity. The inseparability of the subsystems is to the extent that any attempt to focus on one or some aspects and not all would translate to futility borne out of incomplete knowledge; hence awareness creation must necessarily target systematic engagement with each of the subsystems in order to fully understand different intervening variables and the whole system.

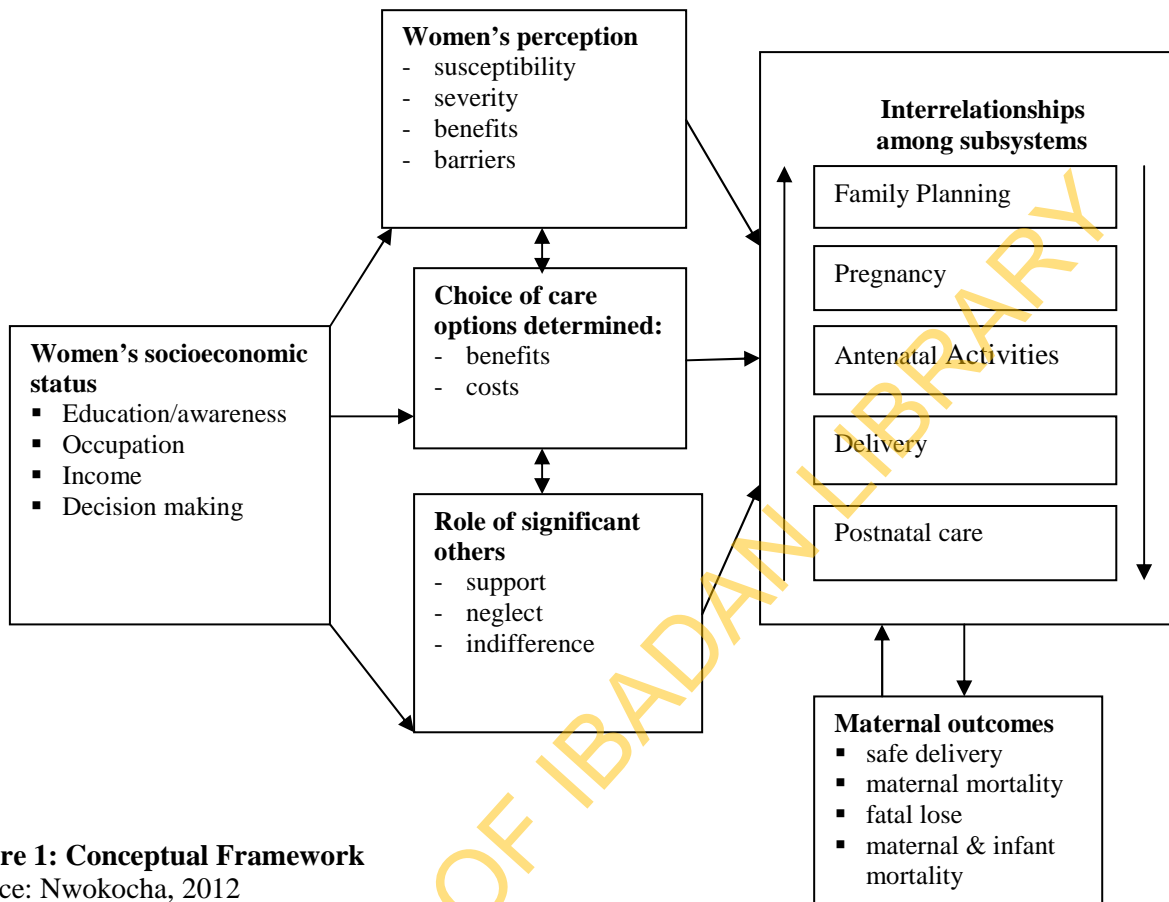


Figure 1: Conceptual Framework
Source: Nwokocha, 2012

Materials and methods

We collected data, over a three month period, from different locations in Nigeria including Lagos, Ibadan, Osogbo, Kaduna, Zaria, Minna, Enugu, Port-Harcourt, Ilorin and Ede. Three main inclusion criteria were emphasized – low levels of education, involvement in petty trading and being clients of microfinance bank as small loan receivers. Preliminary information on the deceased women, such as dates on which these deaths occurred and places of residence at time of death, were made available by the bank relying on data provided by its insurance company.

Data for the study were collected through primary and secondary sources. Primary data were collected using Verbal Autopsy (VA) through 43

In-depth Interviews (IDIs) with widowers of the deceased and 7 Key Informant Interviews (KIIs) with close relatives of some of the deceased in situations where the widowers were not available for IDIs; in the latter category was the mother of an unmarried deceased. Through this method, information on issues pertaining to family planning and child spacing, antenatal activities, delivery and in some cases the postnatal period was elicited. We had initially planned employing the sisterhood method in generating primary data but could not given that virtually in all cases the sisters were not residing with the deceased and therefore not acquainted with events leading to these deaths. The latter method is more appropriate in rural contexts where relatives live in close-knitted settings to allow generalized information on vital phenomena including deaths.

However, most of the deceased women for which data for the study were collected resided in urban centres and hardly had their sisters around.

In addition, unobtrusive observation was undertaken with a checklist containing items relevant to determining the adequacy of maternal health facilities. For each deceased woman, observation included ascertaining the distance between her home, as it were, and the facility she patronised during pregnancy and; the quality of facility in terms of personnel, equipment and environment. More importantly, to ascertain the specialisation of medical practitioners in some of the hospitals considering that not all doctors are skilled in attending to deliveries. All the Faith Based Homes (FBHs) and facilities managed by Traditional Birth Attendants (TBAs) we observed did not have orthodox medical personnel; as such there was no basis attempting to ascertain the specialisation of these attendants. The use of observation for this research was characterised by stiff resistance from some of the facilities that were sceptical about what the research was intended for. However, after a long period of explanation some of the facilities provided us the necessary information. Yet others did not approve such observation; we consider that as one of the limitations of the data.

Secondary data for this study were specific to death certificates issued after the event by orthodox facilities on the immediate cause of maternal death of women that patronised such clinics. We decided to request for these certificates given that most of the widowers are illiterates and could not readily state the specific cause of their deceased wives' deaths; they only merely described the events leading to these deaths. For women that patronised Faith Based Homes (FBHs), Traditional Birth Attendants (TBAs) and Home Based Therapies (HBTs) such certificates were not issued. Thus, we relied on the narratives of their widowers; the latter is also a limitation. Data were analysed through ethnographic summaries and content analysis.

Ethical considerations were emphasised throughout the study in line with the requirements of social science research. The aim of the study was fully communicated to prospective respondents, as they then were, and their freedom

to discontinue participation any time they deemed necessary. On the other hand, what the respondents stood to benefit from the study was also made known to them, as well as an assurance that their anonymity will be guaranteed during and after the study. As a result, pseudonyms could have been used in identifying respondents rather than their real names had that become necessary, to the extent that information could not be traced to any respondent or facility.

Results

The results are presented under various sub-themes which include socio-demographic characteristics, children ever-born and child spacing intervals, antenatal care, delivery and direct causes of death.

Socio-economic and demographic Characteristics

The ages of the deceased (at death) ranged from 25 to 45 years, with those of 40 years and above representing the least frequency (6). Conversely, women in the 30-34 age grouping were 16 in number and constituted the highest frequency. This is an indication that most of them were neither involved in early nor late childbearing which is considered risky. Research shows that pregnancy among adolescents carries heavy risks; pregnant women under twenty years of age are at greater danger of experiencing pre-eclampsia²⁴. However, two of the deceased clients got married at ages 14 and 35. Early age at first marriage and pregnancy implies a prolonged period of childbearing considering that the fecundity period (physiological capacity for childbearing) among these women would persist till about 49 years. The woman that married at age 14, for instance, had six children with the average spacing interval of 15 months, which is 9 months short of the recommended 24 months interval. The woman that got married at 35 years could not conceive until she was 45 years old.

Data clearly indicate that the educational level of a large majority of the deceased women ranged from no-formal-education to secondary school certificate while only two had diplomas. It has been noted that a woman's level of education is related to her occupational status, ability to

recognize symptoms of complications during pregnancy, healthy nutrition, ability to adopt adequate fertility control measures and involvement in household decision making processes²⁰. A study in north-central Nigeria revealed that about three quarters of maternal deaths in 2005 were recorded among illiterate women²⁵. Indeed, considering that all these women were involved in petty-trading activities coupled with the fact that their spouses were/are mainly artisans; their average household monthly income was marginal.

Poor income in the midst of competing family demands demobilizes attempts at accessing recommended antenatal services, dietary intake and maintaining adequate household environment which individually and collectively have implications for health of pregnant women and maternal outcomes. Some of the respondents reported as low as Six Thousand Naira (N6, 000 or \$40) total monthly household income; others reported between ten and Twenty Thousand Naira (N10, 000 & N20, 000 or \$139) as the estimated income. The highest household monthly income reported by one of the respondents was One Hundred Thousand Naira (N100, 000 or \$652).

Children ever-Born and Spacing Intervals

It is well established in literature that short interval birth spacing of less than 2 years increases the risks associated with childbearing²⁶. Beyond the fact that adequate spacing enables mothers recover from the stress of pregnancy, labour and delivery and by implication accounts for reduction in maternal deaths, it allows families to recover from the financial burden inherent in maternity. As such, families of low socioeconomic status face the greater burden and risks associated with prolific childbearing. Ironically, a combination of high rate of illiteracy, lack of access and use of family planning facilities, frustration and boredom among others make couples of low socioeconomic status most vulnerable to high fertility.

Information by respondents on the average spacing interval for children ever-born by the deceased was grossly inconsistent. Most of them reported an average spacing interval of between 3 and 4 years, while a few others stated 2 years. However, when we observed four variables (age at

first marriage, number of children ever-born, spacing interval between last two pregnancies and age at death) it became evident that the figures supplied by most of the widowers we interacted with were inaccurate. Our analysis revealed an average spacing interval of between 13 and 16 months, which are far from the recommended 2 years and above prescribed by the World Health Organization. Furthermore, virtually all the respondents reported not to have used any form of contraception to regulate fertility.

To be sure, pregnancies among these respondents, for the most part, were by chance rather than choice and as such more likely to have occurred before two years. However, by stating correctly the recommended spacing interval when asked shows clearly that the respondents are aware of the essence of such spacing. Thus, a clear line of demarcation exists between their knowledge and reproductive behaviour.

Antenatal Care

The issues investigated about antenatal care include onset of access to antenatal care services for the last pregnancy and spousal communication. Our interest was to find out at what trimester these women got registered for medical examination considering the implications of timing of antenatal care for pregnancy outcomes. We also examined specific facilities used by the women in order to ascertain the distance between their homes and these facilities in line with United Nations' position that women should not live more than five Kilometres (KMs) from a maternal health facility to forestall deaths due to delays in accessing such facilities³.

Findings show that most of the respondents began their antenatal care programmes in the second trimester, a few did in the first and final trimesters, while one never attended antenatal care probably because she never married and attempted to conceal her pregnancy status. Ideally, antenatal care should begin as soon as a pregnancy is identified, but for different reasons only a few women did. However, perceiving pregnancy as a normal condition that does not require special care by some women and their spouses accounted for delays in registration for care services. One of the respondents noted:

During the pregnancy for which she died, antenatal care began during the last week of the sixth month ... it was her earliest; her other pregnancies were at the seventh month. It was just that she was intermittently very sick during the last pregnancy that she agreed to get registered early.

The above scenario depicts lack of awareness and inherent misunderstanding of healthcare requirements during pregnancy. Indeed, the woman could have developed complications and probably died from complications in any of her earlier pregnancies. Worse still, some of these women began antenatal care quite close to their Expected Date of Delivery (EDD). For instance, some of them waited for more than 8 months before their antenatal activities began and as one of the widowers admitted:

It was my fault not to have insisted that she started it early. We had to wait for eight whole months before she got registered. She bought some of the routine drugs such as folic acid, calcium and so on from patent medicine stores and was strong most times... so we were reluctant to have her register. We learnt our lesson the hard way which is unfortunate. Now I have three children to cater for all alone.

Perhaps the couple assumed that going through several pregnancy experiences would have translated to knowledge and awareness that could enable them take care of subsequent pregnancies themselves. We note here that each pregnancy is unique and requires peculiar care; therefore, it is not only dangerous to generalise pregnancies as similar but also suicidal. The major implication of late registration for antenatal is that symptoms of complications would not be detected early before they become life-threatening. As such, most negative pregnancy outcomes are manifestations of neglected or unidentified anomalies that could have been taken care of early through regular antenatal checks and examinations.

Engaging the issue further and particularly the decision making processes relating to onset of antenatal care, a large number of respondents stated that the deceased made the choice. Our position is that assuming the above claim is valid,

you cannot be so sure, patriarchal ethos that suffices in most Nigerian cultures de-empowers females. Women of low socioeconomic status would likely depend wholly on their men including paying for the cost of antenatal services. Even among the few that claimed that such decision was joint, it could also be that their husbands' positions prevailed. It is noted that although loans from the micro-finance bank relatively empowered these women economically, they were still disadvantaged in socio-political and educational aspects of life. As such, male role and responsibility were still central to access and use of medical facilities among these women²⁷.

On the facility that the deceased patronized during antenatal, some of the respondents stated that their late wives utilised hospitals and maternity homes. Spatial closeness of these facilities to deceased homes was the main consideration for the choice; the competence of the providers was least considered. Findings revealed that in some cases the distance was as short as 200 metres. We argue here that patronising a facility that lacks requisite expertise would translate to lack of access to maternal health facilities, with its concomitant consequences. On the other hand, some of these women patronised facilities far beyond five Kilometres from their homes and it took some as long as one hour or more to access healthcare. The major reason adduced for insisting on facilities in distant places is perceived competence inherent in the facilities. Again, such distance has implications for maternal outcomes especially in situations where complications are experienced to the extent of emergency. We note that, through unobtrusive observation and interview, some of the hospitals are sub-standard particularly at the level of sanitation and calibre of personnel.

About 25 percent of the deceased either did not patronise any facility or relied on faith based organizations or were attended by Traditional Birth Attendants. One of the women that did not patronise any facility was probably because she never got married and did not want to make her pregnancy status known in order to forestall community sanctions. Another woman in that category went to stay with the mother who in her estimation was profoundly competent to dictate

and handle complications. She was eventually wrong as the outcome suggested. One of the respondents admitted that the deceased wife patronised a Traditional Birth Attendant, a decision that was taken by the man and the wife for some reasons such as:

...we decided to patronise the TBA for two important reasons. First she is very competent in handling pregnancy related issues. Several people, including the rich, patronise her and were happy with the outcomes that they got. The situation through which my wife died was unfortunate; she could have also died in any other facility anyway. Second, the TBA has a human heart unlike some of the nurses and Doctors you meet in some of our hospitals. Thus, although we spent about an hour to reach her facility we did not mind provided my wife received the quality treatment that the woman was known for.

Clearly, this respondent was ignorant about what constitutes competence and expertise and as a result placed his trust in the TBA to the extent of not minding the very long distance between his home and the Attendant's facility. Our view is that even if the TBA was profoundly competent as claimed by the respondent (we do not agree with that position though), it is dangerous to patronise a facility that could only be accessed in about an hour. The immediate demerit of such distance is that it leads to avoidable delays during emergencies such that cases that could have been effectively managed early become risky. Interestingly, adjudging the TBA as competent was baseless considering that it was the deceased's first pregnancy after ten years of marriage; one then wonders the grounds on which that conclusion was reached.

One of the respondents whose deceased wife relied on a Faith Based Organization in Ibadan in trying to justify the choice of such facility against orthodox and traditional facilities narrated:

The services hospitals offer are just medical; in our environment, we know that a lot happens. Therefore a wise person will go to a place where spiritual services are offered in addition; that is why we decided to patronize

the Church where you pay little or nothing but received double services.

How wrong they eventually were. While we are not in any way against people holding firmly to their faith, it however runs against logic to patronise a medical facility just on the basis of additional spiritual services it could offer irrespective of whether it possesses requisite competencies to deal with the medical needs of its clients.

Place of Delivery and Direct Causes of Mortality

Results show that 44 percent of the deceased women switched facilities between antenatal care and delivery services for various reasons. Six patterns of change of medical facilities were identified and they include: (a) hospital to hospital (also included here are maternity homes) – 13 clients; (b) hospital to Faith Based Homes (FBHs) – 3 clients; (c) hospital to TBA – 3 clients; (d) Faith Based to hospital – 1 client; (e) TBA to Hospital and back home – 1 client; (f) hospital to home-delivery – 1 client.

Hospital to hospital

Respondents adduced different reasons why their late wives switched from the hospitals that provided them antenatal services to another. One of them stated:

My wife gave birth to two of our children in a particular hospital. She also started her antenatal there until we visited a family friend in one of the maternity homes in town. Scan result revealed that her baby was dead... that baby was eventually delivered alive, miraculously. The situation struck us and we decided to patronise the latter facility managed by a midwife that works with a teaching hospital.

The respondent's wife was not as lucky and died in the process. She had stillbirth and bled profusely that the maternity home could not manage the situation. The woman died in a vehicle conveying her to a Catholic hospital, which would have been the third clinic within a short space of time. Another respondent had his wife transferred to a clinic different from where she received

antenatal care because she needed to be operated upon urgently, which the earlier clinic could not have been able to undertake. It was revealed that the woman died two days after the operation from post-operation sepsis that resulted from ruptured uterus and bladder.

One of the respondents recalled that his wife attended antenatal care in Lagos where she was registered, but was taken to Osun State by her father who, as noted by the respondent, wanted the daughter to deliver in his presence. She died of complications after a Caesarean Section (CS). Another respondent claimed that they switched facility when the wife developed complications; with scan result revealing that the baby was dead, he quickly rushed her to a clinic where she was operated upon to remove the dead baby. She died of eclampsia shortly after. Another widower painfully narrated his experience:

My wife got registered in a good Catholic Hospital where she also had our three children. Unfortunately, she started experiencing labour when I was out of town and my Mother-in-law decided to take her to a nearby hospital. She eventually had stillbirth and bled to death thereafter... I should not have travelled during the period and in fact I did not know her pregnancy was due at that time.

Although the widower took responsibility for the event, the scenario indicates ignorance and/or levity in prioritising emotional and physical support for pregnant women, particularly close to their Expected Date of Delivery, for which several men are also culpable. This is especially the case in Nigeria where women have low socioeconomic status and the most important decisions are taken by men. Another client that died from cardiopulmonary failure was transferred to a hospital other than the one from which she received antenatal care when it was eventually perceived that it could not handle post-partum haemorrhage experienced by the deceased. To be sure, virtually all the transfers were outcomes of perceived incompetence in handling complications and emergencies by earlier facilities. It goes without saying therefore that most of the women were lucky not to have developed these

complications in their earlier pregnancies; perhaps the mortality events among these women could have occurred much earlier.

Hospital to Faith Based Homes

One striking thing among all the cases that got transferred from hospital to FBHs is that they were resident in urban centres. One of the respondents stated that the wife only went to their church to pray and labour stated; having been attended by a nurse she died as a result of uncontrollable bleeding. Another client that switched facility did so, on the advice of her church minister who saw vision that suggested the deceased needed to give birth in their mission so as to forestall or resist spiritual attacks. For some other client, switching to FBH did not yield the expected result and was taken to yet another hospital, her widower narrated the incident:

My wife and I decided to patronise a hospital 15 minutes away from our house, but when she had emergency late in the night and considering that we could not go to that hospital, I decided to take her to mission church which was quite close to the house... she laboured for three days and I decided again to move her to a civil service hospital where she had stillbirth. She thereafter developed severe stomach ache and eventually died in a church; typhoid fever was said to have been implicated in her death.

This is arguably a case of recklessness and lack of trust in the ability and competence of personnel in these facilities. Notice, that the widower was just taking decisions on the spur of those tensed moments without, perhaps, putting important factors into consideration.

Hospital to TBA

Result shows that of those that used more than one facility between antenatal and delivery services 13.6 percent reported changing from hospitals to care by TBAs for various reasons. One of them recalled:

My wife's labour started at about 3.00 am and it was not possible to take her to the hospital where she attended antenatal care; more than 30 minutes from our home. We therefore rushed her to a TBA that lives close to our

home. It was surprising that she died few days after delivery as a result of bleeding.

On further inquiry, it was revealed that they considered TBA services better than nothing and could not bear the pangs and shouting of the deceased without acting fast. Our view, however, is that male responsibility and sensitivity would have translated to finding a means of conveying the woman in Labour to the hospital that had known her medical history. Perhaps, the maternal mortality could have been averted. One of the respondents also stated that the late wife was taken to her village in Delta State for child delivery as a result of persistent spiritual attacks. Unfortunately she died even before the expected date of delivery at the residence of a Traditional Healer from undisclosed cause(s). Another respondent regrettably stated:

My late wife registered at a clinic in their own village. However, my mother-in-law took her to a TBA for delivery instead of where she was originally registered; honestly, I do not know why she decided to patronise the TBA. She died shortly after delivery from bleeding or postpartum haemorrhage.

This is a clear case of unacceptable interference from a mother-in-law in a situation that required that a couple take decision. We want to reiterate here, that no matter our level of respect for an individual or group, we should not allow ourselves to be led astray under any circumstance or guise.

Faith Based Home to Hospital

Only one case got transferred from FBH to hospital probably because people would likely, erroneously, see it as limiting the power of God in taking care of all situations. We contend here that taking a pregnant woman to a religious home for delivery without the assistance of trained medical personnel amounts to putting God to test. As the respondent narrated:

Her antenatal care was at Christ Apostolic Church where we thought she received adequate attention, especially spiritual care. She was later moved to a clinic in town when we noticed that she was consistently ill and did not get better. Yet, her convulsive situation

did not improve and the Doctor referred her to a Teaching Hospital. She died before reaching the latter facility.

The delay in accessing health care exacerbated her condition and eventual death. Perhaps, the pregnancy outcome would have been different had she had access to adequate care at the right time and from the right facility such as a teaching hospital.

Home of TBA to Hospital and Home

Experience shows that people usually switch from TBAs to hospitals when the former facility is perceived as incapable of handling maternal situations. One of the respondents who preferred a TBA that lived one hour away from their home to other maternal health providers but had his late wife taken to a hospital by his brother-in-law recalled:

My wife and I, as it were, decided that she patronise the very competent TBA in our area. But when I travelled, my Brother-in-law took her to an Owerri-based hospital when it was discovered that her legs were swollen. Later, they went back to his house in Port Harcourt where she eventually died; he did not bother to take her either to a TBA or hospital.

Just like what was reported earlier, interferences from Significant Others usually undermine family relations. Such interference could be productive, though, if it leads to successful pregnancy outcomes rather than compound maternal health challenges among pregnant women and their families. In the instant analysis, the deceased brother's interference that ended in death that occurred at his home was counter-productive.

Hospital to Home Delivery

The pattern of attending antenatal care at a hospital and attempting to deliver at home is usually not common especially due to the orientation that these women receive from hospital facilities. However, one of the deceased clients was involved in this pattern reported to be her normal approach to childbearing. The widower stated:

She was registered with the Ahmadu Bello University Teaching Hospital (ABUTH) at her instance where she was used to. But all her deliveries took place at home with the assistance of an experienced nurse. Two factors were considered in deciding that she delivers at home – availability of a trained nurse in our neighbourhood and distance to the teaching hospital which is six kilometres away from our house. Unfortunately this time, she started bleeding moments after delivery and was rushed to ABUTH where she was confirmed Dead on Arrival (DOA).

Perhaps, the calculation was that antenatal care was more critical than delivery in recording positive pregnancy outcomes. This case has proved that each stage is as important as another and that no matter how competent a nurse is perceived, it is much better to rely on facilities that have varied manpower and expertise. In fact, it is difficult to justify home delivery in any circumstance apart from, perhaps, a war situation wherein the danger of accessing a hospital facility may far outweigh the risk of delivery at home.

Discussion and Conclusion

This study has not only re-echoed the known fact that maternal mortality and morbidity in less developed societies are high but also that this is particularly so among women of low socioeconomic status. Indeed, the latter suffer the consequences of patriarchy and female subjugation more than other categories of women and are therefore less able to realise their potentials. Yet, some husbands, upon whom their wives have absolute dependence on, are grossly irresponsible in attitude, care-behaviour and finance. For the most part, this level of male-irresponsibility is not deliberate but also a function of the man's low socioeconomic status in terms of literacy, occupation and income. On their part therefore, the choice of maternal health facilities was rational and made on the basis of the perceived benefits. Our respondents both in rural and urban centres did not indicate different attitude and behaviour in terms of wife-support during maternal periods, suggesting that urbanization may not be a

sufficient explanatory factor for attitudinal and behavioural change among illiterates.

Although norms and values in most African communities support close kinship ties and extended family ethos which are perceived to engender relationship building and sustenance, this research found a link with maternal mortality. Clearly, in places where nuclear family relationship is emphasized, mother and father in-laws and any other persons or groups would hardly have the opportunity and audacity to dictate activities related to antenatal, delivery and postnatal. In the instant analysis, these third-party interventions did not ameliorate the despotic tendencies of patriarchy but rather were undesired intrusions into spousal communication. Such interference may bolster calculated irresponsibility among husbands who may already have failed in the expected obligations to their pregnant wives. Ironically, some of these intruders may be unwilling or unable to take responsibilities for the woman's needs during the period; a situation that indeed leaves the woman without any leaning. Third party intrusion is antithetical to family decision making processes and adequate assessment of severity, barriers and benefits of an action related to maternal health.

The findings of this research speak directly to reasons that explain high maternal mortality and morbidity in Nigeria classified among countries with the highest chances of dying from maternal causes. Indeed, most of the deaths could have been avoided with proper and timely antenatal care, male support and delivery in facilities with relatively adequate personnel and equipment. Such a holistic approach to integrating different essential but related aspects of maternity speaks directly to the importance of perceiving pregnancy and its outcome as a system that is decomposable into subsystems. Although most of the deceased clients were of low socioeconomic status, this research revealed that some of them had their families spend more money criss-crossing (from hospital to TBA, back to another hospital or Faith Based Home and so on) maternal health facilities, between antenatal and delivery, than would have been the case for those that depended on a particular functioning health system. This antithesis wherein socioeconomically poorer

people spend more money defraying the cost of maternal care services, from different and often unrelated facilities, is a function of ignorance, scepticism and lack of trust in any one system.

The immediate consequence of such experimental approach to maternal health seeking even during emergencies is the inability of medical personnel to fully understand the medical history of patients whose reproductive systems may have been distorted by inconsistent recourse to different treatment options. In some cases, these women only get to the relatively more appropriate facilities when their situations could no longer be rescued; that is the dilemma of maternal events in sub-Saharan Africa and Nigeria in particular. We contend here that notwithstanding the level of economic empowerment that women achieve, it would not contribute appreciably to reduction in reproductive mishaps without a corresponding increase in awareness and demystification of unnecessary male domination that thrives in feminizing voice-less-ness in family decision making processes. The challenge therefore is in identifying the most appropriate strategies for community sensitization to ensure that reproductive health reorientation achieves the desired goal of reversing Nigeria's maternal-outcomes status within the shortest possible time.

Recommendations

The findings of this research reveal that most of the maternal deaths could have been avoided with adequate care and efforts. This section is concerned with suggesting strategies to reduce appreciably or eliminate maternal morbidity and mortality. Results of the study indicate that direct and indirect factors interact in determining pregnancy outcomes. The most common direct factors include haemorrhage, toxemia, eclampsia, abortion and obstructed labour; these are usually driven by indirect factors such as low socioeconomic status, cultural beliefs and practices, poor access and use of facilities, ignorance among others. The following specific recommendations are made:

1. Experience shows that in a male dominated society such as Nigeria, where men's views are usually dominant, policies, family and

household activities that ignore them are bound to fail. As a result, efforts should be made to make them an integral part of programmes or efforts aimed at safe-motherhood. In other words, achieving safe maternal outcomes will depend largely on how far men are involved since most of them are breadwinners and decision makers. Moreover, their participation in household chores during maternal periods will minimise the stress that their wives would ordinarily go through without such assistance. We recommend that women be invited alongside their spouses for counseling, by caregivers, at least once during each pregnancy (preferably within the first trimester). The essence of bringing them together is to ensure that they come to terms with important issues related to decision making, antenatal care, delivery, postnatal period and beyond.

2. We recommend the use of drama at the community level as a means of driving home the consequences of negative maternal situations including morbidity and mortality and the factors that bring them about. This is important because some people learn better when the situation is presented in real life scenarios than when sensitization follows only the verbal counseling model. Employing the use of drama will reinforce the messages that would be or would have been put across to the intended audience (clients and their spouses). Our view is that since a theatre group will not be readily available to address the concerns of relevant pregnant women at all times, it is appropriate to document such drama in both audio and visual forms. That way, it becomes handy for use in different situations. However, since Nigeria is a multilingual society, the drama should be presented in the three main Nigerian languages and pigeon English, to ensure wide coverage. The drama may also be translated in any other language as the need arises.
3. In addition, it will be necessary to narrate some of the findings of this research and other studies to clients in the course of counseling.

This will clearly reveal the reality (concrete evidence) of some of these situations more than ordinary story-telling would. Together with the drama proposed earlier, the lessons will sink deeply in the heads of these women and their spouses.

4. It is also suggested that governments at various levels should defray the cost of antenatal care for women in their areas of jurisdiction. This will serve as incentive to patronise health care facilities against the choice of cheap and ineffective sources. This study has revealed that for several reasons including poverty, ignorance and over-confidence in their ability to take care of situations during pregnancy, couples take antenatal care with levity; payment by these governments will be necessary to discourage such attitude and behaviour. There are two ways to this. First, is to identify health facilities with competent personnel and equipment, not necessarily general hospitals, where these women will be encouraged to undergo antenatal care free of charge. Second, monitoring antenatal activities of these women in their own chosen facilities and payments made directly to the facility. One advantage that is derivable from this arrangement is that antenatal care will not only be of high quality but also undertaken regularly.
5. Similarly, it is recommended that governments and organisations should take the responsibility (for the latter as part of corporate social responsibility) of paying for the cost of delivery for women of low socioeconomic status that patronise approved facilities. Such incentive will go a long way to discouraging patronage of inadequate facilities including some Traditional Birth Attendants, Faith Based Healing Centres and home deliveries. Findings of this study reveal that some of the women, on their own, switched facilities between antenatal and delivery care; at times preferring Faith-based facilities to the orthodox. Such attitude undermined effective diagnosis among medical personnel who

hardly had adequate knowledge of the medical history of relevant clients.

6. Data from this research clearly demonstrate that interference from significant others such as mother in-laws, brother in-laws among others accounted for decisions that led to catastrophic consequences for deceased women and their families. Consequently, sensitization of pregnant clients should include effective strategies of dealing with pressures from these important quarters while sticking to activities, attitude and behaviour that will engender safe-motherhood. In what follows, we present modules designed to sensitise women on necessary attitude and behaviour that will largely bolster desirable pregnancy outcomes.
7. It has become necessary to educate Nigerian couples of reproductive age on different aspects of maternal health since the prevalence of maternal mortality in Nigeria is one of the highest in the world. The reasons include poverty, ignorance, patriarchy, cultural beliefs and practices among others. As a result, there is a clear need to empower most of these women through a comprehensive awareness creation package. Such training is particularly important in view of the fact that pregnancy is seen in some quarters, especially among people of low literacy and socioeconomic status, as a normal condition that does not require special care.

The modules below showcase the linkage among different stages of maternity that interact to influence pregnancy outcomes. The assumption here is that each of the stages is as important as others and can affect the entire pregnancy process that terminates at the end of 42 days following delivery. In what follows, we present seven modules for the proposed training. The idea is to first train the trainers such as community counsellors, women leaders, clients' relations officers and other relevant individuals who would later train women of reproductive ages and their spouses. We are convinced that a careful, diligent and sustained use of these comprehensive training

modules will positively impact reproductive health attitude and behaviour of women in different Nigerian settings to bring about desired reduction in adverse maternal outcomes.

MODULE 1: Common causes of maternal mortality

Direct causes

- a. Haemorrhage
- b. Toxaemia (pregnancy induced hypertension)
- c. Eclampsia (convulsion and coma)
- d. Obstructed labour
- e. Spontaneous abortion

Indirect causes

- a. Short interval spacing
- b. Poverty (poor nutrition, anaemia etc)
- c. Delays (decision making, accessing facilities, receiving treatment)
- d. Cultural beliefs and practices
- e. Long distance between home and facilities (far more than 5 km)
- f. Ignorance (recognising important symptoms, food intake etc)
- g. Strenuous activities etc.

This module is essential for understanding of specific causes of maternal deaths and as a background that speaks directly to issues in subsequent modules. It is expected that the causes will be taught in a way that the relationship between direct and indirect factors of maternal mortality would become visible to the extent that intended beneficiaries appreciate what they would learn. It will showcase the reality of these causes so that even pregnant women of low socioeconomic status are sufficiently sensitized.

MODULE 2: Family Planning

- i. Meaning and types
- ii. Importance and limitations to success (ideal spacing interval and its justification)
- iii. Why and when family planning fails
- iv. Consequences of family planning failure
- v. Risks associated with abortion
- vi. Types of contraceptives
- vii. Barriers to access – information and services
- viii. Overcoming the barriers

- ix. Fertility decisions (the ideal process)

Teaching with reference to this module will necessitate understanding the role of contexts in defining family planning and its relevant importance. In particular, the influence of socio-cultural, religious and familial factors among others on attitude and behaviour of pregnant women will be engaged. It is expected that this module will encourage participation among intended beneficiaries through experience sharing. That way, relevant Counsellors are better placed to educate these women on relevant issues that may eventually remove obstacles to successful family planning programmes among couples.

MODULE 3: Pregnancy

1. Planning pregnancy (choice rather than chance)
2. Lessons in ovulation and menstruation
3. Recognising early symptoms and what to do
4. Avoiding pregnancies at extreme ages
5. Male role and responsibility
6. Common prescriptions (food, activities etc)
7. Common proscriptions (food, smoking, drinks, activities etc)
8. Sex during pregnancy (truths and misconceptions)

This module is designed to make the point that pregnancies are supposed to be planned rather than occur by chance. This chance phenomenon is the case for several illiterate couples and in particular those in rural communities of Nigeria and sub-Saharan Africa in general. The module is designed not only to emphasize the linkage between family planning and pregnancy but also to highlight individual and household expectations during pregnancy. Here, the roles expected of other stakeholders particularly husbands will be discussed.

MODULE 4: Antenatal care services

- a. Appropriate period to get registered

- b. Appropriate place (identifiable competences, equipment, environment, friendliness, feedback etc)
- c. Maximum distance to maternal health facility and why
- d. Funding
- e. Ideal decision making processes (by whom?)
- f. Roles and responsibilities of care givers
- g. Obligations of care seekers
- h. Components of ANC services
- i. Discontinuing with service provider (what constitutes anathema/beyond the acceptable).

Data for the present investigation on the factors influencing maternal mortality reveal that most of the cases were related to antenatal issues. Needless to say significant attention should be devoted to training and retraining of pregnant women on the dangers of inadequate antenatal practices, which for several reasons such as ignorance, the influence of patriarchal ethos among others are taken for granted. We expect that significant attention will be devoted to each item in the module. Indeed, each of the factors or a combination of some affects these women's predisposition to antenatal services. Again, it is expected that teaching of this module shall follow the interactive design wherein the intended beneficiary is encouraged to relieve her experiences on some of the items.

MODULE 5: Child Delivery

- i. Signs and symptoms of onset of labour
- ii. Dangers of delays in access to delivery care
- iii. Appropriate place for delivery and why
- iv. Who is competent to assist during delivery? (Who is a skilled birth attendant?)
- v. Should Traditional Birth Attendants (TBAs) in any circumstance be patronised?
- vi. Is Caesarean Section (CS) a sign of low will-power?
- vii. Should there be situations where Doctors' advice could be rejected by women in labour?

Notwithstanding the perceived level of experience among women pertaining to childbearing, there is need to further educate them on some important but taken for granted issues around delivery. Probably, engaging a Gynaecologist at some point during the teaching of this module may be essential in understanding some of these issues. For instance, it is difficult for some of these women to accept that not all medical doctors are skilled attendants and therefore not to be patronized. Our findings show that these women hardly distinguished medical practitioners by specialization. Consequently most of the clinics, even when they are located very close to these women's homes, are incapable of assisting women during emergencies that often result in avoidable deaths.

MODULE 6: Postnatal period

1. Breastfeeding (myths and misconceptions)
2. Hygiene behaviour
3. Child immunizations/care practices
4. Prescriptions (food, drinks, practices etc)
5. Proscriptions and cultural taboos (food, drinks, practices etc)
6. Must women wait till appointment dates?
7. Observing the 42nd day check-up (closure of a pregnancy cycle)

With the arrival of the baby, most people tend to become complacent towards essential postpartum practices either out of ignorance or euphoria. However, it has been demonstrated that postpartum mortality contributes significantly to maternal mortality statistics. This module is structured to point out the enormity of the task for families and the danger in levity. Our view is that the responsibility even doubles as care for mother and her child should be undertaken with seriousness. It has clearly been demonstrated that a mother's health is closely linked to that of her baby.

MODULE 7: Beyond postnatal

- a. Resumption of coitus (necessary precautions against mistimed pregnancy)
- b. Exclusive breastfeeding (essence and challenges)
- c. Dietary intake

d. The waiting game continues – coping during the period

For some women, breastfeeding serves as a form of contraceptives, while this is not the same for others. Therefore, managing fertility beyond the postpartum period requires insight, perseverance and diligence which should be carefully taught. This module will engage relevant factors that relate to coitus, dietary intake and avoiding sex without offending your spouse among others.

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