RELIGIOUS AND SOCIO-DEMOGRAPHIC FACTORS INFLUENCING UTILIZATION OF ANTENATAL CARE SERVICES IN ILESA, OSUN STATE, NIGERIA

By

Mary Olaitan**, AYANLEKE**
B. Ed (ABU, Zaria) M. Ed, M. Sc (Ibadan)
Matric. No: 64561

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CERTIFICATION

I certify that this work was carried out by **AYANLEKE, Mary Olaitan** under my supervision in the Department of Sociology, University of Ibadan, Nigeria.

Signature..... Date.....

Dr. O. O. Omololu,
B.Sc (Calabar); MSc; Ph.D (Ibadan)
Department of Sociology,
University of Ibadan,
Ibadan, Nigeria.

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DEDICATION

This work is dedicated

to the glory of God Almighty who has brought me, a poor soul, from the dung hill, and has made me sit with princes

and

to my late parents and mentors Mr. and Mrs. David Atoyebi Ifawole; and Chief Oyedeji Ifawole; all of whom afforded me the solid foundation for this educational programme. May you find favour with the Almighty on that great Day.

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UNIVERSITY OF IBADAN

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UNIVERSITY OF IBADAN

TABLE OF CONTENT

UNIVERSITY OF IBADAN

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

CHAPTER THREE: METHODOLOGY

UNIVERSITY OF IBADAN

UNIVERSITY OF IBADAN

UNIVERSITY OF IBADAN

UNIVERSITY OF IBADAN

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

UNIVERSITY OF IBADAN

LIST OF FIGURES

LIST OF PICTURES

UNIVERSITY OF IBADAN

LIST OF TABLES

UNIVERSITY OF IBADAN

UNIVERSITY OF IBADAN

UNIVERSITY OF IBADAN

ACRONYMS

ANC	Ante Natal Clinic
C.S.	Caesarean Section
FBBA(s)	Faith Based Birth Attendant (s)
FBBHs	Faith Based Birth Homes
HBM	Health Belief Model
IDI(s)	In-depth Interviews
MM	Maternal Mortality
TBA(s)	Traditional Birth Attendant(s)

UNIVERSITY OF IBADAN

ABSTRACT

Inadequate access to Ante-Natal Care (ANC) services is one of the factors responsible for high maternal and infant mortalities in Nigeria. Studies have focused on clinical determinants of pregnancy outcomes with little attention paid to belief systems and characteristic features of pregnant women who utilise ANC in spite of the potential role of religious beliefs system on pregnant women's choice of health care services. This study, therefore, examined the influence of belief systems and socio-demographic characteristics of pregnant women on utilisation of ANC services in Ilesa, Osun State.

Functionalist Theory and Health Belief Model (HBM) were used. Multistage sampling technique was used to select 500 pregnant women at household level (50), faith homes (225) and health centres (225). Ilesa was purposefully selected because of the preponderance of Faith Based Birth Homes (FBBH). Questionnaire was utilised to obtain quantitative data on socio-demographic characteristics, perception of aetiology of pregnancy complications, influence of religious beliefs, adherence to care givers' prescriptions and husbands' roles in pregnancy care. Qualitative data were collected through non-participant observation of 20 sessions of ANC and prayer meetings. In addition, 12 In-Depth Interviews (IDIs) were conducted in each FBBH and orthodox health care institution. Quantitative data were analysed using descriptive and Chi-Square statistics at $p \leq 0.05$. Ethnographic summary was used to analyse qualitative data.

Respondents' age was 29.5 $\pm$ 5years, 86.6% were Christians, 74.6% were married and 30.6% had tertiary education. About 80% attended ANC; and of this, 24.6% had their last babies in FBBH while 11.8% delivered at home. Less than 40.0% completed minimum requirements of four ANC visits. Only 51.6% had ante-natal ultra sound evaluations, 37.6% took two shots of tetanus toxoid while 18.2% refused any form of immunization as a result of religious belief. Adultery (43.8%) and activities of witches and wizards (41.6%) were perceived as causes of pregnancy complications. There was no significant relationship between religious affiliation and place of delivery. Decision making on utilisation of ANC services reflected dominant gender structure as 61.9% of respondents reported that husbands determined the choice of place of delivery. There

was no significant relationship between demographic characteristics of pregnant women and ANC utilisation; age (t= .649), marital status (t=1.038), education (t= -.356) and income (t= -.356) were not significantly related to ANC utilisation. Majority of the IDIs revealed that respondents perceived pregnancy processes and outcomes as more spiritual than medical. Praying, confessions of sins, application of anointing-oil and spiritual baths were perceived as efficacious for warding off evil forces. The ANC providers in FBBH reported that many women could not afford delivery materials thereby causing some husbands to abscond on the day of delivery.

Faith Based Birth Homes enjoyed more patronage than orthodox birth homes. Therefore, there is need for supportive supervision of FBBH by health professionals.

Key words: Ante-Natal, Faith Based Birth Homes, Religious Beliefs, Pregnant Women

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UNIVERSITY OF

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Religion permeates all aspects of Africans' life. Mbiti (1978) observes that religion extends and influences every aspects of Africans' living. Africans are said to be notoriously religious. Religion is the way of life in traditional African society as there are inextricable connection between religion and culture in Africa (Mbiti, 1978). They were naturally born into religion and grew up formulating ideas, beliefs and customs that were religiously based to regulate their daily living.

The Ijesa, like all the Yoruba people, from pre-colonial times, believe in one Supreme Being (God) who created the universe. They believe in the existence of divinities that are believed to emanate from the Supreme Being. They believe that the divinities are ministers of God- the Supreme Being. When there are outbreaks of diseases, the divinities are believed to cause them. Olode or Soponna, for example is believed to be the divinity of small pox and Osoyin is the divinity of healing. When diseases break out, diviners and witch-doctors are employed to curb them. Idowu (1973) states that "diviners in Africa are believed to be under possession of the spirits when they engage in divination and witch-doctors claim that they are chosen by sprits, taught medicine by the spirits and guarded in their profession of diagnosis and healing by the spirits". According to Idowu (1973) as quoted by Jacobs (1977) "the key notes of the Yoruba is in their religion... "full responsibilities of all affairs of life belong to the Deity and their own part is to do as they are ordered through the priests and diviners and that at every stage of life, man is in the hands of the Deities". As a result, religion also influences maternal and child health. It influences their health seeking behaviour in pregnancy care and delivery.

Belief in witches, wizards, sorcery and malevolent spirits prevail. These spirits are believed to cause diseases, barrenness, as well as infant and maternal mortality. Among

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the Ijesa, many rituals are connected with child birth. Sons are preferred to daughters. To be childless is a reproach and barren women would do anything to ensure fertility.

Statistics have shown that more than half a million women die every year during pregnancy-related complications, ninety nine per cent of which occur in sub-Sahara Africa and South Asia alone (Freedman and Maine, 1993; Population Reference Bureau, 2000; Azub, 2011; Adebayo, 2013). Developing nations of Sub-Saharan Africa has one of the highest Maternal Mortality Ratio (MMR) of 900 per 100,000 live births while South Asia has 470. India has the highest Maternal Mortality (MM) 117,000 per 100,000 live births in the world. Nigeria follows after with 54,000 per 100,000 live births. Global estimates are 428 and 400 for 1990 and 2005 respectively. Global decline from 1990-2005 is only 5.4% with an annual decrease of less than 0.1% in Sub Sahara Africa. Africa hosts majority of the 68 countries that are currently off track in achieving Millennium Development Goals (MDGs). These figures do not include many rural women, who for various reasons, do not go to hospital. A basic indicator of national development is the health status of its population and women's health is a critical area, which reflects national health standards and this is basic to women's advancement (Federal Ministry of Health (FMOH), 2007). World Health Organization (WHO, 1978) defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.' It defines reproductive health as 'a state of physical, mental and social wellbeing in all matters of reproduction and not merely the absence of diseases or infirmities in pregnancy status and outcome, abortion and sexual health.' The health of the people contributes to better quality of life and sustained social and economic development. Maternal mortality is an important indicator of the standard of health in different countries. Infant and maternal health are basic indicators of national development but both are high in Nigeria (Akinlembola and Oguntimehin, 2006; Nigeria Demographic and Health Survey (NDHS) 2003; 2008). Federal Ministry of Health (2006) observes that Nigeria contributes about 10 percent of the world's global burden of maternal mortality. The Nigerian scenario remains among the worst in the developing countries. Nigeria Maternal Mortality Ratio (MMR) is 100 times worse than industrialized societies (NDHS, 2008).

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Pregnancy and child bearing sustains any society. Pregnant women are supposed to be the healthiest patients in the hospital, but pregnancy condition places a woman in a state where she constantly needs medical care because it alters the physical condition of the body system. If this stage is not properly managed, it makes the body susceptible to diseases owing to low level of body immunity. This necessitates adequate care of a woman's pregnancy in order to enhance a successful outcome. Adequate antenatal care would result in considerable reduction in maternal and child deaths. Every pregnant woman desires good life and health for herself and her baby. Therefore, she will likely seek means to make herself and the baby healthy. To promote maternal and child health, the health of the women must be well managed.

Health management is an action taken by an individual to remain healthy or prevent illness; or the action she takes to regain her health when she falls sick (Mechanic, 1962). Health care of a pregnant woman may include all the actions she takes from conception to six weeks after delivery to ensure safe delivery and sound health for herself and the baby; such as: pregnancy tests, antenatal treatment, immunisation when due, adherence to routine drugs, exercise, rest and diet prescriptions. Health care for pregnant women includes all actions taken by the woman, significant others, and healthcare providers to make or mar the pregnancy. Studies have shown that poor hygiene, malnutrition, and Human Immunodeficiency Virus (HIV) status as well as lack of appropriate care often increase the risk of serious complications in minor ailments in pregnancy, but proper management will reduce these risks.

1.2 Statement of the problem

In any culture, child birth is a thing of joy, but reproductive health problems account for more than one third of the burden of diseases in women (Mbizvo, (1996); NDHS (2008). Ebhuomhan (2008) and Dada (2008) claim that in Nigeria, an estimated 54,000 maternal mortality (MM) occur per annum due to pregnancy-related problems. This translates as one woman dying every 30 minutes; and for every death, there are about twenty other women who suffer from diseases, disabilities, or physical damage that impede their health for life (Dada, 2008). Unsafe abortions, complications of pregnancy

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and childbirth thus remain serious causes of death and morbidity among Nigerian women (Ladipo, 1989). Most data on maternal morbidity and mortality in Nigeria are derived from hospital statistics. They are not a representative sample, as many women die at home or on the way to hospital unreported.

The foregoing discussion implies that there are 54,000 cases of widowers, motherless babies, bereaved parents and relations. Every year, Nigeria records 1.5 million women in agony of maternal morbidity and many remain so for the rest of their lives (World Health Development Report, 1995 and Dada, 2008). Maternal mortality in Nigeria ranges from 800-1000 per 100,000 live births (Akinlembola *et al.* 2006 and Awosiyan, 2009). The chairman of the National Population Commission (NPC), once disclosed at a press conference in commemoration of the 2012 World Population Day that the Nigerian maternal mortality (MMR) ratio was 545 per 100,000 live births. The MMR in Nigeria shows a disparity between the regions and the rural areas. The north east and the north west have 1349 and 1025 per 100,000 live births, respectively, making the region eight times higher than the south west region. Rural areas have 828 per 100,000 live births as against 351 per 100,000 live births in urban areas. This is due to poor health during pregnancy as well as poor obstetric care. The north is predominantly rural, and less than 31 percent of pregnant women are delivered by skilled health personnel (NDHS, 2008).

An African woman's life-time risk of dying from pregnancy complications is about 1:15 while the risk in industrialized world ranges from 1:4,000 to 1:10,000 (Roth and Mbizo, 2001 and Azuh, 2011). In Asia, the ratio is 1:105, that of Europe is 1:1895 and that of North America is 1:3750 (Azuh, 2011; Abdoulaye, 2006). Among Nigerian women of reproductive age, 1:18 die due to pregnancy-related complications; while in Bosnia and Herzegovina 1:29,000 dies (Population Reference Bureau, 2005 and WFFC MDGs Table 2007). In Nigeria, maternal mortality ratio is estimated at 1:98 per live births; still one of the highest in the world (WFFC MDGs Table, 2007). Data from Federal Ministry of Health (FMOH) showed an increment in level of MM since Safe Motherhood Initiative was launched in Nigeria in 1990.

Causes of maternal death in developing world include haemorrhage, infection, toxaemia and obstructed labour, and illicit abortion (WHO, 1999; United Nations Fund

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for Population Activities (UNFPA) 2001). Adebayo, (2013) asserts that there are five major causes of maternal death: haemorrhage (25%), infection (15%), eclampsia (12%), obstructed labour (8%) and unsafe abortions (13%). These deaths and disabilities could be prevented or reduced if pregnancies are managed appropriately. Adebayo, (2013) states, that these deaths are preventable, with simple prophylactic measure and timely diagnostic measures, as well as treatment of pregnancy complications. Statistics revealed that 2-3 million women develop preventable disabilities, such as severe anaemia, incontinence, uterine prolapsed, damage of the reproductive organs or nervous system, chronic pain, and infertility (Asghar, 1999 and UNFPA 2001). In Nigeria, complications arising from pregnancy and childbirth are leading causes of disabilities and deaths among women. The incidence of maternal mortality is estimated at 15 per 1000 live births, making the country one of the highest on the African continent World Health Development Report, (1995); and WHO, (2001); (Population Reference Bureau, (2005)). Throughout the world, the death of mothers from pregnancy and child birth has become a source of worry and concern, particularly in Nigeria, that has been rated first among poor countries on maternal mortality ratio and least safe nation on matters relating to maternal and infant welfare (Adelani, 2009). WHO (2006) notes that MM ratio in Benin Republic was 859, Gambia and Ghana 540, Liberia 760, Nigeria 800, and Sierra Leone 2000 (Adelani, 2009). Nigeria's case is even worse than those of Gambia and Ghana and war-torn Liberia.

Maternal mortality and maternal morbidity are critical priority problems that demand recognition and concern by all, including policy makers and health administrators. When women are pregnant, their health status becomes complicated. Inappropriate and incorrect treatment or even lack of appropriate and timely interventions may result in maternal deaths. The Nigerian government has been taking some steps to reduce this trend. One of such is the proposed compulsory one-year national service for all newly qualified midwives to enable service spread of antenatal care (ANC) and delivery across the country. World leaders adopted the Millennium Development Goal (MDG) number five to improve maternal health and reduce maternal mortality by 75% by the year 2015. In line with this goal, Nigeria in the National Reproductive Health Policy set the goal of reducing MM by half within ten years (Federal Ministry of Health, 2001).

UNIVERSITY OF IBADAN

This is the year for the fulfilment of the Millennium Development Goal MDGs (2015), there are still high maternal deaths in the country, and there is no clear evidence that Nigeria has yet achieved any remarkable improvement. Harrison (2012) avers that evidence has shown that, at the current rate of progress, Nigeria will not achieve the Millennium Development Goals (MDGs) before 2040.

However, these deaths place a significant burden on the health system of women and families. Many studies have attributed this challenge to the state of health of pregnant women, poor delivery process, poor antenatal and postnatal care utilisation of available health care services, as well as distance of health facilities (NPC, 2000; 2004; Azuh, 2011). Aniebube and Aniebube (2010) studied the attitude of pregnant women to a new antenatal care model with four antenatal visits (focused antenatal care) in Enugu, Nigeria. Only 20.3% of the parturient desired a change to the new model. Ibeh (2008) investigated maternal mortality index in Anambra State, Nigeria and attributed high maternal mortality to poor socio-economic development, weak health care system, low socio-economic status of women, as well as socio-cultural barriers to care utilisation. He found that about 99.7 percent of women in the locality attended antenatal clinics, with 92.3 percent of them making 4 or more visits before delivery. Okonofua, et al. (1992) investigated risk factors that affect maternal mortality in Ile-Ife, Nigeria and found that maternal deaths involved young women of poor socio-economic status. Their study revealed lack of prenatal care among all women in their sample.

There are various health actions that pregnant women can take to manage their health and that of their foetus. These include regular attendance at antenatal clinics (ANC), taking prescribed drugs, resting, as well as eating balanced diet. A major issue that this study investigated is whether or not pregnant women in Ilesa took appropriate health actions to ensure safe delivery. Among the numerous factors that were investigated was the influence of religious belief system on choice of care. This factor has not been well investigated. This was the focus of this research, as the health needs of these women require a holistic approach.

Though Ilesa was privileged as early as 1913 to host a Western medical centre established by the Methodist Mission; and more hospitals, maternity centres, and clinics

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have been established, do these translate to utilization? There are sixteen government maternity centres, a general hospital, a teaching hospital as well as numerous privately owned hospitals and maternities that are all close to the people. The people do not have to travel more than one kilometre or spend more than fifty naira (₦50.00) to get to the nearest hospital or maternity centre. In fact, the maternity centres are mostly within walking distance to the residences of the citizens. Are pregnant women patronizing them? What are the factors that determine whether or not a pregnant woman will seek health assistance from any of these places? Are there advantages in proximity of pregnant women to the health-care services available? These problems generate further questions. How do social and demographic factors influence decision on care during pregnancy? What is the perception of pregnant women on aetiology of pregnancy-related complications? How does religious belief system influence pregnant women's health-seeking behaviour? Among women that patronize hospitals, do pregnant women adhere to basic instructions and prescriptions? What roles do men play in caring for the health of pregnant women?

1.3 Objectives of the study

The study investigated pregnancy care in Ilesa Osun State, Nigeria with the assumption that spiritual and socio-demographic variables are determinants of health-seeking behaviours. The general objective of the study was to examine pregnancy care among women in Ilesa, Osun State. The specific objectives were to:

1. Examine pregnant women's perception of aetiology of pregnancy complications.
2. Explore the influence of religious belief systems on pregnant women's health-seeking behaviour.
3. Examine social and demographic factors that influence decision on care during pregnancy.
4. Investigate adherence of pregnant women to care providers' prescriptions and basic instructions.
5. Identify men's role in caring for the health of pregnant women.

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1.4 Significance of the study

In Northern Nigeria, about 2,100 women die per 100,000 live births. This figure does not give a perfect picture, as more women die quietly at home unreported. Almost half of infant deaths in Nigeria results from poor care at the time of delivery and labour (Dada, 2008). As many as 300 million women, more than a quarter of all adult women, suffer from short-or long-term illnesses related to pregnancy or child birth. A recent survey conducted by the National Democratic Health Survey has it that 12,000 women develop Vesico Vaginal Fistula (VVF) every year in Nigeria. Fistulae-holes in the birth canal allow leakages of urine or faeces from the bladder or rectum or both, making the affected women permanently incontinent. Most of these young girls have been abandoned by loved ones and society because of the stench that oozes from their bodies. Because of their condition, they are treated like lepers, or outcast (*Leadership*, 2011). Between 500,000 and 1 million women live with it and become social outcasts, turned out by husbands and families.

Maternal mortality accounts for 36% of the female reproductive age group. Maternal mortality is four times higher in poor villages than in developed ones (Yola, 2012). WHO (1998) statistics reveal that 1,600 women die daily from pregnancy complications and 50 million women suffer maternal morbidity. At least, 18 million of these cases are long-term and crippling. Fortunately, maternal deaths are not mere misfortune or unavoidable but can be prevented, through interventions that are known to be cost-effective and within the reach of developing countries. These deaths should not be allowed to continue. All that is needed is strong political commitment. Government, internal agencies, non-governmental organizations (NGOs) and other partners need to make concerted efforts to achieve this.

In addition to these, most of the studies on pregnancy care have been predominantly on antenatal care attendance, accessibility and availability. There are other factors such as perception of aetiology of disease, religion, and husband's role in decision-making in obstetric and general maternal care that have great influence on pregnancy care. These are the gaps this study tried to fill.

UNIVERSITY OF IBADAN

A reduction in maternal mortality (MM) and morbidity would greatly reduce cases of widowers, motherless babies, bereaved parents and relations as well as orphans and vulnerable children. This will also reduce agonies of the 1.5 million Nigerian women in danger of maternal morbidity (World Health Development Report, 1995; Population Reference Bureau, 2005; Dada, 2008). Furthermore, as maternal mortality and maternal morbidity happen when these women are economically productive, a reduction in them would enable the women to contribute to the economic growth of their families, in particular, and their country, in general. Those in morbid conditions will be able to enjoy healthy lives.

1.5 Study setting

1.5.1 Ethnographic details

This section focuses on ethnographic details of Ilesa in Osun State, Nigeria. The geographic and historical development, pre-colonial and post-colonial political organizations, health institutions, and religion are discussed in details.

1.5.2 Geographical information

The study was conducted in Ilesa, Osun State. Osun State has thirty LGAs. Ilesa was one LGA until 1996 when that LGA was divided into two (Ilesa East and Ilesa West). The headquarters of Ilesa East is at Iyemogun Road, Ilesa, while that of Ilesa West is at Aladie, at the outskirts along Osogbo Road, located on a large expanse of land. The population of Osun State was 3,416,959. The population of both local government areas was 212,225. The female population in both LGAs was 106,519 (2006 Population and Housing Census). The two LGAs lie within the rain forest belt, north east of the Greenwich and $7^{0}30^{1}$ North of the Equator (Adeyekun, 2000; Adefila, 2004;). Both LGAs are urban. They have an annual mean rainfall of about 60 inches and are endowed with fertile farmlands. Ilesa has about eight months (March to November) of rainfall. Abundance of rainfall encourages breeding of mosquitoes that makes pregnant women in study area susceptible to malaria. However, it allows fruits and vegetables to be grown in abundance. This makes it possible for pregnant women to eat them and avoid anaemia. A

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popular saying in Ilesa is *"e suun han f'ogede se laalede Ijesa eye lee je*." (Bananas and plantains are so many in Ijesa land; birds feed on them).

The LGAs are situated on hills ranging from 1200 to 1300 feet above the sea level with a landmass of about 250 sq kilometres (Adefila, 2004). Imo hill housed the former colonial masters and was the headquarters of North Eastern Yoruba Division. The LGAs are blessed with large-scale deposits of gold. They are blessed with beautiful landscape with projecting hills which range from 1200 to 1300 feet above the sea level, while some areas are relatively plain. They share boundaries with Oriade, Atakunmosa East and Atakunmosa West, and Obokun LGAs.

1.5.3 Historical background

The study covered a part of Ijesa land in Osun State of Nigeria. One of his sons was believed to have established the Owa Omiran dynasty in Ilesa between 1150 and 1255AD (Adeyekun, 2000). Prior to the 11th century, there were loose and scattered settlements of people in Erin-Oke, Imesi-Ile, Ipole, Igbadae, Erin-Ijesa and Ibokun, but little was known about them until this prince came and overran the communities. The legendary Prince Owa Ajibogun left Ile-Ife to conquer and settle there. He was believed to have stayed in different places at Ilowa and Ilugbin before other subsequent Owas shifted the capital to the present Ilesa – meaning '*Ile ti a sa*' (the land of the selected people) (Adeyekun, 2000). The colonial imperialists came and overran Ilesa between 1902 and 1920. Ilesa was later made the headquarters of Yoruba North Eastern District.

1.5.4 The people

The major inhabitants of Ilesa are the Ijesa-speaking people. They are a sub-group of the Yoruba ethnic group and claim descent from the legendary Yoruba ancestor, Oduduwa. The Ijesa people are men of valour (Fatubarin, 2008). They have aversion for passivity, mediocrity and cheating. They have travelled far and wide. It is believed among the people that wherever Ijesa people cannot succeed, no one else can succeed there (Fatubarin, 2008). The people believe in themselves and would not want to depend on others for their sustenance. The statement '*Meeje lowo re ni*' (you are not feeding me) is

UNIVERSITY OF IBADAN

very common among the people. Adeyekun, (2000) states that 'Ijesa are hard working, straight forward and progressive'; each Ilesa person (man and woman alike) wants to make it in life without recourse to a friend or relation. Begging is frowned at and is uncommon in Ilesa, as in other towns. The people accommodate settlers from other parts of the country. Town planning in the community dates back to early ages. The people embrace self-help projects.

1.5.5 Political organisations

Prior to the colonial era, Owa Obokun was the paramount ruler. He ruled supreme over Ijesaland. He reigned through a complex hierarchy of traditional rulers/chiefs (*Elus* and *Aaroes*). He communicated orders, directives and advice to the grassroots through these chiefs. Communication followed the same route upward to the Owa. He was the political head and power radiated from his palace through the chiefs to the citizens (Adeyekun, 2000). However, with the invasion of the Europeans, his power and grip over the citizens was eroded. The colonial masters did this by humiliating the reigning Owa-Obokun Atayero by arraigning him before the colonial court for collecting poll tax from his subjects. Next to Owa are a number of traditional chiefs who individually and collectively advice him on issues. Confidential matters are reserved for closet advisers while the less confidential and less intricate are for council of chiefs. This history reveals the patriarchal nature of Ilesa. Most political posts were held by men and so were important decisions.

For administrative purpose, there are three distinct chieftaincy groups─Obanla (leader), Ogboni of Ibokun, Ogboni of Ijebu-Jesa, Ogboni of Ipole, and Oba Odo of Ilesa. In strictly Ilesa affairs, the Ogboni of Ibokun and Ijebu-Jesa were excluded.

At Ilesa, there are three chieftains (Agbanla) one of which is hereditary, while the others (Obanla and Oba Odo) are attained. Achievements are more important to the people than names. Anyone who holds a position of authority must be ready to perform. The Ogbonis of Ilesa advise the Owa on severe matters. The Ogbonis of Ilesa include the Iwole or Aare (high chiefs). Aare advises the king. The leader of this group is the Odole Risawe. The group forms the inner caucus and frontline advisers to the Owa (Adeyekun,

UNIVERSITY OF IBADAN

2000). The Elegbe are war lords that defend the monarch and Ijesa territory. The leader is Lejoka; other members are Loro and Lejofi. They were always ready to take war alerts from Owa. However, in peace times, their prowess is now depicted at annual festival of Ogun and Iwude Ogun. Loro doubles as Aare and as Elegbe. He was Owa's representative in the military. In palace affairs, the Loro acts more as Elegbe. In tribute or fees sharing, he shares from both groups. In both groups, only the Loro is hereditary, while the Lejoka and Lejofi are attained titles. The decision of Owa and the high chiefs are passed to the citizens down the hierarchy of chiefs to the Loriomos, who are chosen quarters' heads or leaders.

Next to these two are the lesser chiefs Aare Odo or Elegbe Odo, who are of lower order. The lesser chiefs include Lukinran, Risikin, Sorundi, Salosi, Sawe, Lodifi, Losara and Lokoyi. The upper layer of the lower group produces quarter heads who effectively administer various quarters of Ilesa. Another group of chiefs that are consulted in craft, medical or spiritual affairs are grouped as Alapokurudu (palace chiefs), babalawo (diviners) isegun (Physician) aworo (priest). At the lower levels, women are not left out of the administration in Ilesa. Titled women chiefs are Yeyerisa, (the women leader), Risa Arise, Yeye Saloro, Yeyedole, Yeye Segbua and Yeye Bajimo. These are women's mouthpiece in the palace. Their views are sought and respected in women's affairs, markets, and cleanliness of the town, parenthood and reception of visitors. All women's titles are achieved. This could explain why the women are hard working.

The colonial masters, in 1952, reformed the Native Administration (NA). This produced more representatives (Ijesa Representative Council). This was known as Ijesa Divisional Council, which was split into Ijesa Northern and Southern District Councils. Ilesa was the headquarters of North East Yoruba Divisional Council during the colonial imperialism (Adeyekun, 2000). The Northern District Council became Obokun and Oriade LGAs, while Ijesa Southern District Council became Ilesa and Atakunmosa LGAs. In November (1996), Ilesa and Atakunmosa were further split into Ilesa East and Ilesa West; and Atakunmosa East and Atakunmosa West.

UNIVERSITY OF IBADAN

1.5.6 Economy

Farming is the occupation of about 60% of the working population. The land is fertile which helps in cultivating food crops, various types of fruits and cash crops. The Ijesa are known for trade and merchandise. They are foremost among businessmen; they are industrious, adventurous, enlightened and prayerful (Fatubarin 2008). They started the local hire purchase and credit system known as 'Osomalo' (I will be in squatting position) derived from the way they collected outstanding debts from their customers. They introduced 'buy-now-and-pay-later'. They are scattered in many places, plying their trades among various tribes. They supplied soldiers' needs during wars at Congo and Biafra. They are bold and tread where others fear to tread. They introduced 'ready-made dresses' to the people '*Ijesa gba mi ode kaaro*' (Ijesa safe me from ridicule, there is a function to be attended the next day). These are dresses already sewn to different patterns and sizes. This was the forerunner of the modern-day ready-made clothes. Prior to this time, when people bought clothes, they gave to tailors who took some time to get them sewn.

They produce of *eni oree, eni ewele and eni ateka*. These are different types of quality mats that predated the modern-day rugs and carpets (Fatubarin 2008). They produce and market kolanuts. This is why they are called *Ijesa Osere, Onile Obi*─Ijesa whose land grows kolanuts in abundance (Fatubarin 2008). Ilesa is one of the leading commercial centres in Osun State, and its inhabitants are known to be very frugal in spending money. The Ijesa people surpassed most other communities and set the pace that people always say jocularly, that if an Ijesa man goes to the university to read Economics or Business, he has gone there for a postgraduate study because he already knew enough for a first degree in any of these courses by daily interaction (Fatubarin 2008). Commercial activities are boosted with the presence of many banks - First Bank, Union Bank, Mainstreet Bank, First City Monument Bank, Wema Bank, IBTC Bank, GT Bank, Zenith Bank, Access Bank and Oceanic Bank, to mention but a few.

Many Ijesa women are also traders. They engage in various finance-generating activities that make them fairly financially independent. The women have control over their income and may not necessarily give such to their husbands. The husband may

UNIVERSITY OF IBADAN

borrow money from the wife when he is financially hard up, with the understanding that he will pay back when he is able. If he refuses to pay back, he cannot force his wife to help him out during another financial crisis.

1.5.7 Socialization

With the coming of Christian missionaries and introduction of Christianity, formal education started in Ilesa. The first primary school, St. John's School Iloro, Ilesa, was established in 1888 and in 1900 another school, Holy Trinity School, Omofe, Ilesa, was established. In 1934 and 1954, Ilesa Grammar School and Obokun High School were established respectively. As a result of early introduction of formal education, the Ijesa people are fairly literate. As at the time of writing this theses, Ilesa has fifty-two Primary Schools, twenty-two Secondary Schools, a College of Education and a College of Health Technology, one Federal Science and Technical College, one Science School and a Special School for the handicapped.

1.5.8 Health Institutions

The Methodist Church Mission first introduced orthodox medical system to Ilesa in 1913 (about one hundred years ago), and was known as Wesley Guild Hospital, now part of Obafemi Awolowo University Teaching Hospital (OAUTH). It is located in Ilesa East Local Government Area. Wesley Guild Hospital provides primary, secondary as well as tertiary healthcare and referral services for the population in Ilesa and adjoining areas. It served as the last stop for medical cases in the hinterland of the then Western Region (Fatubarin, 2008). It provides tertiary health care with highly specialized services provided by modern diagnostic equipment. It serves as referrals for Osun, Ekiti, Ondo, and Kwara States. No patient in labour is refused admission here, whether booked or unbooked, referred, complicated or otherwise.

Ilesa West has a state general hospital. The two local government areas have twenty health centres and posts; fourteen of which take deliveries. The delivery centres are Ajanaku, Isokun, Oke-Iyin, Ilaje, Aragan, Irebami, Idasa, Egbe-Idi, Ayetoro, Irojo, Oke-Oye, Imo, Ijamo, and Igbaye. Each of them takes an average of 7.44 births per

UNIVERSITY OF IBADAN

month. Antenatal attendance at the health centres averages 38.88 per month. OAUTH takes average antenatal attendance of 232.2 per month, while State General Hospital takes an average of 26.75 deliveries per month (delivery records from these maternities and hospital). In addition to the above, there are numerous private hospitals and maternity centres. Doctors and nurses and, sometimes, ward aids, run them; some of them are retired while others are still in government service.

1.5.9 Religious belief system

To attempt a definition of religion would be a herculean task because of its scope and diversity. Many people have made several attempts but their definition have been greatly criticized because of the shortcomings. Joseph (2015) views religion as "absolutely a matter of faith and a belief in the existence of a Supreme Being" (*Olorun, Olodumare Atererekari aaye).* Religion according to him has two obligations: "the acknowledgement of the supremacy of God and the adoration and worship of that God."

Prior to the advent of Christianity and Islam, Ilesa predominantly practiced Traditional religion. There was the worship of *Olodumare* the Almighty God through the mediums of Ifa (god of divination) ogun (god of iron) and other deities. The Ijesa also believe in immortality of the soul. They believe in the spirits of the ancestors which can be evoked for blessing and to avert dangers. Rituals and ceremonies are observed in remembrance of them to ensure their continuous watch over the living members of the community. In Ilesa, there are annual Egungun and Iwude festivals on 26 of December to commemorate this belief. Those who have embraced Christianity do elaborate burial, outing and remembrance services for the departed. Fifty, forty, thirty, twenty and ten years' remembrance ceremonies are common. Sometimes the people that organized them were not yet born or were babies at the time the individual died.

One is not sure of definite time Christianity came to Africa but, from the earliest period, its presence had been there. However, it is certain that the first sets of missionaries landed in Nigeria on 1st April 1842. When they came, they established schools, built hospitals and clinics and several paramedical institutions (Idowu, 2007) but the work of these missionaries did not address "to reality of evil and malevolent forces as embodied by force of witchcraft and sorcery" (Idowu, 2007). The result was that some

UNIVERSITY OF IBADAN

would openly profess Christianity but secret consult witch-doctors and fortune-tellers for protection. The missionaries requested its adherents to renounce all cult practices and use of charms, amulets and other cultic protective materials to take part in its sacrament but did not give the natives alternative by exposing them to the power of the gospel that could banish these forces.

Then in 1918, there was a deadly influenza epidemic and economic depression which killed over 250,000 people in southwest Nigeria (Adewale, 1986). This led to the closure of many mission churches to avoid further spread of the epidemics. Many of the Yoruba Christians were disappointed in these mission Churches that were helpless in the face of disaster. They started prayer and healing fellowship to check the outbreak. Odubanjo, a member of the prayer cell, came across the *Sword of the Spirit* a publication of The Faith Tabernacle in America, which influenced him greatly. The publication emphasised the power of prayer alone to heal and to provide for worldly needs and condemned the use of any medicine whatsoever (Idowu, 2007). This belief made the group to be at loggerheads with the Anglican Church. The group faced a lot of persecution from the church and was forced out of St. Saviour Anglican Church. At the same time, one Sophia Odulami claimed she had divine direction to use particular rainfall water for healing. She was persuaded to join the prayer cell. The group became Diamond Society, which had its first meeting on Jan. 22nd 1922 (Idowu, 2007). This group emphasized the important role of prayers in the face of adversity. It was the habits of this people to pray several times in a day for revival in land. They observed hours of prayers and vigils. Odubanjo a member of the group had started another chapter of the prayer cell in Lagos, which was named Faith Tabernacle, after a group in America. Not long after this, many chapters of this prayer cell sprang up in various parts of Nigeria, including Ilesa. This was what led to the birth of prophetic healing movement in several parts of Africa, particularly the Aladura movement in western Nigeria. This was a platform for the Oke Ooye revival of 1930. Leaders of this movement were former members of St. Saviour Anglican Church, Ijebu Ode.

Christianity was introduced to Ilesa between 1867 and 1874 when Owa Oweweniye invited the Reverend C. A. Gollman and other white missionaries. They preached and got many people converted to Christianity. Between 1845 and 1893 *Owa*

UNIVERSITY OF IBADAN

Obokun Bepo Agunloye (the paramount ruler t that time) stopped the practice of human sacrifice in Ilesa (Adeyekun, 2000).

1.5.10 The Oke-Ooye Holy Ghost Revival

The Oke Ooye Revival was born in answer to the prayer of these people. Three separate angelic visitations were experienced by the leaders (Babatope J.A. Daniel Orekoya and Joseph Ayo Babalola) of these prayer cells.

On the 9th of October, 1928, Joseph Ayo Babalola, while fasting, claimed to have received divine call to leave his trade for spiritual assignment. He was anointed for the work and received three gifts with spiritual symbolism:

a. Bell –symbolising prayers, to bless and to call people to prayers; to drive out hosts of darkness and invite heavenly hosts to the meeting.
b. Staff –symbolising authority and power over all the forces of darkness and evil.
c. Bottle of water, which is symbolic of the curative and healing power of the Holy Spirit through the medium of water (Idowu, 2007),

In his ministry, he sanctified water to cure the sick and his authority to deliver those oppressed by the enemy. Divine healing was paramount in his entire message from town to town. He thought the people to desist from the use of herbs and all native medicines but to trust in the Lord for healing. When he visited his home at Ilofa to preach, many people rose against him and refused to repent and three hundred people died of smallpox epidemic. The people that remained alive began to come to Babalola for prayers to be cured. A prayer group soon emerged from the Anglican Church at Ilofa. Those who spoke in tongues were eventually excommunicated from the church (Idowu, 2007). As Babalola continued his preaching, prayer and miracles attended his prayers and his fame spread to the hearing of members of Faith Tabernacle, who invited him to their meetings. He eventually joined this group and was baptised.

On July 9th 1930, the leadership of Faith Tabernacle met to discuss a 24-point agenda on doctrinal issues in Ilesa. Paramount on the agenda were:

- Whether polygamists should be baptized in the church.
- Whether the name of Jesus alone was sufficient and adequate for healing.

UNIVERSITY OF IBADAN

As they were deliberating on the second issue, a dead boy John Obi Ogundipe was brought to the meeting and Babalola resuscitated /restored him back to life with the name of Jesus. News of this miracle reverberated all over Nigeria and beyond, as newspapers carried the stories of this revival. Many that were sick found their ways to Oke Ooye and received their healing. Before long, the great Oke Ooye revival began it led to the birth of two main Apostolic Churches. Idowu (2007) views this as beginning of modern Pentecostalism and real power evangelism and gospel in Nigeria. For the next two months, crowd continued to increase from all walks of life and towns to Ilesa that no hall could be found to accommodate them. The sick, the barren and even corpses were brought for prayers.

Not long, Joseph Ayo Babalola, at 24, suddenly found himself at the centre of a great revival which no religious leader in Nigeria ever experienced. It was the first indigenous Holy Ghost Revival in the West Africa sub-region. Idowu (2007) claims that Joseph Ayo Babalola could be regarded as father of Pentecostalism in Nigeria. According to him, Oke Ooye marked the high point of spiritual regeneration, the centre of religion and moral transformation for the people of Nigeria. In this revival, Jesus only was the point of attraction. All seekers were directed at Him. Babalola pointed all seekers to look at Jesus and believe in Him but they should forsake their idols. Babalola reported that he did everything according to the leading of the Holy Spirit. Witches, wizards, juju priests, witch-doctors and other fetish practitioners were said to have submitted their powers under this great revival. Many people received the Holy Spirit with the evidence of speaking in tongues and impossibilities were made possible. Several people that were kilometres outside Oke Ooye were touched with the wave of revival, some in their farms, homes and places of work. Some of such people were responsible for the revivals in their different towns and villages. They heard voices while working on their farms kilometres away to go to Babalola at Oke Ooye. Such men included Toro Owo, who started the revival at Ipagun and Igbara Oke; Joshua Ojo, at Ijero-Ekiti; and Peter Adewuyi of Efon Alaaye (Idowu, 2007).

The Oke Ooye revival was for both physical and spiritual healing. It was for healing souls that were disfigured by sins and the devil, and body ravaged by sickness and diseases (Idowu, 2007). Many people that were afflicted and suffering under the

UNIVERSITY OF IBADAN

yokes and torments of witchcraft and satanic power were said to be liberated, freed and healed. Witches, witch-doctors and sorcerers submitted the instruments they used to torment and afflict their victims and confessed their sins publicly. Barren women and impotent men had their children and the people's trades prospered. Lost people retraced their ways to their families and many that ran away because of witches and wizards were said to have returned to their families. The blind saw, the deaf heard and the dumb spoke and myriads of afflictions were dealt with (Idowu, 2007).

Prior to the 1930 revival, traditional worship had strong association with fetish, magic and occultism. The magicians, sorcerers and witch-doctors held sway. The occult and secret societies were in control and had their ways. There was no alternative power to challenge or revoke their sentences or decrees. Christians and others lived with fear, witches and wizards were believed to torment their victims without respite. Charms and traditional medicine were utilized by some Christians until this revival when the Lord demonstrated to all His power over charms, idols and shrines. A mythological tree was set on fire in front of *Owa's* palace and there was no evil repercussion that followed; rather there was mass conversion of traditional worshippers, and juju and *Ifa* (god of divinity) priests to Christianity. In many places Babalola visited, he entered forbidden forests and removed their altars without any consequences. These people confessed that Babalola operated with higher power. They surrendered their charms and heaps of images and occult materials for burning.

At Oke-Ooye, divine judgement came upon the unrepentant and evil ones. There were only two options- confession of sins for the penitent and death for the unrepentant. Those that died were:

- Those who had done wickedly in the past
- Those that went back to idolatry after being healed by the power of God
- Those who came to test the power of God.

Many of the sicknesses that were brought to Oke-Ooye were perceived as having their roots in the spiritual world and were enforced by forces of darkness. Therefore, they could not be helped by medical science but were delivered at the revival. Those who were afflicted and drank the 'water of life' vomited strange objects and were delivered. Long-standing problems and battles were won as God intervened in the affairs of men.

UNIVERSITY OF IBADAN

The Oke-Ooye revival was not attached to any denomination, Anglicans, Baptist, Methodists, Muslims and traditional religious members met at Oke-Ooye. But after some time, Babalola said he saw a vision that as he was catching fishes, others were throwing the fishes back to the river. He interpreted that to mean that there was a need to establish a church to put his converts in. This was what led to the establishment of Christ Apostolic Church and The Apostolic Church. Babalola emphasized divine healing as the power of God to heal as well as the need to renounce idolatry and turn to the Living God. *Omi Iye* (water of life) characterised this revival. From the day of his commission, Babalola claimed he was called of God to sanctify water for the healing of all ailments of the people. Participant at this revival brought bottles of water which Babalola prayed on and sanctified in the name of Jesus for people to drink and birth with. Rigorous and ceaseless prayers were said night and day to bring the power of God down. Many instant miracles happened thereafter. Almost a century after this revival, rigorous prayers are still being said in FBBHs to draw the hand of God for supernatural intervention in their affairs. In some of the churches, healing and deliverances were the major reasons for attending the revival and many people came to give testimonies of their deliverance. Many people claimed they had been to the hospitals and traditional healers but it was prayers of faith that delivered them. This practice continued and was transferred to the Faith-Based Birth Homes. The faith homes have special days (usually Wednesdays or Fridays) set apart for prayers and healing purposes. These spiritual healing homes also serve as clinics and maternity for pregnant women. A common song at the revival is:

Jesu Olomi Iye re Omi Iye
Omi Iye, iye re o Omi Iye
Babalola Olomi Iye Reo
Omi Iye. Mo ti sonuu o wa mi ri
Omi Iye, iye reo Omi Iye

Meaning

Jesus, the giver of living water is here.
I was lost he sought me.
Babalola is here with this life-giving water.

Before this revival, the majority of Ijesa people were in Traditional Religions while, Christianity was in the minority. However, after this revival, the balance tilted in favour of Christianity. One of the greatest impacts of this revival was massive conversion to

UNIVERSITY OF IBADAN

Christianity, particularly the Pentecostal Aladura group. This had altered the socio-religious balance of Yoruba land permanently (Idowu, 2007), especially in Ilesa, the seat of the revival. Ilesa is still predominantly Christian. This revival greatly increased conversion to Christianity so much that, as of the time of this research, most of Ijesa people are Christians, mainly in the CAC and other Aladura churches. This revival made Christianity relevant to the local people who used to see Christianity as white man's religion. According to Idowu (2007), Christianity did not emphasize "enough spirituality in a spiritually active and alive culture... in the battle of the gods, missionary operations were done with blunt scalpel" This might be why the areas of Yoruba land that were evangelised by missionaries are now predominantly Muslims while those that were evangelised by Africans are predominantly Christians.

Prior to this revival, conversion and genuine encounter with Jesus was not the condition for conversion to Christianity but desire to benefit from mission education, health programmes, and get employment from the Colonial government (Idowu, 2007).

Further the revival swelled up the existing Churches; they found it difficult to cope with the new converts. Life was said to be better for the generality of the people, as they lived at peace with each other. Many wicked people were said to be converted to Christianity and lots of charms that were used to perpetrate evil were burnt. These helped to liberate the people. The revival whetted people's appetite for education so as to be able to read the Bible and sing the hymns.

Idowu (2007) notes that 2,000 copies of Yoruba books and pamphlets of A B D (Yoruba alphabets) were sold in Ilesa alone in September 1930. This provided the background for Awolowo's free education of the 1950s. From the time of this revival people gave themselves to regular attendance at prayer meetings, vigils, Bible study and church service. During the course of the revival, many left the hospitals to receive divine healing, The Wesley Guild Hospital that had about five hundred patients had four to five left; others had run to Oke-Ooye for divine healing. It got to the point that Doctors were thrown out of jobs. The doctors complained to the District Officer of lack of patronage. The District Officer summoned Bablola to his office and queried him on the content of his water. People came with bottles of water to revival grounds and Bablola prayed on them. They carried this home for drinking, bathing and applying to any area of their

UNIVERSITY OF IBADAN

bodies needing healing. Almost a century after this revival, members of CAC, Aladura Churches and pregnant women still carry kegs of water to their churches for prayers. The water is believed to have the same healing efficacy as the time of Babalola.

Churches have been categorised into groups; churches that have Western origin, like Catholic, Anglican, and Salvation Army are Orthodox Churches. African Independent Churches (AICs) are those that emerged within the Mission Orthodox churches from the 1920s. They are also known as Indigenous Church Movement or Aladura and African Indigenous Churches. They are self-supporting and do not depend on missionaries abroad for financial and spiritual assistance. These were churches that were founded by Africans for Africa.

In traditional religion, women serve as priestesses, medicine women and seers; they are also used in antenatal and child care. In Ilesa women are trained as traditional healer and doctors. They also take deliveries. They are I*ya abiye* and *agbomola* (women who ensure safe delivery for mother and child). After the Oke- Ooye revival, converted women continued these services in the churches. Some women even became church founders.

Prior to the introduction of orthodox medicine, traditional medicine was the dominant medical system available for millions of Africans (Abdullahi, 2011). It is the oldest form of health care available. WHO (2000) defines traditional medicines "as the total knowledge, skills, practical based on theories, beliefs and experiences indigenous to different cultures whether explicable or not used in maintaining of health as well as the prevention, diagnosis, improvement or treatment of mental illness. Healers are addressed as *babalawo*, *onisegun* and *adahunse*. They do not merely treat diseases in patients but also attempt to ensure the social and emotional equilibrium of the patience based on the community rules and relationship (Hillenbrand, 2005, quoted in Abdullahi, (2011). Traditional healers "act as intermediaries between the visible and invisible worlds...and determine the spirit which is at work and how to bring the sick back to harmony".

Ijesa land is also blessed with many other religious leaders whose religious activities have taken them to enviable heights. Late Canon Akinyemi was among the frontline Anglican religious leaders. George Vincent Agbebi was among the first

UNIVERSITY OF IBADAN

missionaries that came to Ilesa. His efforts with Reverend David Hinderer laid the foundation of Anglican Communion. Bishop John Falope was the first Anglican Bishop of Ilesa Diocese and Most Rev. Timothy Abimbola Akinnigbagbe was the first Diocesan Bishop of Ifaki. He was commissioned a Priest and a Deacon. He was the Archbishop of Ilesa. Late Apostle Timothy Obadere, founder of World Souls Evangelical Mission (WOSEM) and world Evangelist of a version of the C.A.C. Among the present-day Christian religious leaders are Pastors W.F. Kumuyi of the Deeper Life Bible Church, from Erin-Ijesa; S. K. Abiara of Agbala Itura, from Erinmo; E.A. Adeboye of the Redeemed Christian Church of God, from Ifewara; and Apostle Fakeye of the C & S Church Movement Ayo ni o.

Ilesa is the capital of Ijesaland. The inhabitant regard it as a citadel of the Christian faith, 'the place where God dwells' and the present-day new Jerusalem. The Ijesas' show of deep affection for God is epitomized by their patronage of many religious houses and mountains for prayer, revivals, vigils, early morning evangelists and prayer warriors.

In fact, almost every four houses have a church auditorium, whether small or big, and because of the people's religious inclination, there are many religious birth houses attached to these churches. Some women who attend these churches patronize their birth houses and invite their pregnant friends to do same. Some Christian denominations in Ilesa are Christ Apostolic Church (CAC), The Apostolic Church (TAC), Anglican Church, Methodist Church, Christ Trumpeters' Church, The Redeemed Christian Church and Deeper Life Bible Church. There are numerous Cherubim and Seraphim and Celestial Churches. The Ijesa see themselves as beloved of God (Fatubarin, 2008). The Ijesa women are very religious; many churches in Ilesa have more women than men. Many women are *oludasile* (church founders).

The CAC has nine birth houses with an average of five deliveries per month per house (C.A.C. FBBAs, 2009). The Apostolic Church also has a birth house attached to its Mission at Irojo Headquarters Church with an average of four deliveries per month. All of the religious birth houses have antenatal days and clinics. The CAC runs antenatal clinics on Wednesdays, with average of 30 pregnant women in attendance in each birth house. The Holy Ghost Fire Church also has a birth house within her compound. Other

UNIVERSITY OF IBADAN

churches that run birth houses are The Redeemed Christian Church, Christ's Trumpeters' Church, Cherubim and Seraphim and Celestial Churches. Some of these churches were established on the threshold of divine healing and efficacy of prayers without medication. This belief system is transferred to their birth houses. Emphasis is laid on the pregnant women believing in the efficacy of prayer and hygienic lifestyle. A lot of time is devoted to prayers for safe delivery and against known and unknown enemies during their antenatal clinics. Traditional birth attendants and home-based obstetric care were not easily identified in the local government areas. This study, therefore, focused on care-seeking in Western hospitals and faith homes.

Some of the maternity centres the researcher selected had been established as early as the 1940s; pregnant women have found them trustworthy. Women that were born in some of them go there to give birth to their children. One of the conditions for selecting a care giver is that s/he must have taken deliveries for more than ten years and has good patronage, taking at least two deliveries per month, but the male Faith-based birth attendants (FBBAs) do not fulfil the condition of two deliveries per month although they must have fulfilled the required condition of ten years and above. One of the male FBBAs had started taking delivery since 1993 and claimed he had taken more than twenty deliveries, including twins and triplets. His educational qualification was JSS 2. He is an itinerant CAC/FBBA. He claimed that he specialised in complicated cases. The other male FBBA completed secondary school. He was the founder of a Cherubim and Seraphim Church. The rest were female FBBAs from various Pentecostal churches. The two male FBBAs were purposively selected because they were rare and the only ones that could be identified.

UNIVERSITY OF IBADAN

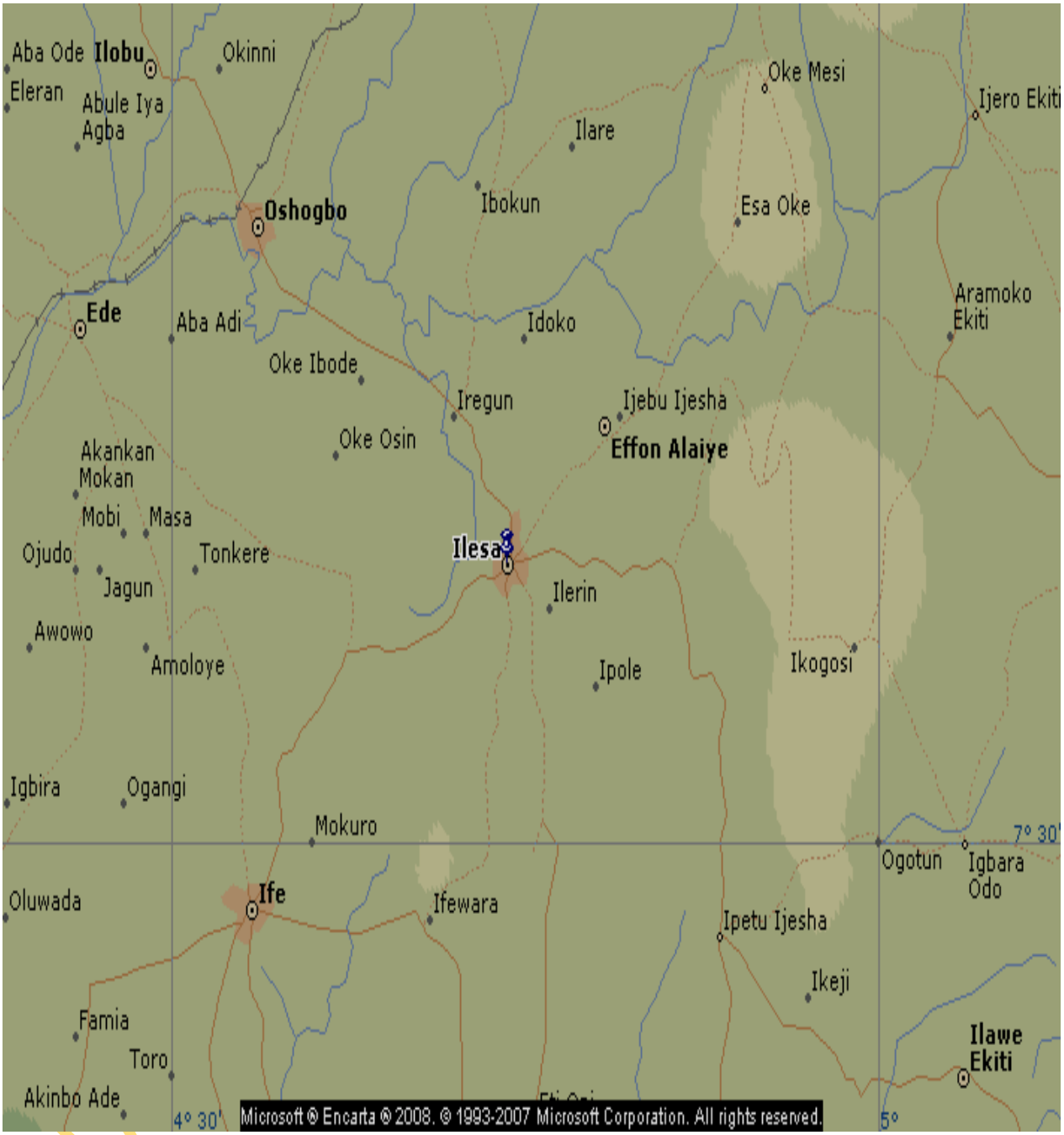

Figure 2: Map of Ilesa, South Western Nigeria

SOURCE: Microsoft Encarta 2008 © 1993-2007 Microsoft Corporation

1.6 Definitions of concepts

1.6.1 Health care is the totality of all that a woman and significant others do from conception to six weeks after delivery, to ensure sound health for the pregnant woman and her baby. This includes pregnancy test to confirm that the woman is actually pregnant; regular antenatal attendance; and adhering to drug regimes, immunisations, exercise and food prescriptions, as well as other instructions given.

1.6.2 Pregnant women: women who were pregnant at the time of study. All the respondents were pregnant as at the time of study.

1.6.3 Primigravidals (Prim) women who were pregnant for the first time.

1.6.4 *Multigravidals* were women with second to fourth conceptions.

1.6.5 Grand multigravidals were women with fifth and subsequent pregnancies.

1.6.6 Booked pregnant women were women who had attended a minimum of four antenatal clinics and have done all the recommended tests and taken all the needed immunisations.

1.6.7 Unbooked pregnant women were women who did not adhere to therapy stated above. Such women registered only in case there was a complication. They neither took immunisation nor attend ante-natal clinics. Some took only one immunisation and did not show up for the rest, while others did not take immunisation at all for religious reasons. Some of them just appeared on the day of delivery because there was a complication where they intended to deliver.

1.6.8 Caregivers were those who assisted pregnant women in hospitals and faith houses: nurses, doctors and faith-based birth attendants (FBBAs).

1.6.9 Maternal mortality is death of a woman while pregnant or within 42 days of termination of the pregnancy, irrespective of the duration or site of the pregnancy or from any cause related to the pregnancy, or aggravated by the pregnancy itself or its management but not from accidents (WHO, 1978).

UNIVERSITY OF IBADAN

1.6.10 Ijesa people are a sub-group of the Yoruba people of South-West Nigeria. Ijesa is the spoken dialect of the people. They are in the south-eastern part of Osun State. Generally, Ijesa women are hard-working and the majority of them engage in one business or the other. Most of the the Ijesa women are traders and one assumes they can attend, pay hospital bills and take health decisions.

1.6.11 Focused Antenatal Clinics (FANC) refers to help sought and obtained by pregnant women during conception till 42 days after delivery. It is aimed at producing healthy mother and baby. WHO recommends at least four FANC visits at 16 weeks, 24-28 weeks, 32 weeks and 36 weeks. It emphasises quality of visits rather than number of visits.

1.6.12 Morbidity is disease condition aggravated by pregnancy condition, such as Vesico Vaginal Fistula (VVF), arthritis and pregnancy induced high-blood pressure.

1.6.13 Eclampsia refers to pregnancy induced high blood pressure which leads to convulsion and coma. It is defined as sustained diastolic blood pressure of 90 mmHg or more (Emdex, 2008/09).

1.6.14 Trimester is division of pregnancy period into three equal parts of three months each. The first three months (1-3months) of pregnancy is referred to as the first trimester, 4-6 months second trimester and 7-9 months third trimester. The first trimester of pregnancy is usually associated with vomiting, tiredness and general weakness of the body. During the second trimester, the woman is generally healthy and her body has adjusted to the pregnancy state.

1.6.15 Religion is the people's believe in Supreme Being and the people's trust in Him in pregnancy care.

1.6.16 Social demography has to do with pregnant women's characteristics such as age, economy, and their influences on pregnancy care

1.6.17 Antenatal care services are care received in orthodox care centres.

1.6.18 Singles means pregnant women who were never married: teenagers and single mothers

UNIVERSITY OF IBADAN

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Literature Review

2.1.1 Perceptions of pregnant women on aetiology of pregnancy complications

Pregnancy is the means by which man or animals prevent their races from extinction. Fishcer's (2002) study in Ghana revealed that pregnancy is perceived to be a gift from God and it is in his plan; and so, no woman should avoid it. In every culture, childbirth is a thing of joy that calls for celebrations. However, health-related conditions threaten the joy associated with childbirth and this is having negative effects on Nigeria among other nations (Adelani, 2009). Every pregnancy and labour ought to be normal and expected to end well, but in reality, things go wrong that about 5-15 per cent of pregnancies experience major complications, which require medical intervention at referral health care level (Fatusi and Ijadunola, 2003). They end in inevitable abortions or special cares have to be given to carry such babies to term. For instance, among African women, 640-1100 women die for each 100,000 live births (FMOH, 2007; WHO, 2004; 2006). This translates as one woman dying every ten minutes and about 54,000 maternal deaths annually in Nigeria alone (NPC, 2001; *Nigerian Health Review* (NHR), 2006). It should be possible to detect these complications early and correct them if women receive adequate antenatal and postnatal cares. Perception of aetiology of pregnancy complications involves a group of people's belief about causes and treatment of pregnancy complications. How a group perceived pregnancy problems will affect the care they seek. Perception of aetiology of diseases will affect their health care-seeking behaviour in pregnancy. Many people perceive pregnancy complications from the religious point of view. They lay much emphasis on religious and supernatural forces. This perception will affect pregnancy care. If people have extensive belief in witchcraft and supernatural causation of disease or influence in other spheres of life, they may prefer delivering their babies in prayer houses and faith clinics to delivering them in

UNIVERSITY OF IBADAN

orthodox medical homes. Asuquo, Ottong, Olaniran and Duke (1992) assert that rural communities in Cross River State of Nigeria associate post-partum haemorrhage to witchcraft, supernatural forces, adultery, reincarnation, and the character of the woman; and believe that only prayers, sacrifices, and confessions could save the life of the woman.

From the scientific point of view, however, there are various causes of pregnancy complications. These could be biological and / or social. Some biological causes of pregnancy complications include age of the woman and parity of pregnancy. Studies have revealed that MM increases with age and parity. MM is relatively high at young ages less than 18 but lowest at 20-29 therefore, the safety age for parturition is 20- 29. MM increases as maternal age increases.

- Women aged 17years and under as well as women aged 35years and older run the pregnancy risk of MM 3-4 times greater than those within 20-25 age brackets (Chase 1977, reported in Chattopadhyay *et al.* 1983). Young maternal ages has been associated with obstructed labour, pre-eclampsia and narrow pelvis while older women are at greater risk of haemorrhage, pregnancy-induced hypertension and uterine prolapsed and post-partum haemorrhage. Women having first births have also being found to be at higher risk than second and third births (WHO, USAID)
- Women having their fifth or subsequent pregnancies run the risks of MM 3 times greater than women within 20-25 age brackets (*WHO Statistics Annals* 1973-1976).

To avoid complications of all sorts, women should avoid pregnancies before age 18 and after 34 years.

The following are some of the biological symptoms of pregnancy complications:

- haemorrhage, swelling face and legs
- Excessive vomiting, rashes on vulva, offensive discharge, sudden lower abdominal pains, weakness, anaemia, dizziness, fever, shivering attacks, infections, painful and frequent urination, thick vaginal discharge, high blood pressure, convulsion and excessive weight gain.

UNIVERSITY OF IBADAN

The study of Pembe *et al.* (2009) in Tanzania revealed that women had low awareness of obstetric complication signs. Half of the respondents were not aware of any sign of complication. Only one in four women recognized haemorrhage as pregnancy complication, while only 1.5% of them realized that prolonged labour was a complication. Only 18% perceived retained placenta as complication. However, in Pempe's study, she found that knowledge of complication increased by age and parity. This may be related to their experience and number of ANC attendance. Primigravidals (prim) were less aware of complication signals. She recommended that prim need more counselling sessions and health education, stressing introduction of safe motherhood to girls in school before they get pregnant to improve awareness of danger signs.

Fishcher's (2002) study revealed that, when complications and infertility occur, they are attributed to witchcraft and demons, and that solution was to appeal to a god of fertility. She reported that, when the babies eventually arrived, the infertile woman must return with sheep and goat to fulfil her pledge. Infertility was also perceived as punishment for disobeying God and remedy was in fervent prayers, fasting, repentance and drinking 'blessed water.' Herbs were given to nourish the mother and the child. Energetic and fervent prayers said to God for protection and safe deliveries were regarded as 'main medicine.' It was believed that intuitive knowledge during prayer sessions had a great potential of revealing the sexes of the unborn baby. The respondents perceived infertility was attributed to stomach ache, and women were encouraged to praise God for their healing.

2. 1. 2 Religious belief systems and pregnant women's health seeking behaviour

Religion is seen from different angles. Some view it from the fear of creation angle, as a result of viewing the vastness of universe and the one who maintains it (Ekeke and Ekeopara, 2010). The second school of thought is that Africans saw their limitation and weakness in the face of death, calamities, earthquakes and other things that are beyond their control and see that the Supreme Being can be drawn to help through appeasement and sacrifice. Africans feel they need this great power to assist in their experiences and powerlessness. God is real to Africans as a real personal entity whose

UNIVERSITY OF IBADAN

help can be sought in times of trouble, one who is able to protect all people(Ekeke and Ekeopara, 2010).

To Anti (n.d.) however, religion is the beliefs and practices associated with the supernatural which embraces a code, a creed and a cult. The creed deals with the philosophy, beliefs or faith of the people. The code has to do with the ethical dimension, while the cult focuses on the rituals ceremonies of the religion.

In Yoruba belief, the Supreme Being, *Olodumare* is believed to be the Chief and King. He is superlative in worth, permanent, unchanging and reliable. To the Yoruba he is equally *Olorun* the owner of heaven and earth-- the author of all living. He is *Kabio osi* (He that cannot be queried or challenged). He has no equal and no image is attributed to Him. The Ijesa believe in this mighty God.

Culture is perceived as a way of life of members of a society; the collective ideas and habits which they learn, share and transmit from generation to generation. It includes the belief systems, rules, values, and principles, which a group of people have inherited from their predecessors, through which they have come to illustrate how they live and do whatever they do (Haralambos and Holborn, 2008). Traditional African religion like culture extends to affect every aspect of Africans' live. Religion plays a dominant role in the way a woman perceives and cares for her pregnancy as well as prepares for her delivery. Each culture has its own values, beliefs and practices with regard to pregnancy and birth. Various definitions have been given by different schools of thought to religion.

From Functionalist perspective, religion is to meet society's needs of social solidarity. Hamilton cited in Haralambos and Holborn (2008), argue that religion can have greater hold on the individual than the society. Malinowski (1954), also cited in Haralambos and Holborn (2008) views religion as reinforcing social norms and values and promoting social solidarity. Malinowski (1954) identifies situations of emotional stress that threaten social solidarity as the concerns of religion. Such anxiety and tension-provoking crisis of life, like marriage, childbirth and death are examples of emotions that disrupt social life. Malinowski argues that 'deaths...are perhaps the main sources of religious belief'. He found rituals attached to tension and anxiety-provoking situations and uncertainty, such as fishing in open sea.

UNIVERSITY OF IBADAN

To the pregnant women, the possibility of MM is emotionally stressful; they may attend religious activities to reduce anxiety and provide confidence in pregnancy and delivery. Parsons (1964) cited in Haralambos and Holborn (2008) also sees religion as a mechanism for adjustment and coping with the unknown and uncertainty as well as uncontrollable factors that can threaten a successful outcome. Religion provides a means of adjusting and coming to terms with such a situation through rituals to act as 'a tonic of self confidence.' The function of religion is to provide meaning to events that are frustrating and contradictory. The religion of an individual affects all aspects of his life including childbearing.

Belief system is significant in all aspects of pregnancy care and decision on contraceptive utilization. The religion of a group of people plays a dominant role in their health care. Some religious groups will not seek orthodox caregiver help for some symptoms and some believe in divine health and healing and are against blood transfusion and deliveries through Caesarean Section (CS). Adams (1987) avers that religious beliefs affect the health care practices of the Amish in America. He found that religious and cultural practices of the Amish resulted in health care beliefs and practices that were different from the dominant American culture. For instance, the Amish are excluded from health insurance schemes and have different perceptions of health and illness; do not practise birth control; do not take immunisations nor prenatal care and use a variety of traditional and non-traditional health care providers. Fishcer's (2002) study in Ghana revealed that, in contraceptive use, his respondents sought clearance from their religious leaders. Traditional priests provided certain herbs for contraception.

A people's concept of health and disease influence utilization of health care facilities and the type of help sought in pregnancy. Individuals with low social status often perceive illness and disease from pre-natural and supernatural points of view and are not naturally disposed to the use of Western medical facilities. Western medicine, on the other hand, does not recognize the role of supernatural powers in health problems. However, when therapeutic management of signs and symptoms of a disease becomes ineffective, supernatural powers are often thought to be responsible (Jegede, 2010). The low income people often perceive some diseases as being mystical, resulting from the neglects of the gods, broken taboos or ritual errors (*Centre for Gender and Social Policy*,

UNIVERSITY OF IBADAN

2002). Sacrifices and rituals are made to appease the offended gods. Rituals may involve slaughtering animals, and preparing special food items at road junctions. Pregnancy complications such as haemorrhage, is usually attributed to mystical causes (*Centre for Gender and Social Policy*, 2002; Jegede 2010).

For religious reasons, as well as to prevent pre-marital sex and promiscuity, some Nigerian societies practise girl-child marriage. These girls are married out at tender ages before they are physically and emotionally mature. This is because parents prefer to send their daughters as virgins to their prospective husbands to avoid promiscuities so that the girl is 'safely delivered' to her husband in 'pure state' (Erinosho, 2006). Early marriage predisposes the girls to high pregnancy-related complications, such as severe anaemia, pregnancy-induced high blood pressure, VVF and high mortality rate (Erinosho, 2006). In predominantly Muslim areas, a girl-child is given out in marriage after the first menarche. This practice promotes early childbearing with its attendant consequences (Adelani, 2009). When girls below 18 years get pregnant and are delivered of babies, they may suffer irreparable damage. Such girls have small pelvic girdles, which may not allow passage of babies, and this might result in prolonged labour. The babies may die and the mothers become infected. If they survive, holes may be created in their bladders and rectums, which will cause them to leak and be smelly. These girls are sent back to their parents who, in turn, often discard them because of their condition. Thousands of such women are abandoned and rejected. To repair the damage costs time and money. This situation could be avoided if men would refuse to put girls under 18 years in the family way as it could be their first and last pregnancies (Ransom-Kuti, 1990).

The practice of early marriage and the purdah system in Islam expose women to risk, as women having difficult labour cannot be taken out of the homes without the express permission of their husbands. This custom can cause serious delay in getting a woman with complication to hospital. Purdah also restricts women from receiving advice from other women. This will affect women's perception and knowledge of pregnancy complications.

When girls marry early, as a result of religious obligation, all life's major decisions are taken for them by their fathers and later by their husbands. Early marriage

UNIVERSITY OF IBADAN

also exposes the girls to sexual networking when their spouses cannot satisfy their economic needs. The girls tend to have sex for financial gains. This also predisposes them to sexually transmitted diseases and HIV/AIDS. Early marriage leads to a cycle of poverty. The girls have not been able to learn any trade to fend for themselves and their children. Such children become poor, their children are poor, and the cycle of poverty continues to widen.

Kisekka *et al.* (1992) found that religious barrier is responsible for 29 percent of his respondents' non-deliveries in hospital. Many of their respondents saw maternal mortality and childbirth complications as the will of Allah, which must be taken calmly. They note that women have aversion to exposing their nakedness to male health workers, (doctors inclusive) because these are "strange men gazing at their nakedness". This may probably be because Kisekka's respondents were Muslims and their religion prohibits close, direct social and physical contact between males and females. Among the respondents of Afsana and Rashid (2001) were women who were not comfortable to open their bodies to either female or male health workers. This category of women preferred to deliver at home with the assistance of older women.

2. 1. 3 Faith clinics / Faith based birth attendants (FBBAs)

These are churches that hinge their therapy on the efficacy of prayers and confession of sin(s) (Erinosho, 1989). They believe that sin is the cause of man's sorrow, sickness and disease. When a man sincerely confesses his sin(s), he is emotionally, psychologically, and spiritually relieved. His guilt is removed and he becomes free from guilt. When he prays or is prayed for, God heals him supernaturally. Levin (2001) investigated how knowledge of various aspects of religiousness contributes to determining health and well-being. He argues that religious affiliations and frequencies of attendance at religious services are associated with long living and good health. There are observable behaviour patterns that promote health in religious houses as a result of high level of social support that accompanies being religious. Members provide emotional and prayer supports that help the sick to recover from ill health.

UNIVERSITY OF IBADAN

Similar to Fishcer's study in Ghana, many Nigerians believe that pregnancy and childbirth are supernatural events that need the interventions of God. The Yoruba for instance, believe that children are gifts from God, and that faith-based midwives are in a position to assist in prayers during the supernatural processes of pregnancy and childbirth (Adekunle, 2001). When diseases and illnesses defy medical cure and hospital investigations prove fruitless, many Nigerians believe that prayers have to be made for cure to be achieved. There are belief systems that attribute birth complications to supernatural forces. Witches and wizards are blamed for obstetric emergencies. Many women believe that prayers made in faith homes protect them and ward off the power of witches and wizards; as a result, some pregnant women prefer faith delivery sessions to orthodox medical care. Some religious and traditional sects do not utilize orthodox medicine at all but depend only on the efficacy of prayers while some combine the two. Some religious groups, like Jehovah's Witnesses refuse transfusion of blood in complicated labour especially haemorrhage. Asuquo *et al.* (1992) aver that, when postpartum haemorrhage occurs among some rural communities in Cross Rivers State of Nigeria, a spiritualist is sent for or the affected woman is taken to the prayer house because the women believe that everything is possible with prayers.

However, religious homes have also been associated with high maternal deaths and morbidity. Owolabi, Oyo State Commissioner for Health in 2009, shut all mission houses in the state because he claimed that 36,000 women die annually from avoidable complications before and after delivery in the hands of unqualified personnel in mission houses. But pregnant women and significant others perceive faith homes as efficacious. Currently, there are various health-care delivery systems for pregnant women in Nigeria namely: traditional birth attendants (TBAs), faith clinics/houses, community based and orthodox Western medicine. In Ilesa, faith clinics and western medicine are the most prevalent. Medical personnel regard faith based homes as traditional birth attendants (TBAs).

UNIVERSITY OF IBADAN

2.1.4 Reasons for extensive patronage of traditional birth attendants (TBAs)

TBAs are usually females that are elderly who acquired their skills generally by delivering babies themselves or by working with other TBAs (Eades, Brace, Osei and Laguardia, 1993). Their skills and experience are locally recognized and respected (Muazu, 1992; Adekunle, 2001). They usually reside in the community, and this makes them easily accessible to women and so they take deliveries of 60-80% of births. They regard their practice as God's gift. Nigeria, like other developing countries, makes extensive use of TBAs during pregnancy and labour. This is partly because child delivery is regarded as a social event, rather than a medical one. TBAs serve special roles in primary health care delivery. If appropriately trained and supervised, they can play extra roles in immunisation, family planning education and contraceptive distribution as well as diagnose for referrals of complications. They help to take simple midwifery to women in their homes and reduce congestion in hospitals. Their services are not as costly as institutionalized maternity services, just as payment can be waived or postponed to a more convenient time.

According to Leedam (1985), TBAs performed an estimated 70-90 percent of deliveries in African countries in 1974. The proportion of births attended by TBAs in rural areas is greater than that of urban areas; In rural areas, the TBAs are probably the only available health care providers (Eades, *et al.* 1993). The proportion of births attended by TBAs in North East, North West and North Central Nigeria is far greater than that in the other geographical zones (NDHS, 2003). Various reasons have been adduced for the extensive use of TBAs in Nigeria which include: cultural beliefs and practices, proximity and convenience of accessing places of delivery, costs of services, treatment and handling of pregnant women, especially in labour and delivery. *Population Reference Bureau* (2005) posits that only 35 per cent of Nigerians have access to modern medical services, while the other 65 per cent employ the services of traditional healers. Many women still acknowledge the skills of modern hospitals in handling complications than the TBAs; yet, they believe in the expertise of TBAs in other aspects of childbirth (Muazu, 1992). They claimed they felt comfortable because the TBAs are part of them and know what is required and what they expects from them.

UNIVERSITY OF IBADAN

O'Mahony and Steinberg (1995) assert that two-thirds of rural South African women deliver at home with the aid of TBAs. *Population Reference Bureau* (2005) report notes that only 35 per cent of Nigerian women are delivered by skilled personnel. Ekanem *et al.* (1975) observe that many women still prefer TBAs even where trained midwives and physicians are available because of the TBAs' experience, kindness, skills, and interest in the welfare of the baby. Williams and Yumkela's (1986) study revealed that 85% of mothers preferred TBAs because they were more easily accessible, more friendly, and kinder during delivery, and their chages were less expensive than those of hospital deliveries. TBAs are believed to have special rituals and religious roles to play in pregnancy (Adekunle, 2001).

The TBAs not only take deliveries, but they also treat women's diseases, disorders and infertility, threatening abortions and deformities; they also do spiritual healing (Eades *et al.*, 1993). They employ natural methods and manipulation. The TBAs provide antenatal and postnatal services as well as medicine for some childhood ailments. They provide herbal treatment and nutritional advice for pregnant women to prevent problems, stimulate foetal growth, and hasten labour (Muazu, 1992; Eades *et al*, 1993). They assist to keep the woman in a squatting position, hold her hands and massage her back while contractions are on. They encourage the woman not to shout or push too hard to avoid tears. When tears occur, they treat the injury with hot water (Muazu, 1992). At deliveries, the TBAs cut the umbilical cord, bath mother and child Such umbilical cords are cut with razor blade, knife or even palm fronds. These could be sources of infection for mother and child, as some of the equipment are not sterilised. In Muazu's study, the TBAs took care of the mother and the baby for a week, washing their clothes and bathing for them (Muazu, 1992). They still have contact with both mother and child weeks after delivery; and give advice on breastfeeding and mother's nutrition (Eades *et al.* 1993).

When women who are delivered at home experience complications, many TBAs refer such complications to hospitals (Muazu, 1992; Eades *et al*, 1993). But many of the TBAs reported that the women do not go to hospital owing to financial and transport limitations as well as disrespect and painful treatment from hospital personnel (Muazu, 1992). Akpala, (1994) suggests the need to urgently train more TBAs in obstetric services

UNIVERSITY OF IBADAN

such as antenatal care, risk detection, referral conduction, delivery under septic condition and postnatal care to reduce maternal mortality and morbidity.

WHO had recognized the need since the early 1970s and encouraged countries to evolve training programmes for the TBAs. Countries that have been involved in this training have increased and the impact has been drastic reduction in maternal and infant mortality (Greenwood, Bradley, Byass, Greenwood, Snow, Bennet and Hatib-N'jie, 1990). There are general proposals to adapt some practices of one health care provider to the other, especially Western medicine to traditional indigenous midwifery, so that the advantages in both may be enjoyed. This may reduce the negative aspects of indigenous medicine. The major problem, however, is that traditional and Western medicines do not have common concepts. They are based on different philosophies and their integration may be difficult (Jegede, 2002).

To reduce the then high maternal mortality rates in areas served by the TBAs, the Bayalu Rural Development Society in India carried out community-based projects with farm families in Indian State of Karnataka. Women groups selected TBAs for training and pressured health authorities to provide gynaecological services and regular visits by auxiliary midwives. The project evaluations showed that participants were more likely to have at least three antenatal visits and to have trained personnel attend to them during childbirth than non-participants. Participants were more likely to indicate that they had the right to make decisions and move freely outside the home.

2.1.5 Utilization of antenatal care services

Home deliveries have been the pattern of deliveries since human existence. The first idea of midwives occurred in Exodus Chapter 2 of *The Full Life Study Bible*, King James Version (1992) where it was written that Egyptian midwives attended to Israelite women. With the introduction of orthodox medicine to Europe, delivery shifted from home to hospitals. As utilization of orthodox medicine increased in Europe, so decreased maternal mortality from over 1,000 per 100,000 live births in the 18th century to 10 per 100,000 births in 1989 (Royston and Armstrong, 1989) and 13 per 100,000 live births in U.S.A. Western medical service was introduced to Africa, Nigeria in particular, via the

UNIVERSITY OF IBADAN

colonial administrators and missionaries around 1906. It was extended to Ilesa (the study area), Shagamu and Ado-Ekiti in 1913 (Fatunbarin, 2008). This service was later spread to other parts of Nigeria.

Fatusi and Ijadunola, (2003) argue that less than one third of public-sector facilities meet comprehensive essential obstetric care standard. This makes it difficult for these facilities to take care of referral needs of the people. In developed countries, regular enquiries are made to eliminate available risk factors, and this has brought maternal mortality to negligible level. A woman's risk of dying from pregnancy and childbirth in developed countries is 1 in 7,300; while that of sub-Saharan Africa is 1 in 22 (*United Nations Development Programme* (UNDP), 2010). Maternal mortality ratio (MMR) in developing countries is 10 times higher than that in developed countries and national statistics in these countries are rare and inaccurate, as analysis of MM is based on experiences in individual hospitals. Estimated MMR in different communities in Nigeria is as follows:

Rural Areas - 828

Urban Areas - 351

South West - 165

South East - 286

North-West - 1025

North-East - 1549 per 100,000 live births.

While the estimate for the nation is 840 (NDHS, 2008; Limwattanawon, Targcharoensatthien, and Smiak, 2011, Unicef, USAID n.d.).

Haemorrhage and hypertensive disorders account for the largest proportion of these maternal deaths (Okonfua, 2012). Haemorrhage is believed to account for 34% of MM; infection 17%; pregnancy induced hypertension 11%; obstructed labour 11%; abortion 11%, eclampsia 11%; malaria 11%; and anaemia 11% (Salama, 2008). Mothers with severe anaemia are predisposed to increased risks of maternal death, stillbirth and neo-natal death and their infants are at increased risks of low birth weight, premature death and/or cognitive impairment (Tinker and Ransom, 2002). Anaemia also predisposes

UNIVERSITY OF IBADAN

babies to be born prematurely as well as increases their chance of dying before their first birthdays.

One in every five African women has a risk of losing a newborn child during her life time (Graham, 1991; Sindiga, Chacha and Kanunah, 1995; WHO, UNICEF, UNFPA, 2001). Most of these deaths are preventable if appropriate health measures are taken. Such measures include antibiotics for infections, caesarean sections for obstructed labour, blood transfusion and oxytocic drugs for haemorrhage, sedatives and other drugs for eclampsia. Other preventive measures include better health care during pregnancy, delivery and post-partum period; antenatal care, providing initiated HIV testing and counselling, skilled attendance at delivery, emergency obstetric care and family planning (Salama, 2008). When these measures cut across and integrate the home, community, outreach and facility-based services, these interventions can have multiple benefits for mothers, children and communities in which they live (Salama, 2008). Unfortunately, such treatments are not available to many women for cultural, social, religious, and economic reasons.

In many pregnancy complications, there are not early warning signals that an emergency may occur. Complications do occur at dying minutes when they are least expected. Some of the women who survive become chronically ill and eventually die from conditions such as diabetes and infectious hepatitis (Paul, 1993; Dada, 2008). It is not only imperative to save mothers' lives, but it is also a sound investment that benefits the families, the communities, and countries (Wardlaw, 2008).

The hospital authorities expect pregnant women to adhere to certain conditions. A pregnant woman is expected to come for booking after missing two consecutive menstruations that is about eighth or tenth week of pregnancy. She is expected to attend ANC at least four times: one at first trimester, one at second trimester and twice at the third trimester, and adhere to all the tests and immunisation schedules.

Health workers recommend a maximum of five doses of tetanus toxoid injection for a lifetime vaccination. The first dose at first contact, the second after four weeks, the third six months and the fourth and fifth doses one year interval. An unimmunized pregnant woman must take at least two doses each within 4 weeks and the third six

UNIVERSITY OF IBADAN

months after. Women that do not attend ANC early may not be able to take more than one or two. NDHS (2003) reported that almost half of their respondents did not receive any tetanus toxoid injection. Only 20-40% of pregnant women in northern Nigeria received two or more immunizations, compared with 62.7% in the South. Women that utilize ANC are faced with the problem of financing materials that the hospital authorities expect them to purchase. Women who attend ANC are supposed to book with two thousand and five hundred naira for the first booking and one thousand and eight hundred naira for subsequent pregnancies. These costs cover tests of retroviral, hepatitis, blood group, ultra sound, genotype, urine and packed cell volume (PCV) as well as other measurements, like blood pressure, weight and height.

When women attend ANC, health talks on appropriate diet, personal hygiene, what to expect in, and preparation for labour, breastfeeding; care of the baby (appropriate way to bathe the baby) are given. Such talks also include: indication of pregnancy complications, what to do when labour sets in, and indication for surgery as well as postnatal check up. Following health talk are pelvic and abdominal palpation, and prescription of appropriate routine drugs. During the course of booking and subsequent antenatal attendance, the midwives or nurses check for danger signs like swollen feet, face, and body.

2.1.6 Social Factors that influence decision on pregnancy care

Different studies have laid emphasis on minimum travel distance to increase utilization of health-care services. Federal Ministry of Health (1988) and Jegede (2002) noted that women would want to utilize clinics near their homes because of travel time and transport cost. Most Nigerians do not want to travel more than 5 kilometres on foot to receive health care service. Okafor (1982) argues that the cost of travel has serious implications for location and utilization of health care services, as most people want to spend less on transport. Proximity, high income, and participation in occupation are important determinants of utilization of health care delivery services. Logistic problems, such as availability of transport and good roads, are some of the factors that influence health management of pregnant women. In Ilesa, there are no problems of transport

UNIVERSITY OF IBADAN

because the health care facilities are within walking distance to all citizens. The question is whether or not women make adequate use of these facilities.

According to Jegede (2002), Nigeria has a ratio of one health facility to about 10 rural communities. The majority of women with prolonged labour complications in many hospitals are patients from remote rural areas. *Safe Motherhood Progress Report* from Guinea Bissau on maternal mortality revealed that half of maternal deaths occurred among illiterate women who were 10 kilometres away from health care centres or hospitals who had no antenatal care and were delivered at home (WHO, 1978). Ilesa has many health centres within reach. But do the pregnant women make use of these facilities?

Audu-Airede, (2000), reports that the introduction of users' fees has been found to lead to increased MM in many places in Nigeria especially in University of Nigeria Teaching Hospital, Enugu; where MM ratio was said to have increased by about 600% since 1987 when users' fee was introduced in government-owned hospitals. Antenatal care, hospital delivery and emergency obstetric care have become inaccessible to many Nigerians. Some women come to hospital as a last resort only when complications have set in and mother is, perhaps, on death road (Audu-Airede, 2000). Kaufman (2002) found that Chinese women knew the importance of hospital deliveries but still delivered at home because of users' fees. Less than six percent of women delivered in hospitals, while the other deliveries took place at home attended by a relative or a friend. In Ejia China, pregnant women perceive quality of local services too poor and birth attendants inadequate and, because they could not afford hospital bills, they usually deliver at home, attended by a friend or a member of the family.

High fertility rate is another issue in maternal mortality. Women are subjected to repeat childbearing at short intervals, either to satisfy their husbands' quest for a large family size or as a means of adjusting to the very high infant morbidity and mortality on the continent. The situation is exacerbated by cultural beliefs and practices and poor medical delivery system that hinder access and use of hospital facilities during emergencies (Ajiboye and Adebayo, 2012). This is compounded by other harmful traditional practices, such as female genital mutilations. Average fertility rate in Nigeria

UNIVERSITY OF IBADAN

is 6.0. In northern Nigeria, fertility rate is 6.6 and in the South fertility rate is 5.5. Early childbearing is partly responsible for this high fertility rate in Northern Nigeria. For instance, 21% of girls have given birth by age 15.

Birth spacing affects the health of mother and child. Women who give birth when they are too young or too old or have babies too closely spaced are at risk of birth complications and infant mortality. For instance, a newborn baby that is less than 24 months younger than the next older siblings is 2.2 times more likely to die than one that arrives after 36 months. Women with high parity are at high risk of maternal mortality and their newborn children are at increased risk of death (Tinker and Ransom, 2002). Women above 35 years and those who had more than four pregnancies are known to be at increased risk of maternal mortality and morbidity. So, in the interest of their health, women should not have children when they are above 35 and should not have more than 4 pregnancies.

Women bear the greatest brunt of physical labour at home and farm, and this brings about premature aging. Frequent pregnancies reduce women's resistance to illness and fatigue, yet they are pressed into numerous pregnancies such that, by 50 or 55 years, they are disabled by arthritis and hypertension. High MM is a result of low status of women and low coverage of health care services (Ransome-Kuti, 1990).

Cultural patterns are important because they lead to an understanding of factors underlying disease patterns in a community. These cultural patterns give insight into people's values, knowledge of and attitude to health and disease. Oke (1995) notes that socio-cultural factors affect utilization of medical facilities as well as predispose an individual to accepting or rejecting utilization of medical facilities. Jegede (1998; 2010) claims that, the culture of a particular group of people, at specific periods of time, always influences their ways of living in that society.

In addition, much less value is placed on the female child than the male. The female child is less nourished and given less formal education. When resources are scarce, the girl child's education is stepped down to give place to the boys. When sickness strikes in a family, the girl is withdrawn from school to take care of the sick. Many parents still arrange child marriage for their girls. This result in early pregnancies,

UNIVERSITY OF IBADAN

with its attendant complications like Vesico-Vagina Fistula (VVF), prolonged labour and anaemia. Females are exposed to genital cutting. Male child preference encourages high fertility and maternal mortality. Desire to bear sons will make women anxious to bear children without proper spacing. A woman will go in for as many pregnancies as possible in order to have a male child who will secure her right to inheritance in her husband's house. Studies in India revealed stronger preference for sons than daughters.

According to Onwudiegwu, (1997) and CGSPS, (2002) with the worsening economic situation in Nigeria, the health status of Nigerians would be the worse for it. Deepening economic crisis has worsened poverty level, resulting in increased promiscuity, prostitution, adolescent sexual experiences and unwanted pregnancies, HIV/AIDS, and unsafe abortion (Audu-Airede, 2000). Effective use of family planning methods at this time can contribute to improved maternal and newborn health by helping women to avoid pregnancy when the risk of poor outcome is high (Ayongwa, 2006).

Limwattranon *et al.* (2011) report that most African leaders failed to allocate to health 15% of their national annual budget, as they committed themselves in 2001. The percentage of allocated is far below WHO's estimate to health at any given year. The resources available are allocated to infrastructures and VVF. A situation where there is misallocation of available resources to infrastructures and VVF while women with prolonged labour cannot afford emergency CS is not good enough. Cost of transportation, travel time, condition of the road or distance, aggravated by incessant shortage of petroleum products, result in high cost of transportation to take women with emergency obstetric complications to the hospital. This is also complicated by drivers' unwillingness to have their vehicles soiled with blood. All these result in delay in reaching facilities.

Social elements, such as gender inequalities and social class are basic determining elements of health. Oke (1995) avers that some diseases are occasioned by poor diet, clothing, and housing that are direct effects of cultural origin. Adekoya (2012) found strong but inverse relationship between socio- cultural factors and choice of health care. The result of his study revealed that the culture of patriarchy, income and where one resides are determinants of when one commences care and the choice of health providers.

UNIVERSITY OF IBADAN

Mubiru ba (Mak) (2012) asserts that women's social definitions and perception about pregnancy influence ANC-seeking behaviour patterns. Women with positive perspectives towards pregnancy seek ANC. To such women, pregnancy provides joy, happiness, and pride, promotes social status, and safeguards marriages. It is an avenue to access love, care, support and gifts. On the other hand, women with negative perception do not seek ANC. They perceive pregnancy as misery, sadness, pain, suffering, regrettable and uncomfortable experience. Mubiru ba (2012) found that the perception of these women were culturally constructed and rooted in their taboos, rituals and practices of their communities. These social constructions prevent the women from seeking ANC care to avoid bad omen that could harm the pregnancy. Culture, therefore, cannot be divorced from the health status of a group of people; poor health is a direct consequence of cultural practices (Adelani, 2009). Until and unless some cultural practices are modified, most health problems cannot have feasible solutions. Some of these practices include food prescriptions and proscriptions, attitude to operative deliveries, ignorance, decision-making patterns and ill-equipped hospitals to take care of emergencies.

Among some societies, balanced meal is preserved until after delivery, when relatives are around to see that they eat good meals even though the foetus would have been deprived. Among other cultural groups, balanced meals are proscribed for nursing mothers until seven or nine days after delivery for baby girls and boys, respectively. Some women prefer to reserve their money for expensive clothing, trinkets and elaborate naming ceremony rather than make adequate preparation for balanced meals or pay medical bills because of cultural factors. Women expect their husbands to provide balanced meals and pay medical bills while they spend their money on clothes and trinkets. Adelani (2009) avers that most women would not get ready the needed items for delivery, probably due to nonchalance, ignorance, and poverty. Therefore, education must be structured for women to prioritize safe motherhood.

Another social factor is attitude to Caesarean Section (CS). Most women expect delivery to be normal, but when things go wrong they go to any length to avoid CS. They think that unless they have normal delivery, they have reproductive failure and insist on trying against medical advice. They deliberately delay permission in the hope that, with time, normal delivery will take place. At times, they are lucky and are delivered

UNIVERSITY OF IBADAN

normally, but some are not so lucky and, by the time the permission is given, things would have gone dangerously bad. When operative delivery is needful, women should accept the inevitable to save their lives and their babies.

Adelani (2009) identifies three types of delay that contribute to poor obstetric care, disabilities and deaths.

1) Delay in taking decision to seek medical care because of ignorance and inability to recognize danger signs of complications and lack of birth preparedness by pregnant women and their families. Ignorance occurs when pregnant women and significant others are ignorant of early symptoms of pregnancy complications.

2) When it becomes obvious that a problem is at hand and the woman decides to seek help, she is faced with the problem of decision-making, taking permission from an absentee husband, and where to get money. When these obstacles are surmounted, the problem of transport between the home and facilities surfaces: the woman in a difficult labour may have to trek or be put on a donkey in the North or in boat in riverine areas for a long journey to facilities. This delay is further aggravated by poor road network, impassable roads, communication gap between pregnant women and health care providers, and lack of individual or family's means of transportation. These can cause serious delay in getting a pregnant woman to the hospital. In order to find solutions to transport problems, Pate (2012) suggests collaboration with Nigerian Union of Road Transport Workers to assist women in need of urgent obstetric care in villages. Pate (2012) was of the opinion that maternal and child health will receive a boost as the Nigerian Union of Road Transport Workers (NURTW) provide emergency services to pregnant women in rural areas in northern Nigeria.

   However, Onwudiegwu (1993) and Adekunle (2001) were of the opinion that when the women eventually arrive, they may not receive adequate treatment because needed materials to aid delivery may be in short supply; relations of the women have to pay large deposit or buy the material themselves. Sometimes, the relations have to go back to the villages to get more money. This could be an additional 8-10 hours, which may spell death of the mother, the child or both.

UNIVERSITY OF IBADAN

This has led to a corresponding increase in the number of pregnancy complications and subsequent maternal deaths.

3) At the hospital, delay in receiving appropriate care due to delay in access to staff and facilities; lack or inadequacy of competent and/or committed hospital personnel─ doctors, nurses, and attendants─stare them in the face, as many doctors and nurses refuse rural posting (Adelani, 2009).

There is evidence that pregnant women that needed augmented labour like CS or blood transfusion had been delayed to the point of death due to administrative bottlenecks when health workers gave priorities to registration and payment than to patients. The causes of type three delays may also include unavailability of antenatal, delivery and post-delivery cost. Before women reach well-equipped facilities, their conditions would have worsened considerably, leading to avoidable MM or maternal morbidity. When the economy is the problem, the community should know that government cannot provide everything, and be aware of hospital limitations so that they come well prepared when they bring patients to avoid unnecessary delays. The community could evolve a financial self-help so that no woman is prevented from going to hospital because of lack of funds.

In addition, a combination of previous unfavourable experiences with health care providers; lack or poor supply of consumables and equipment; delay in referral of patients as well as lack of essential obstetrics care in facilities can also contribute to type 3 delay.

Muazu (1992); Kisekka, Ekwenpu and Olorukoba (1992); Afsans and Rashid (2001) note that, women may not be willing to be examined by men or may be reluctant to discuss reproductive matters with men. When such women have to discuss with male physicians, they may not open up.

Another cultural practice which militates against utilization of Western obstetric care is the inability of the hospitals to accommodate delivery in squatting position (normal delivery in hospitals is lying on the back but home deliveries are in squatting positions). Further, some hospitals do not bath babies in the first 12 hours of delivery and many people believe that babies that are not bathed would have body odour in future. This also may militate against hospital delivery. Those who are delivered of babies in

UNIVERSITY OF IBADAN

hospitals are eager to be released to go home so that they can quickly bath their babies to avoid their babies having such odour. Some hospitals do not allow hot baths for mothers. The Hausa believe that exposure to cold after childbirth may lead to ill health. As a result, mothers are made to eat hot spices, have very hot baths, and sleep in overheated rooms during the first forty days of delivery. Although this practice enhances personal hygiene, it results in severe burns and injuries. Severe burns on the breast may make breastfeeding impossible. Others may sustain such burns on their private parts. These get infected and those who survive have severe scaring and harrowing effects in their private parts that make future delivery difficult or impossible (Ekwenpu, 1990). Nwokocha (2006) claims that, the Ibani people of Rivers State in Nigeria attach great importance to how the placentas of their children are disposed of. Therefore, mishandling of such placentas by hospital care providers may hinder patronage.

There is the cultural practice of post-delivery sexual abstinence for lactating mothers, no sexual activities are allowed until the baby is 2½ years old. This practice exposes the husbands to polygyny or extra-marital affairs with the attendant exposure to HIV/AIDS and other sexually transmitted infections.

Another cultural practice is '*Gishiri'* cuts, a traditional practice among the Hausa people of northern Nigeria, in which the birth canal, especially the vagina, is cut with a razor blade. This leads to loss of blood and extensive injuries and severe damage to adjacent organs, like the bladder and rectum. This may result in Vesco Vaginal Fistula (VVF).

Shehu (1992) identifies polygyny as another cultural factor that affects pregnancy care. In a polygynous marriage, the pregnant woman has to share her husband with other co-wives. She may not be given any special treatment except she is clearly seen to be sick. The diet of a pregnant wife in a polygynous marriage is not different from that of other members of the family. She takes of the food provided by the husband for all members of the family. This may be inadequate for her and her foetus. Further, the ridicule of co-wives may prevent the pregnant woman from seeking help early. This may contribute to prolonged labour. There is also the tendency for women (especially in polygynous marriages) to compete to have many children so as to produce many males to

UNIVERSITY OF IBADAN

enable them to have fair share in the husband's property at his demise. Hence, Shehu's respondents desired as many children as Allah willed regardless of the opinions of medical professionals. Cultural practices that encourage childbirth at short intervals and multiple pregnancies confer no advantage on women.

As a result of their belief that pregnancy is a normal process, women in labour in Sokoto State of Nigeria are confined to a room by themselves. They are to show bravery and will and should not call for help even in prolonged labour. By the time a problem is discovered, complications must have set in. Among the Hausa people, pregnancy and childbirth of the firstborn must be in modesty, shyness, disguises and secret (Kisekka, *et al.* 1992). The woman is socialized such as not to flaunt her pregnancy; to isolate herself and deliver her baby in solitude. She is to show no signs of pain or fear. Even when a pregnant girl cries out for help she may not receive it quickly as other co-wives or neighbours or traditional birth attendants (TBAs) may believe that she is being lazy and has not taken her lessons seriously. Such women are, exposed to high-risk labour. TBAs do not even attend to births of first babies; they only come after a woman's self-delivery to cut the umbilical cord. This frequently contributes to delays in early detection, timely diagnosis and assistance in childbirth complications. This is even more so since the first babies are delivered when the mother is also a child with less developed pelvic.

Cultural taboos and superstitions proscribe some food items for pregnant women. Such proscriptions are detrimental to the welfare of mothers and babies. Proscribed food items include snails, chicken, gizzards, fish, pig, antelope, grasscutter, egg, melon soup, groundnuts, sugar, sugarcane, honey, cocoa beverages, banana and mangoes (Wahab, 2004 and Erinosho, 2006). Yet these food items have abundance of protein, carbohydrates, vitamins, fats and minerals that reduce women's susceptibility to diseases and infections. Diets that have sufficient nutrients and calories are essential to carrying pregnancy to term, but many women lack them. Vegetables and fruits are prescribed but even then the prescriptions are based on the notion that they cleanse wombs. These food taboos are imposed on pregnant women and children when they need them most for growth and development of healthy babies.

UNIVERSITY OF IBADAN

In many societies, women suffer food discrimination; they have access to food only when all males have eaten though they are saddled with the responsibilities of preparing them and are overburdened with other household chores (Erinosho, 2006). As a result of poor nutrition, women could not combat anaemia, infection and haemorrhage. It has been found that maternal weight, especially gestational weight gain, is linked to the birth weight of the infant. The nutritional status of pregnant woman is believed to be closely related to peri-natal outcome. Poor maternal nutrition has been linked to spontaneous abortions, low birth weight, hearing problems, brain damage in children, stillbirths and congenital malformation (Erinosho, 2006). Anaemic women are unable to withstand even moderate blood loss and so cannot carry babies to term.

In addition to the burden of pregnancy, the workload of the average Nigerian woman is twice that of her male counterpart. She spends hours fetching water, gathering sticks and cooking food in addition to farming and the secular work or business. Even among the working class, women still run shops/ businesses after the close of their official work.

Among some societies, pregnant woman should avoid sunshine so that evil spirits would not destroy the pregnancy. Physical exercises, such as bending of legs, lying backwards and walking about, are discouraged because it is believed that the baby's cord will be entangled around him. In some other societies, excessive exercise is encouraged during the third trimester to shorten the labour period. In some societies, pregnant women are to carry heavy load to induce smooth and quick labour. Some of these cultural practices should be reviewed and adjusted so as not to jeopardize the health of pregnant women and babies.

Other social factors that have affected maternal health care utilization include repeated strike actions by hospital personnel for better conditions of service. Incessant strikes actions and lock-outs are most common in the teaching hospital in the study area. During the course of this study, the teaching hospital chosen for the study was on strike four times. Women who booked there for delivery had to make alternative arrangements at critical times. Most pregnant women envisage that there will be a strike action at the time they are to give birth, so they always book in alternative care-giving centres.

UNIVERSITY OF IBADAN

Shehu (1992), in his study in Sokoto State, Nigeria, revealed that the socio-cultural practice of early marriage is a big factor in maternal mortality. Some women start reproduction from as early as 13-14 years and have babies until nature stops them. CONNOHPD (1997), in their studies in Kaduna and Katsina States, Nigeria, found that the normative age of marriage for girls is 12-15 years, contrary to the minimum accepted 18years by UNICEF and medical experts. They found that illiteracy was high among women because very few of them went beyond primary school, if they ever went to school at all. The respondents' reasons for giving out the girls early was that girls become sexually mature earlier than boys and it will not be correct to watch a girl become big while staying in her father's house. In their opinion, the appropriate place to grow big is in the husband's house. Other informants commented that they did not want the girls to bring shame to them by getting pregnant outside wedlock or becoming promiscuous. They also perceived early marriage as a kind of luck for the girls because delay might mean she would lose the opportunity of getting married. They were of the opinion that if the girl got married around ages 20-25 she might have lost her virginity. Most men want to catch the girls young. These girls are married to men aged 20-25, or 40-60, majority of whom are not virgins themselves. One wonders why a man who is not a virgin will be bent on marrying a girl that is a virgin.

The (2003) *Nigeria Demographic Health Survey* reported that 30% of Nigerian females have begun childbearing by age 18, and by age 20, 40 - 48% of northern Nigerian women have begun childbearing. However, studies have shown that neo-natal and maternal deaths are lowest among mothers aged 20-29 (NDHS, 1990; 2008). Child marriage tends to increase MM in Nigeria as these young adults are not physically and emotionally stable for the stress of pregnancy and childbearing (Adelani, 2009). The teenage period should be a transitional one in which teenagers grow up and mature, but many of them experiment with sex and engage in illegal abortions, which often result in life-threatening complications and lots of them die annually as a result of this. It is essential to provide accurate and understandable information about sexuality and contraception to girls, using culturally acceptable approaches so as to avoid unnecessary risks (Adelani, 2009).

UNIVERSITY OF IBADAN

Ekwenpu (1990) states that, the best result of childbirth is between 20 and 30 years where children are spaced evenly between 2½ - 3 years and are not more than 4. If girls are allowed to go to school, they would not get married early and they will use the time to grow up. Education will be profitable to them to take decisions, seek help, know where to get help and have resources to pay for services.

2. 1. 7 Influences of demographic factors on care during pregnancy

Economy is an indicating factor in illness and health. The health of a pregnant woman depends on her personality and economic backgrounds, as well as who provides the finance in health care. The dangers women face in pregnancy and childbirth are closely connected to their socio-economic status. Harrison, (2012) notes that, Nigeria's social, economic and political chaos is the underlying problem militating against safe motherhood. Adekoya (2012) reported strong significant but inverse relationship between the socio-cultural factors and choice of health care, as well as incongruous relationship between the pregnant woman and nursing mother's residence and health care consumption. Oke (1995) avers that upper and lower social classes have different values, which influence their health status as well as utilization of health facilities. Younger middle-aged people and those who are educated with higher income utilize modern health facilities.

Thus, there is a great difference between the health care of the poor and that of the rich. The literate are prompt to attend the orthodox health care system, as they could easily afford it, while the poor and illiterate tend to utilize traditional medicine because they could not afford the charges in Western health care (Jinadu, 1998). Erinosho (1977) asserts that the literate do not uphold the influence of magic and religion. Even in developed countries, the poor die much younger than the rich. Health problems are concentrated among the poorest within the poorest countries (WHO, 2001 and *Population Reference Bureau*, 2005).

The poor are vulnerable to ill-health and disease because of lack of financial resources and balanced diet. The poor have large families that lack nutritious meals, and cannot rely on trained health professionals because of users' fees. The rich, however,

UNIVERSITY OF IBADAN

have smaller, better-nourished families and are better informed on utilization of health services and can afford users' fees. Women's education that favours good health and healthy practices is also lacking among the poor, who are also disadvantaged because they live in rural and remote areas. They lack clean water, good and safe housing, and efficient transportation. Among the poor, there are social norms of early marriage and discrimination against women, all of which predispose women to poor health. The poor usually receive fewer benefits from the health system than the rich. Governments allocate higher health budgets to urban hospitals than the ones in the rural areas where the poor reside. One of the respondents in the study of Asuquo *et al*. (1992), in buttressing the impact of economy, said 'If you do not have money, do not bother to go to the hospital; your wife might as well better stay at home and die'. Professional assistance at delivery is critical to maternal health because most childbirth complications cannot be predicted in advance, and this is not available to women because of their low social status. Births to women in the richest quintile are nearly five times more likely to be attended by a trained professional, such as nurse, doctor or midwife (*Population Reference Bureau,* 2004).

Traditionally, in many societies, family planning is a taboo and continued fertility is accepted as evidence of feminism and youth. This results in high fertility rate that can cause pregnancy complications. Lack of access to family planning methods or husband's refusal of the utilization of any of the family planning methods are reasons for high fertility rate, coupled with failure to seek modern health management. *Population Reference Bureau* (2005) estimated 5.7 live births per woman for Nigeria. *Population Reference Bureau* (2004), in its studies in 53 countries observes that wealthy women are more likely to have less total fertility rate that is, life-time births per woman, less number of adolescent deliveries, less children mortality, less percentage of children with stunted growth and less percentage of malnourished women. But the rich are likely to have more percentage of women using contraceptives, more women with three or more antenatal care visits, and more percentage of births attended by medically trained personnel.

In Benin Republic, for instance, the poor women have 7.2 total fertility rates, while the rich within the same country have 3.5. The poor had 198 per 10,000 childhood mortality rate, while the rich had 93 per 10,000 (*Population Reference Bureau*, 2004). When we compare this with industrialized countries, this is still high. Fifty-nine percent

UNIVERSITY OF IBADAN

of the poor had three or more antenatal attendances, while 92 percent of the rich attended three or more antenatal clinics. Trained medical personnel attended to fifty percent of the poor at birth, while medical personnel attended to 99 percent of the rich. Only 20 percent of the poor women in Bolivia received skilled care at delivery. The story is the same in all the 53 countries studied. Therefore, maternal mortality is highest in the world's poor countries and among the poorest population within every country (*Population Reference Bureau*, 2005). The key finding of *Population Reference Bureau*, (2004) is the same nearly everywhere. Inequality in accessing health care and health status are persistent. The poor women and their children face greater health risks and are less likely to use key health services than those that are better off. The poor are disadvantaged in nearly all the factors that contribute to good health like education, knowledge of health matters, nutrition, and use of health services. The wealthy women are nine times more likely to have completed secondary education than the poorest in most countries (*Population Reference Bureau*, 2004). The literate are already used to queuing up, registration and physical examination, which may be strange to the illiterate.

Population Reference Bureau (2004) reported that the rich women are more able to decide for themselves to seek health care than the poor. In Peru, for instance, only 39 percent of all the poor can take personal health care decisions. The poor pregnant women suffer malnourishment and this makes them susceptible to diseases and poor health. Almost a quarter of the newborn ones in the developing world start life with some degree of impaired growth and malnourishment. Impaired growth in the womb predisposes infants to low birth weight, which may lead such children to early mortality as adult. This also predisposes children to other developmental problems such as poor attention and a high burden of disease throughout life. Low birth weight may lead to short underweight adults. If the baby is a girl, she is likely to have obstructed labour, which is dangerous for her and her baby; and the cycle continues (Tinker and Ransom, 2002). Even in poverty-ridden societies, women suffer the effects of poverty than men because women have unequal access to economic opportunities, education and power structure.

The greatest danger to women's health is lack of education. The largest number of illiterates in the world is women. Low level of education for women has been said to have implications for knowledge, perception, attitude and maternal activities. Bongaarts

UNIVERSITY OF IBADAN

(1997) asserts that the higher the woman's education, the more likely her knowledge of contraceptive methods, and the more likely they are to be independent in decision-making. NDHS (2003) observes that reproductive health behaviour, contraceptive use, and children's health are linked to education of household members. The illiterates may also find official conduct of orthodox medicine cumbersome. Therefore, giving women sound education would liberate them from male dominance and enable them to utilize maternal care service. Educating the women would make them knowledgeable about antenatal care and detecting early signs of complications. The literature reveals that the uneducated bear largest number of children and lose most. They fail to understand simple concepts and perform worse in attending ANC owing to economic constraints and conflicting advice on efficacy from ancient and modern health care.

Low level of education for women has been found to have implications for their knowledge, perception, attitudes and maternal activities. Bongaarts (1999) cited in Nwokocha (2006) asserts that the higher the woman's education, the more likely her knowledge of contraceptive methods, and the more likely she is independent in decision making as regards reproductive health and adoption of birth control. The 2003 NDHS observed that reproductive health behaviour, contraceptive use, and children's health are linked to education of households. A lot of studies have found statistically significant relationship between economic status and health. The (2003) NDHS showed that the poorest are also least likely than the wealthiest to use basic health services such as immunisation, maternity care, and family planning (*Population Reference Bureau*, 2004).

Formal education plays a significant role in the use of reproductive health services as well as ability to communicate with care providers. Education will increase the value people place on their lives and health. This will, in, turn increase utilization of Western reproductive health services. Socio-economic elevation and improvement of status as well as provision of universal formal education with fertility control will lead to a more gradual and sustained decline in the level of maternal deaths in Nigeria. NDHS (2003; 2008) revealed that the higher the educational attainment of women, the less the number of children they desire to have is. Laraia *et al.* (2006) found that most of the women that have problems with food security had lower income, less education and were younger than women from food secured homes.

UNIVERSITY OF IBADAN

Age has vital social and cultural dimensions. In most Nigerian societies, age is power and it connotes authority and superiority. Age is revered, and the aged are seen as possessing ability to think and make decisions. The younger persons depend on the elderly for taking decisions. Jegede (1998) states that the higher the age, the lower is the use of modern health care services. Contraceptive use is highest among married women in their 30s and 40s and lowest among 15s-19s. The authority of the aged is also noticeable in the roles mothers-in- law play in decision-making in hospital attendance and parity. There are cases of mothers and mothers-in-law who insist that their daughters or daughters-in-law have more children after the couples have agreed on the number of children they intend to have and one sees their will and decision prevailing. These elderly women also play significant roles in deciding health care facilities to be patronized.

Furthermore, gender issue influences reproductive health. Patriarchy makes wives depend on their husbands for economic survival and encourages the culture of silence and submission in women. Side by side with patriarchy are widowhood rites practices. At the demise of the husband, the widow is sometimes shared as part of the man's property. She is assigned to marry male relation of the husband, an act that increases her exposure to sexually transmitted and HIV infections, late pregnancy, haemorrhage, labour complications, and death (*Centre for Gender and Social Policy Studies*, 2002).

Different studies have revealed that with the worsening economic situation in Nigeria, the health status of Nigerians has been the worse for it, and that general health indices in Nigeria are worse than that of developed and other developing nations (Onwudiegwu, 1997; CGSPS, 2002). Deepening economic crisis has worsened poverty level, resulting in increased promiscuity, prostitution, adolescent sexual experiences and unwanted pregnancies, HIV/AIDS, and unsafe abortion (Audu-Airede, 2000). Effective use of family planning methods at this time can contribute to improved maternal and newborn health by helping women to avoid pregnancy when the risk of poor outcome is high (Ayongwa, 2006).

UNIVERSITY OF IBADAN

2.1.8 Adherence of women to hospital's instructions and prescription

Orthodox Western health care was introduced to Nigeria by both the former colonial masters and Christian missions. It consists of primary, secondary and tertiary health care centres. Trained doctors and nurses manage them. Availability of skilled care during child birth has been critical to maternal and newborn health and survival. It has been found to save lives of mother and child. For instance, when a newborn child does not cry or breathe despite the stimulation provided, the skilled health attendant can provide artificial respiration (*Population Reference Bureau*, 2004). This health care delivery system enjoys the greatest government patronage and funding. This institution has been valuable in reducing maternal and child mortality, as adherence to its regimes has been found to save lives of mothers and children where such facilities and staff are available. However, in Nigeria, WHO's numerical targets of 1 doctor to 10,000 patients and 15 percent of the annual budget to health are yet to be achieved. Only 6.5 percent of Nigeria's budget goes to health and, of this, less than 3 percent goes to maternal health (Adewuyi and Tsui, 2000; Musibau, 2012). When complications occur, referrals are made from the other care givers to hospitals. If the patient arrives early before complete damage has been done, such complications could be remedied. Shortages of manpower, drugs, and equipment have not allowed this care giver to perform optimally. This is further aggravated by low economic level that has hitherto encouraged brain drain in medical services. This health service is further plagued with inadequate coverage and unreliable infrastructural facilities as well as non-adherence to its regimes.

Adherence to (or compliance with) a medication regimen is generally defined as the extent to which patients take medications as prescribed by their health care providers (*Bosworth and the National Consumers League* n.d.). Adherence to medication usage is defined as the proportion of prescribed doses of medication actually taken by a patient over a specified period of time. There are patients who do not consume every pill at the desired time. Rates of adherence for individual patients are usually reported as the percentage of the prescribed doses of the medication actually taken by the patient over a specified period (Weisbart, 2012). Some investigators have further refined the definition of adherence to include data on dose (taking the prescribed number of pills each day and the timing of doses (taking pills within a prescribed period).

UNIVERSITY OF IBADAN

WHO () describes adherence has a multidimensional phenomenon determined by the interaction of five sets of factors. These dimensions are discussed below.

- Social/economic: People who have social support from family, friends, or caregivers to assist with medication regimens have better adherence to treatment. Unstable living environments, limited access to health care, lack of financial resources, cost of medication, and burdensome work schedules have all been associated with decreased adherence rates.
- Provider-patient/health care system: The relationship of the doctor-patient is one of the most important health care system-related factors impacting adherence. A good relationship between the patient and the health care provider, which features encouragement and reinforcement from the provider, has a positive impact on adherence. Poor or lack of communication concerning the benefits, instructions for use, and side effects of medications can also contribute to non-adherence, especially in older adults with memory problems.
- Condition-related: Long-term drug administration for many chronic illnesses and adherence to such treatment regimens often decline significantly over time. This often happens when patients have few or no symptoms and the absence of them is a barrier for people to take their medication. It is important for the patient to understand the illness and what will happen if it is not treated.
- Therapy-related: The complexity of the medication regimen, which includes the number of medications and number of daily doses required, duration of therapy, therapies that are inconvenient or interfere with a person's lifestyle and side effects, have been associated with decreased adherence.
- Patient-related: Physical impairments and cognitive limitations may increase the risk for non-adherence in older adults. Lack of knowledge about the disease and why medication is needed, lack of motivation, low self-efficacy, and substance abuse are associated with poor medication adherence.

Adherence rates are typically higher among patients with acute conditions, as compared with those with chronic conditions; adherence among patients with chronic conditions is

UNIVERSITY OF IBADAN

disappointingly low, dropping most dramatically after the first six months of therapy. There is no consensual standard for what constitutes adequate adherence. Some trials consider rates of greater than 80 percent to be acceptable, whereas others consider rates of greater than 95 percent to be mandatory for adequate adherence. Weisbart, (2012) found in responses to a questionnaire, that typical reasons cited by patients for not taking their medications included forgetfulness (30 per cent), other priorities (16 per cent), decision to omit doses (11 percent), lack of information (9 per cent), and emotional factors (7 per cent), and 27 per cent of the respondents did not provide a reason for poor adherence to a regimen (www.nejm.org).

According to the World Health Organization (WHO), non-adherence to the medical regimen consists of a major clinical problem in the management of patients with chronic illness. Rates of non-adherence with any medication treatment may vary from 15% to 93%, with an average estimated rate of 50%. In an Australian hospital, 59.1% non-adherence was reported among pregnant women with chronic health conditions. Non-adherence was not intentional, as many of the women noted that forgetfulness was the most common reason. Matsui (2012) argue that non-adherence with medication is a common problem in pregnancy. This may have potential consequences as patients may not achieve their therapeutic goals. As pregnant women try to keep their underlying diseases under control, fear and anxiety regarding the potential harm of the drug on their foetus may result in non-adherence.

Improving adherence enhances patients' safety. It is crucial for health professionals to assess the patient and foresee the possible causes of non-adherence and follow a policy for increasing medication adherence and achieving the best health outcome. Adherence to prescribed medication is a key component in management of health in patients, the benefits patients derive from medication depend on adherence to prescribers' instructions. Non-adherence includes: delay in prescription fills, cutting dosages and reducing the frequency of administration (Bosworth n.d).

The care a patient received will determine whether or not the individual will go back for further treatment or will eventually utilize the prescription given. The quality of interaction between patients and physicians and the emotional impact of interaction may

UNIVERSITY OF IBADAN

elicit satisfaction, unhappiness, or anger (Jegede, 2010). These emotions have been found to influence adherence to medical regime. When patients are satisfied with the outcome of visit to any healthcare delivery centre, they are likely to adhere to recommendations and return for follow-up. They are also likely to recommend such for others. But if the interaction is poor and the physician is insensitive, clients might be deterred from revisiting the physician.

2.1.9. Adherence to hospital regimes in the developed world

Bosworth (n.d) asserts that non-adherence to essential medications has grave consequences on public health, as it has enormous burden on the world health care system. He claims that half of the 3.2 billion annual prescriptions in the United State of America are not taken as prescribed. McCharthy, quoted in Bosworth, states that approximately 125,000 deaths annually reported in USA are linked to non-adherence to medication. Osterberg and Blaschke (2005) aver that between 33 and 66 per cent of medication- related hospital admissions are due to poor adherence. The total cost of non-adherence ranges from $100-300 billion each year. Among patients with chronic conditions only 50-60 per cent were found to have adhered to medication as prescribed despite the fact that they were aware that the therapy would increase the quality of their lives. Osterberg and Blaschke (2005) also reported an average adherence rate of only 43 to 78 per cent among patients receiving treatment for chronic conditions and about half of the patients stopped their medications within six months. Matsui (2012) did a meta-analysis of 569 studies in London and reported that adherence to medical treatment ranged from 4.6% to 100%, with an average of 75.2%. Seriousness of underlying conditions did not ensure adherence even when not taking the medication had unfavourable disease outcome.

2.1.10 Adherence to hospital regimes in African countries

Sangare *et al.* (2011), in their study in Uganda, found that recommended anti-malarial drug were used according to the guidelines in only 30.1% of all second and third trimester episodes. Self-reported malaria was extremely common in this population and

UNIVERSITY OF IBADAN

adherence to treatment guidelines for the management of malaria in pregnancy was poor. Lugolobi also found that only 32% of HIV patients' pregnant women in Uganda adhered to ANC attendance. There was no significant difference in the demography of those who adhered and those who did not.

It is clear that the full benefit of the many effective medications that are available will be achieved only if patients follow prescribed treatment regimens reasonably closely. *Wikipedia* (2011) notes that a strong percentage of women in Benin received prenatal care at some time during their pregnancy. Estimates have indicated that 97% of women received prenatal care in 1996 and 88% in 2006. It was estimated that in 2006, 93% of women in urban areas and approximately 85% of women in rural areas received prenatal care, though rural estimates varied by department. About 61% received the four prenatal visits recommended by World Health Organization. Of those women who had prenatal consultations, 86% took iron supplements, and only about 45% had any kind of nutritional counselling.

According to *Wikipedia* (2011), the use of technology in prenatal consultations has increased; in 2001, about 8% of women had ultrasound diagnostic tests, while, in 2006, 21% had the same tests. Further, the recommended two doses of tetanus toxoid vaccine were received by only 56% of women in 2006. It is most likely that a woman seeking prenatal care will use the services of a midwife for consultations; about 80% of these women were found to see a midwife or nurse prenatally.

The following symptoms were found to motivate women to seek out prenatal care; symptoms that prevent the completion of daily tasks; indications of abnormality, such as bleeding, pain, or fever; fears of miscarriage; and fears of repeated complications seen in prior pregnancies (Wikipedia, 2011). If a woman does not notice any indications of complications during early pregnancy, she may opt to wait until late into the second trimester or third trimester to seek out prenatal care.

Barriers to accessing prenatal care include cost and transportation. Women in Benin reported that negotiating funds from husbands for prenatal care or associated prescriptions can lead to arguments between spouses as well as frustrations between patient and provider. In Benin, pregnancy is often a way to gain status and respect in one's community; therefore, getting pregnant can become more of a pressure from

UNIVERSITY OF IBADAN

society than an individual's choice. Some women in Benin hinted that pregnancy indicated good fortune, but others could not help but express concern about the extra costs another child brings. Beninese women also describe pregnancy and birth as a time of great vulnerability, and more specifically, as a time 'where life and death converge' (*Wikipedia*, 2011).

2.1. 11 Adherence to hospital regimes in Nigeria

Antenatal care has the effect of giving pregnant women the opportunity to have any problem detected and treated early. Labour complications are anticipated so that when they occur, prompt steps are taken to save the mother and prevent injuries to the baby. ANC affords pregnant women opportunities to receive health education on simple hygiene, nutrition, care of baby, and other factors responsible for high maternal death. Essential obstetric care ensures care for high-risk pregnancy and complications.

In Nigeria as at 2003, 63% of the women receive ANC and 21% from doctors and 37% from nurses; only 47% made four minimum recommended number of visits and the majority attended only in the second trimester. Among these, only 55% were instructed on pregnancy complications; 58% received iron tablets; two thirds had urine and blood tests, while only 47% received tetanus toxoid vaccine. Sixty per cent of births occurred at home; only one-third of deliveries were attended by skilled attendants; only a small proportion received post-partum care (2003 NDHS). About 50 per cent of Nigerians received tetanus toxoid injection, while only 57% attended ANC from trained personnel. Yahaya and Yahatu (2009) investigated the proportion of women who kept to their appointments and found that only 30.7% of the women kept all their appointments. The proportion of women who had three visits was 32%. There was no socio-demographic difference among those that attended and those who did not attend. Forty one per cent of rural and 61% of urban centres received ANC from doctors and 23% from nurses and midwives (Giwa- Osagie *et al*., 1990).

A factor that may affect adherence to health care system is the attitude of orthodox health providers. Strained relations usually occur between the health workers and patients; among the health workers themselves for example doctors/nurses;

UNIVERSITY OF IBADAN

clerks/patients; and patients/nurses (Jegede, 1998). All these bounce back on the patients. However, even where hospitals are available and accessible, the level of adherence of pregnant women to instruction would determine their effectiveness. Women attend the antenatal clinics only when they have problems, such as bleeding and pains, but when such disappear, the women discontinue clinic attendance (Matsui, 2012). Many women regard pregnancy and childbirth as natural processes that should not be interfered with. Seeking hospital intervention should be a last resort after complications have occurred and home management has failed. Many women admitted attending antenatal clinics only to register and have a card in case complications occur during childbirth.

Introduction of user's fees also affects the level of adherence of women to hospital regime and reduced utilization of antenatal care, hospital delivery and postnatal care. A study in Jammu and Kashmir, India revealed that 9% of the respondents perceived delivery in health facilities as too exorbitant. To solve this problem, community participation was encouraged. Women groups were mobilized to organize self-help programmes to raise money to set up small clinics and stock them with drugs and raise money for hospital delivery.

2.1.12 Husbands' and significant others' roles in decision making and health care in pregnancy

Women are faced with multiple choices to make in childbearing; but women are often not allowed decision-making regarding care-seeking during pregnancy, birth or the postpartum period. A major factor that inhibits ANC attendance is the role of husbands and significant others in pregnancy care. The support and encouragement of these people can go a long way to assist pregnant women. Ilesa is patriarchal in nature and the husband decides where, when and how his wife goes about pregnancy care. Access to ANC, therefore, depends on the socio- economic status of the husband who plays dominant roles in taking these decisions. The husbands are regarded as lords, heads and masters of their families and, in almost all situations, their decisions are final. In most African societies, Ilesa inclusive, men dominate and absolutely control actions and interactions in their families in virtually all spheres of social relationships; therefore,

UNIVERSITY OF IBADAN

women depend on their husbands and significant others. Barret (1988) views patriarchy as a type of household organization in which the father dominates other members of the extended kinship and controls economic structure.

Kisekka *et al.* (1992), in their studies in Zaria, found that women delay in seeking hospital care because they were in purdah and their husbands were in total control of their spatial mobility. When a woman is experiencing obstetric complications, the husband's explicit permission and authority must be sought before she can be transferred to hospital. This situation is compounded when the husband travels and cannot be reached on time. The women's socio-economic status, coupled with a husband's access to quick and summary divorce by 'tallah,' generates a sense of insecurity and powerlessness which makes it very difficult for women to defy or question their husbands' decisions even if they are detrimental to their own health. CONNOHPD (1997) asserts that men perceive divorcing their wives at any time as a right that can be done at will and sometimes they do it under the influence of alcohol. When a woman is divorced she has no right to anything from the husband and, since early marriage did not allow her access to education or apprenticed training, she becomes economically powerless.

Kisekka *et al.* (1992) in a study in Sokoto, Nigeria, reported that husbands engineered 71.6 percent of those who attended antenatal clinics, as they were the sole decision makers in their wives' health care. Husband's disapproval accounted for non-attendance in antenatal clinics and not delivering babies in hospitals. In a patriarchal society reproductive health that does not involve men would be of little or no impact. Studies have identified the need for men's involvement in their partner's well-being. Some areas where men are supposed to contribute to reproductive health include:

i)planning their families

ii) supporting contraceptive utilization

iii) stressing and participating in seeking maternal care

iv) ensuring nutritional food for their wives during pregnancy

v) arranging for skill delivery

vi) avoiding delay in seeking care

UNIVERSITY OF IBADAN

vii) helping after baby is born and

viii) being a responsible father (UNICEF, 1998).

In the past, women were the target of reproductive health so that there are more family planning methods for women than for men. Recently, however, studies on reproductive health have shifted to men because more men were found to want larger families than women probably because women bear the greatest burden of pregnancy and child birth (Isiugo-Abanihe, 2003). Men's decisions are also very vital with regards to when a woman's condition is serious and need medical attention. Murthy *et al.* (2002) claim that women's dependence on men for accessing health care is one of the barriers for poor utilization of reproductive health care services. Men's action or inaction at critical times can spell death of the baby or the mother or both. The Cairo International Conference on Development (ICPD) 1994 and Bejing 1995 brought into the limelight the need for men to change their attitudes to reproductive health and gender issues. UNDFPA (1995) suggested the importance of responsible, respective and non-coercive sexual behaviour and shared reproductive decision-making.

Studies in India revealed that men were aware of ANC, delivery and postnatal care, yet they did not accompany their wives to hospital. Those who did only went to confirm pregnancy, but subsequently pregnant women went alone or in company of other women. A further research reported that when some men attended ANC, they were not given adequate attention. They had to wait in the hospital corridor until their wives were ready. The report of FGD in Jammu and Kashmir in India revealed the view of some of the men that attended ANC with their wives:

> We are ready to get involved in accessing maternity care to our women. Men do accompany them, pay for their medical expenses, allow them take rest and even help them in sharing the household chores during pregnancy. However, when we accompany them to hospitals during their pregnancy or delivery, our maternity care hospitals have little to offer to men. Neither are we allowed to accompany our spouses in the OPD, nor is there any waiting room for men. Men have no option but to stand outside the main entrances of the hospitals and create hurdles in the movement of patients and staff. When hospitals or maternity wards are out of bounds for men, how can you expect them to interact with men?

UNIVERSITY OF IBADAN

Another participant had this tale to tell:

> Like other responsible husbands, I also visited the local hospital a number of times with my wife. After all, she is carrying and nurturing my pregnancy and the expectant child belongs to both of us. True, I cannot share the pain of pregnancy but I have to support my wife during pregnancy, child birth and even in child rearing and caring. Though I had the impression that a lady doctor would talk to both of us, yet during these ANC visits, I was never called by the doctor to come inside and share information about the progress of pregnancy, any advice and precautions for safe pregnancy, information related to medicines, diet and other such issues. I do not know whether any government hospital in this State has a system to provide any education to male members. Staff working in these hospitals has a negative attitude towards men and they generally say to us that men have no business in maternity hospitals.

Jammu's study revealed that two thirds of husbands were present during at least one ANC check-up. However, only 28% of them were informed about what to do in pregnancy complications, while only 20% were aware of any sign of pregnancy complications.

Men who make it to ANC should be well informed about what is expected of them in labour and delivery. More importantly, they should be well informed about signs and symptoms of complication and what they can do in each case. Hospital authorities need to look into how they can get husbands involved in pregnancy care by making provision for would-be fathers.

This study revealed that men have limited knowledge of reproductive health. About 78% of men could not identify fertile period in a menstrual circle; more than half could not identify symptoms of pregnancy complications; while 71% were not aware that symptom of sexually transmitted diseases (STDs) may not be apparent, and that STDs can be transmitted from mother to unborn babies. A substantial proportion of the men were not informed about the need for ANC or delivery in health facilities. Forty-seven per cent of Indian men reported that their last babies were not delivered in health facilities because they did not feel it was necessary and did not allow it. The good news is that men are becoming the focus of reproductive health and soon men will become sensitized on their roles. The success of any health campaign depends on the cooperation

UNIVERSITY OF IBADAN

of the husbands. Husbands who want to acquaint themselves with contraceptive use have limited options available to choose from as health technology focused mainly on producing contraception for women. Husbands need to be sensitized on the great responsibilities placed on their shoulders and should take up increased financial responsibility for food and drug.

As husbands dictate movement of their wives, they need information to be able to help their pregnant wives in time of emergencies. Many husbands are ignorant of and may not perceive dangerous signs and symptoms of pregnancy complications. It is imperative to educate them about this. Pregnant women need to get emotional and financial support from their husbands. Husbands must be sensitized to know that balanced diet, proper clothing and ANC are vital for safe delivery of healthy babies. They are to be educated on special emotional needs of pregnant women and be involved in family planning, especially vasectomy. They should recognize that things can go wrong at any time in labour and there is need for personal and environmental hygiene.

In developed countries, the roles of husbands have gone beyond merely pacing up and down the hospital corridor awaiting the announcement of the arrival of their babies. They are now included from when the pregnancy test is positive to prenatal appointments and birth classes. Where the husband has aversion for blood or body fluids, he is allowed to stay in a safe distance which his comfort zone will permit. This could be beside, behind or on top of his wife's bed during delivery (www.parenting.ygoy.com).

Husbands should be aware that lack of adequate rest and post-delivery heavy workload are sources of complications. They should be aware of direct and indirect causes that are responsible for maternal deaths. Direct causes include severe anaemia, induced abortion, ruptured ectopic pregnancy, eclampsia, obstetric haemorrhage and obstructed labour. Indirect causes include perception of cause of complications, harmful cultural and traditional practices, poor health facilities and infrastructural deficiencies, poor health providers' attitudes, viral hepatitis, abnormal haemoglobins, heart disease, bacterial infections, deprivation, ignorance, mass illiteracy and underdevelopment.

Apart from husbands, mothers, mothers-in-law, and grandmothers were found to influence pregnant women's health management. Kisekka *et al.* (1992) revealed that in

UNIVERSITY OF IBADAN

northern Nigeria, disapproval from these women accounted for 45 per cent of non-attendance at antenatal clinics, especially during the first pregnancy. Pregnant women may also influence each other on where to receive appropriate care. Many people usually give advice to primigravidals. These women usually recommend one caregiver or the other based on their former experiences, particularly the kind of care received during their last visits.

From the foregoing, it can be established that MM is high in Nigeria but preventable if adequate and early health care delivery is received. Such care should include: safe and clean delivery, accessibility and transport to health facilities, family planning, emergency care and safe blood transfusion. Marriage should be contracted only after 18 years for females. There should be adherence to optimal breastfeeding, tetanus toxoid immunisation, healthy living and adequate nutrition and other instructions. Education of the girl child is a must. There should be good, workable and adequate referral system and feedback. There should be decision-making opportunities for women. It is important that health care be accessible, affordable, and cost-effective to reduce maternal mortality. This will be effectively done if conditions of living in rural and urban areas are conducive and encourage urban health workers to settle anywhere. There should be available basic, supervised, affordable, and equipped antenatal care centres. This has not been because of various social, religious, and economic factors that affect women's ability to seek hospital care. Pregnant women may avoid hospitals where hospital staffs do not allow delivery in squatting position or bath babies immediately after delivery, or where male health workers attend to pregnant women.

Economic reasons also affect health care in pregnancy. The poor are less likely to attend hospitals because of user's fees. They are more likely to have high parity and low birth weight. They are less literate and lack essentials of life. Cultural practices of early and forced marriages are more rampant among the poor. In order to reduce maternal mortality and morbidity rates, therefore, both the poor and the rich must have access to modern health care delivery system.

UNIVERSITY OF IBADAN

2.2 Theoretical framework

Functionalist Theory and Health Belief Model (HBM) were used as the theoretical background for this study.

2.2.1 Functionalist Theory

Talcott Parsons pioneered the functionalists' approach to sociological study of health in the early 1950s. He argued that all social actions should be understood from how they help society to function. He saw sickness from the social dimension and as a disruption and harm to the society. He viewed illness as a form of deviance which disturbs effective functioning of the society, as the sick are unable to perform their normal social roles. Illness needs to be controlled and the sick have to be helped or controlled to perform their social roles again. Parsons saw sickness as a social rather than biological concept. Being sick was a form of social role (sick role). There are rights and obligations that are attached to this role. The sick has a right to be exempted from his normal social obligations. This depends on the seriousness of the illness and other people's acceptance that a person is genuinely sick. The sick should not be blamed for their condition and should be looked after by those who are well. The sick, on the other hand, should perceive their condition as undesirable and seek to be well. They must seek medical assistance and cooperate with professionals to get well. Refusal to do these disqualifies a sick person from appropriating the sick role. The person should be forced to perform his social roles (Haralambos and Holborn, 2008).

However, the sick role does not take cognisance of chronic illnesses from where the individual may not recover over a long time. To Parsons, the doctor has to legitimise an illness but many people may not attend the health care providers' homes to be labelled sick. There are many people who ignore their sicknesses. In addition, patients have their own needs and wishes when they attend clinics. Doctors and patients are not always in harmony in treatment of illness. Parsons' sick role was modified by Safilios-Roschild (1970) to rehabilitation role for the chronically ill and disabled. This involves them accepting and learning to accommodate their condition by maximizing their ability and cooperating with medical professionals. The rehabilitation involves helping such

UNIVERSITY OF IBADAN

individuals return to normality by adjusting psychologically to their new identity (Haralambos, 2008).

Pregnant women are regarded as the healthiest patients in hospitals. They are expected to attend hospitals and adhere to doctor's prescriptions and instructions to enable them to have successful outcomes. In pregnancy, the woman and others must perceive pregnancy complications as serious and life-threatening and the pregnant woman must be exempted from normal social obligations.

To Durkheim, religion is to meet society's need for social solidarity. Social facts lie at the heart of his discussion on religion. Social facts are social structures and cultural norms and values that are external and coercive of the actor. He distinguished two types of social facts: material and non-material. Durkheim (1961) addresses religion as non-material social facts. He shows that religion is a strong integrative force through its instilling of common values and identification (Wallace and Alison, 1986). He notes that religion has the ability to dominate individuals and elevate them above their ordinary abilities and capacities (Ritzer, 2000). Durkheim (1961) argues that all societies divide the world into two: the sacred and the profane. Society creates religion; the symbol is a totem, an emblem that distinguishes a clan from another. The sacred are revered, awed, respected, and honoured. This reference transformed the profane to sacred. Durkheim (1961) argues that worshipping god is worshipping society. To him, the sacred is superior to man and man depends on it.

Durkheim (1961) notes that social life is made possible by collective conscience without which there will be no society. Religion reinforces the collective conscience. As people worship in society, they recognise the importance of social group and their dependence on it. Religion strengthens the unity of the group and promotes social solidarity. Religion, in modern society, expresses some collective sentiments through the development of a set of religious beliefs which expresses the nature of the sacred and the relationship which they sustain with each other. There is also the need for a set of religious rites which are rules of conduct in the presence of the sacred. A religion requires a church or a single overarching moral community.

UNIVERSITY OF IBADAN

Durkheim views totemism as a religious system in which certain emblems, such as plants and animals, are regarded as sacred emblems of the clan. Totems are material representations of the immaterial force. In the study area for this research, many pregnant women patronize religious houses for care giving and certain materials, such as water, oil, sponge, soap, rivers and mountain tops are regarded as sacred; and religious leaders take pregnant women there for prayers to avoid complications. Many of the pregnant women bathe in flowing rivers and/or pray on mountain tops to ward off evil. In many societies, pregnancy is perceived from religious view point. They believe that pregnancy is a gift from God and religious houses have appropriate solutions to whatever complications arise from pregnancy.

2.2.2 Health Belief Model (HBM)

Symbolic interactionism perceives illness as a social definition and not direct result of some form of diseases. A disease condition may be present in a person but he may not define himself as ill. Rosenberg (1989), quoted in Haralambos and Holborn (2008), assert that, disease does not exist as a social phenomenon until it is somehow perceived as existing.

Illness behaviour explores the patterns of behaviour people engage in when they decide whether or not they are actually unwell and the action they should take as a result of their decision. To Mechanic (1968), illness behaviour is the way in which symptoms are perceived, evaluated and acted upon by a person who recognizes some pain, discomfort and other signs of organic malfunction. Sociologists claim that a large number of people who feel 'unwell' do not visit a doctor. There are more illnesses than are presented to the doctor (Haralambos and Holborn, 2008).

The HBM is a psychological model that was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services to explain and predict preventive health behaviours, like utilization of health services, including screening and immunisation programmes. HBM focuses on attitudes and beliefs of individuals to health issues. It was developed in response to the failure of the free tuberculosis (TB) health screening programme, so as to explore other health

UNIVERSITY OF IBADAN

behaviours and apply them to illness behaviour. It is a psycho-social model of health-seeking behaviour of a person who believes he is healthy for the purpose of preventing disease and a person who feels ill to regain his health. It is the process by which an individual weighs the risk to his health, accesses the benefits, and removes the barriers to actions taken. Becker *et al.* (1977) further investigated what influenced people to visit a health caregiver.

The HBM assumes that beliefs and attitudes of people are important determinants of health-related actions. It provides an understanding and predicts how a patient will behave in relation to his health and how he would comply with therapy.

The HBM is based on the understanding that a person will take a health-related action (that is, attend antenatal care) if that person:

- feels that a negative health condition (that is, maternal mortality or morbidity) can be avoided,
- has a positive expectation that by taking a recommended action, she will avoid a negative health condition (that is,attending antenatal clinic will prevent pregnancy complications and stillbirths), and
- believes that she can successfully take a recommended health action (that is, she can attend clinic and use routine drugs comfortably and with confidence).

The HBM consists of three stages:

- ❖ Factors that lead the person to undertake recommended compliance behaviour. These factors include an individual defining herself as ill, her perception of the extent of harm which the illness may cause to her body and interference to her social roles as well as the extent she will benefit from receiving treatment.
- ❖ Modifying and enabling factor refers to the probability that the ill person will adhere to the recommendations of health professionals. This will depend on such things as the age of the person, financial, social and physical cost of treatment; attitudes of professionals; and the social importance of people encouraging her to consult a medical professional and adhere to treatment.

UNIVERSITY OF IBADAN

- ❖ This stage involves whether or not the individual will adhere to all, some or none of the recommendations, depending on the outcome of the two stages above.

Therefore, being ill, seeking medical attention and adhering to professional recommendations have social and medical undertones. There is a complex interaction between the individual, his perception of health, illness and the medical profession, and the view of social network around them (Haralambos and Holborn, 2008).

The model identifies three major variables that influence health behaviour:

i). Perceived amount of threat which is sub-divided into:

a) Importance of health matters to the individual

b) Perceived susceptibility to disease

c) Perceived seriousness of the consequence of the disease.

ii). the attractiveness of value of the behaviour, which depends on perceived probability that action will lead to desired preventive result.

iii). Perceived benefits of taking action, which depends on a personal dispositional factor such as age. Other factors include income, place of work, residence, transportation, occupation and education.

The HBM is based on the assumption that an individual will take health-related action, such as attend antenatal clinics or take tetanus toxoid if she feels that maternal and/or child mortality or morbidity will be avoided. If a woman has positive expectation that if she attends antenatal clinics and takes recommended routine drugs and rest, she will avoid negative health conditions; she will have safe delivery and her pregnancy will be convenient and comfortable. She will likely patronise Western orthodox hospitals.

The HBM was further spelt out in four constructs: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers.

Perceived Susceptibility is an individual's chance of being infected with a disease. In this study, only pregnant women can be susceptible to pregnancy complications: such as haemorrhage, obstructed labour, pregnancy-related mortality and morbidity.

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Perceived Severity indicates an individual's opinion of how serious her health condition is. For instance, women who perceive pregnancy as natural, normal way of life may not take pregnancy seriously and may take no health initiative. Many people believe that nobody takes delivery for goats and sheep, and these animals do not have complications. So they believe that, as pregnant women, they too will not have complications. Such women may not perceive any risk in pregnancy and so may take no action; whereas another woman, who perceives pregnancy as a step between life and death, will take preventive precaution.

Perceived Benefits: The individual may ask herself or others the benefits of attending or not attending antenatal clinics or taking hospital regimen. Will taking action reduce risk of mortality or morbidity? What are the benefits that she can derive from health care providers? What benefits can she derive from combining some or all health-care delivery systems?

Perceived Barriers: When an individual perceives modern health management as efficacious and wants to patronise it, there may be barriers that will prevent her from taking actions. These barriers may include psychological, emotional, or financial cost. A pregnant woman may intend to patronize modern health care but may lack the wherewithal to do so. She may not be able to afford user's or registration fees; as well as the cost of accompanying relative, drug, accommodation, and feeding. Significant others may not approve of her seeking health care in a particular place. They may recommend other place(s). Ignorance of what to do or where to go may be a barrier to the pregnant woman.

Cues to action are a new concept that was added to the model to include strategies that activate action. These may include information on the radio, self or other people's experiences, bodily symptoms, encouragement from husband, other pregnant women, mother, and mother-in-law. When a woman perceives herself to be susceptible to pregnancy complication and maternal mortality/morbidity, perceives the condition as severe (life threatening or can lead to partial or permanent morbidity), and she weighs the benefits of taking action against taking no action and suffering the consequences; when she weighs the consequences of action or inaction on herself, on her baby and others, she

UNIVERSITY OF IBADAN

may take action depending on her emotion, time and financial cost. When she places all costs side by side with consequences of inaction, she may take positive action by attending antenatal clinics and delivering her baby in hospital.

A more recent addition to the HBM is the concept of *self-efficacy*, or one's confidence in the ability to successfully perform an action. This concept was added by Rosenstock et al. (1988) to help HBM better fit the challenges of changing habitual unhealthy behaviours, such as being sedentary, smoking, or overeating.

Day by Day (1977) criticized HBM for concentrating on negotiation between medical professionals and patients while ignoring wider social factors like inequality and pollution which are the actual causes of ill health.

UNIVERSITY OF IBADAN

2.2.3 Conceptual Framework

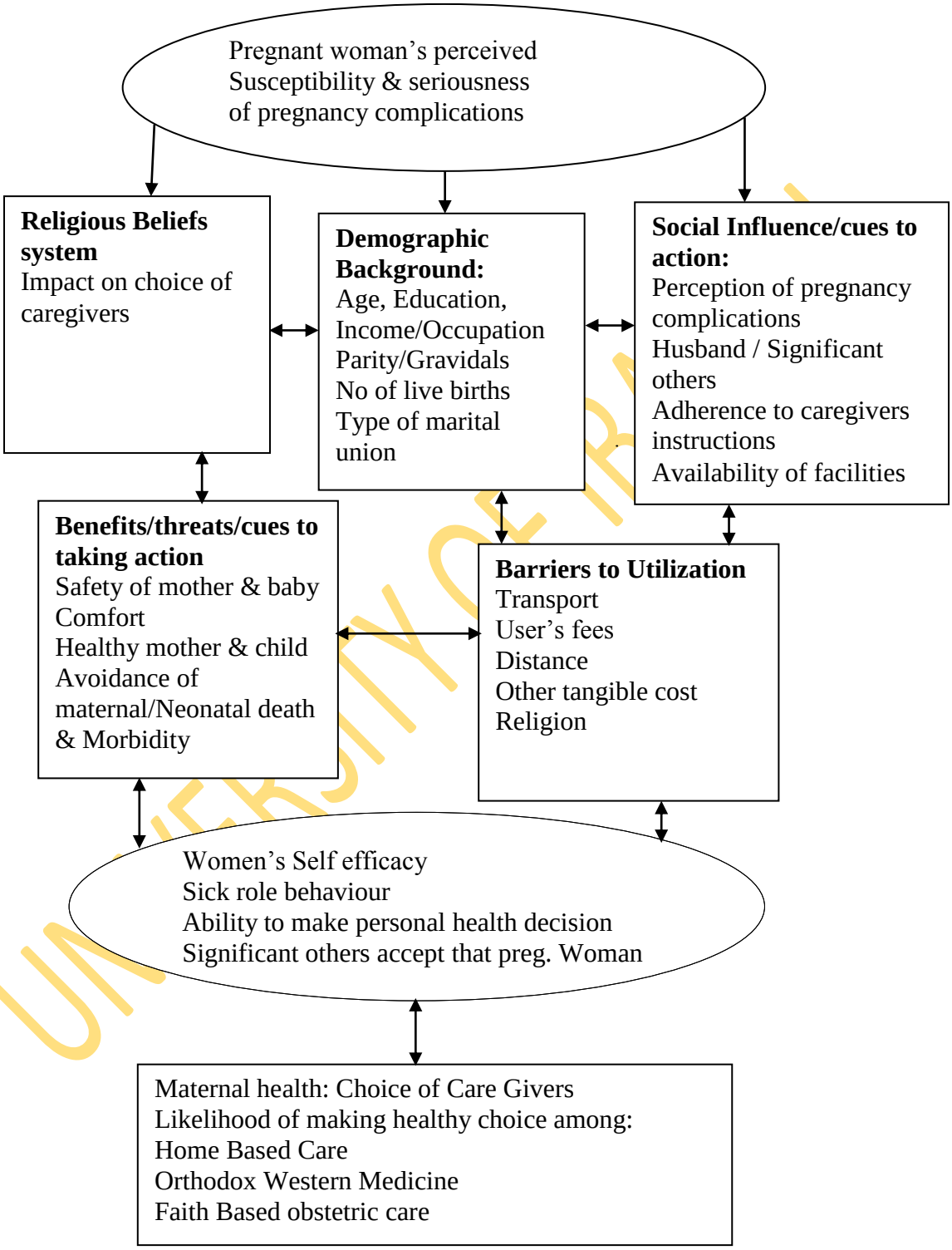

Figure1: Conceptual Framework on Pregnant Women's Maternal Health (Adapted from Rosenstock, Stretcher and Becker, 1994)

2.2.4 Explanation of the conceptual framework

Pregnancy is a social issue. It places women in need of health care services. Women's social standing reflects their utilization of ANC. Women in low social and demographic status find succour in FBBAs for financial reasons. Religion, however, plays a dominant role in utilization of health care services. Religious factor is strong, social status may become irrelevant to utilization of health care services. The attention the pregnant woman pays to her health is determined by the nature of her pregnancy whether the pregnancy is the first (*primigravidals*) or subsequent ones (*multigravidals*). The type of pregnancy will also determine the care she gives or receives as well as her adherence to instruction from caregivers. For instance, elderly and teenage primigravidals are perceived as susceptible to pregnancy complications and will receive special attention from orthodox care givers than a woman in her early twenties. Her perception of the seriousness of her health condition will dictate her level of adherence to the caregivers' instruction. A woman who has primary or secondary infertility, health history of chronic diseases, history of multiple births or repeated abortions will be perceived as susceptible to pregnancy complications which will be perceived as being serious. Such woman will give herself and receive special attention. A woman's perception of her susceptibility to and seriousness of pregnancy complications will determine the type of maternal health-care she chooses. This will, as well determine her level of adherence.

Demographic background and social influences will determine a woman's self-efficacy and ability to take medical decisions. A woman who is enabled by her social and demographic backgrounds can weigh benefits and threats from each caregiver to herself and her baby. If she has the physical and social means to seek help, she will take health decision. Having weighed the benefits and hazards she might face with each of the caregivers, she may opt for a particular care provider or another. At a given time, she may decide to combine them to her mutual benefit. Whatever decision she or significant others arrive at will determine the health care giver she will patronize. A woman might determine to utilize a particular caregiver but barriers of transport, user's fees, distance, and other physical or psychological ones may prevent her from doing so. She may have to opt for another. For instance, a woman may perceive hospital care as effective and life-

UNIVERSITY OF IBADAN

saving yet is unable to defray its costs. She may make do with FBBA because they are free or their payment may be deferred.

The support of significant other−husband, her mother, mother-in-law, friends, neighbours, and other pregnant women in the neighbourhood−will also help to determine what her decision would be. The experience of the *primigravidals* is different from that of the *multigravidals*. The *primigravidals* usually have a lot of solicited and unsolicited advice from women around. These affect how they seek and receive care. The sick role accept that pregnant women need assistance and the community must be ready and willing to render it as well as exempt her from her social obligations.

UNIVERSITY OF IBADAN

CHAPTER THREE

METHODOLOGY

Both quantitative and qualitative research techniques were utilized to generate the data for this study. Quantitative study had to be triangulated with qualitative because, unlike matter, human beings possess consciousness and cannot be studied as subject matters. Humans, according to positivists, see, interpret and experience the world in terms of the meaning they construct as social realities. Many sociologists advocate that quantitative methods are inadequate on their own for collecting, analyzing and interpreting data, and that they are inappropriate in subjects that deal with human behaviour. Some sociologists suggest that qualitative approaches should be used to supplement quantitative methodology, while others advocate that qualitative approaches should replace quantitative approaches altogether.

For this work, both methods were combined for the work to enjoy the strengths of both and eliminate the weaknesses in them. While quantitative data are presented in numerical form, qualitative data are presented using content analysis. Qualitative data are perceived as richer, more vital and having greater depth and are more likely to present a true picture of a way of life of people's experience, attitudes and beliefs (Haralambos and Holborn, 2008). It is believed that only qualitative approach can help discover meanings behind social actions.

This chapter therefore presents the design and methodology employed for this study. These are presented as follows: research design, study population, sample design, research instruments (survey, qualitative methods) ethical issues, methods of analysis as well as limitation to the study.

3.1 Research design

Research design is the strategy and plan utilized by the researcher to investigate the research questions and test the hypotheses. It involves the decision to make the

UNIVERSITY OF IBADAN

research a qualitative or a quantitative one or to make it a combination of both. This study triangulated both methods to allow the one to make up for the weaknesses of the other. As stated earlier, sociologists advocate that quantitative method alone cannot capture social realities and man cannot be subjected to scientific methodology as matter. This combination will enable one to capture social phenomena. This is an explorative research. The main approach used for data collection was the qualitative method (in-depth interviews and case study). Structured and semi-structured questionnaire, and secondary records were triangulated to elicit robust information that helped to complement the qualitative information collected from the respondents.

3.2 Study population

This study targeted pregnant women, their husbands and their care providers in hospitals and faith healing homes in Ilesa, Osun State, Nigeria. All women who were pregnant at the time of the study, their husbands and their care providers formed the study population. Pregnant women and their spouses were selected as respondents so as to capture current behaviour pattern among the respondents. Data were collected from pregnant women at faith homes and hospitals. Quantitative data were generated from caregivers (lay and professionals) at 12 faith homes and 12 orthodox caregivers. The two local government areas (LGAs) in the town had 21 wards, ten of which were randomly selected; five from each LGA. Questionnaire was utilized to generate quantitative data, while in-depth interviews and observations were utilized to generate qualitative data. Additional information was obtained from Obafemi Awolowo Teaching Hospital (OAUTH), Ilesa delivery records from 2004 to 2008 on maternal loss and pregnancy complications that were reported in the institution.

Five hundred and ten copies of the questionnaire were administered to pregnant women in form of personal interviews but five hundred of them were usable. The respondents were reached by repeated call backs to ensure that the questionnaires were usable. The questions were related to socio-demographic factors, the role of religion, adherence of pregnant women to hospital regimes, and husbands' roles in care-seeking. Pilot study was conducted in two of the wards that were not selected for the study. A total

UNIVERSITY OF IBADAN

of 500 pregnant women were surveyed based on the selection above. There were 250 respondents from each of the LGAs. Twenty-four caregivers and ten husbands of the respondents participated in the in-depth interviews. Twelve in-depth interviews were conducted among clinical caregivers and 12 among faith based birth attendants (FBBAs). The fieldwork held between June 2009 and January 2010.

3.3 Sampling Techniques

The multistage sampling technique was employed in selecting the survey respondents and ten of the twenty-one wards in Ilesa. Pregnant women in the selected wards were identified at households (50), hospital/maternity centres (225) and in faith homes (225). Trained research assistants administered the questions to the women. Twenty-four in-depth interviews (IDIs) were conducted with FBBAs and hospitals caregivers; twelve were conducted among each of them. Heads of seven government maternity centres, five private hospitals, and the only general hospital were interviewed. Twelve heads of faith delivery centres were identified in their churches' delivery houses for interview. The birth houses were purposively selected. Those selected had a minimum of 30 pregnant women in attendance in their weekly faith clinics: three each from CAC and Cherubim and Seraphim Churches; five from other Pentecostal churches and one from The Redeemed Church of God. Only two male FBBAs were identified using snowball method and both were part of the IDIs. Ten willing husbands were also interviewed; one from each street. They provided information on men's roles in pregnancy care.

Twenty visits were made to prayer meetings and ANCs to observe the conduct of activities in them. In the prayer houses, the researcher joined in their prayer sessions and wrote down the major prayer points. In the hospitals, she listened to health talks that were given to the women and observed care giver- patients relationships.

The researcher could not identify practising traditional birth attendants, as all those identified utilizing herbs and other rituals claimed they were faith care providers and operated under some established churches; in most cases, they were the founders of

UNIVERSITY OF IBADAN

such churches. They claimed that they did not have legitimate training but were inspired. However, hospital care givers regarded them as TBAs.

3.4 Research instruments

The research instruments were utilised in this study includes:

1. urvey questionnaire
2. ey informant interviews (KIIs)
3. n-depth interview (IDIs)

3. 4.1. Survey Questionnaire

This study was a descriptive survey that documented current caregiving patterns among pregnant women in Ilesa. Only women that were pregnant were interviewed to ensure accurate reporting and analysis of current health care. The questionnaire was designed to contain open-and close-ended questions on issues that can help to elicit enough information on the subject matter. The open-ended questions enabled the respondents to report their personal opinions on the subject matter. The questionnaire was divided into five sections: Socio-demographic characteristics of the respondents, religious beliefs, adherence of pregnant women to care providers' prescription, women's perception of pregnancy complications and husband's roles in decision-making pattern in pregnancy (*see Appendix* I).

3.4.2 Key informants interviews (KIIs)

is an example of the qualitative method. This was useful in this study because it was open-ended and enabled the researcher to have access to the caregivers and husbands of

UNIVERSITY OF IBADAN

the women to elicit information. Its flexibility and practicality allowed the researcher to probe into the activities of the health providers

3.4.3 In-depth interviews (IDIs) were with the husbands of the pregnant women.

Two female research assistants were involved in the IDIs. One had a PhD and the other was an undergraduate with a wealth of experience. The IDIs were conducted among heads of the Faith Homes, maternities and hospitals. The questions were on the qualifications of care providers, number of delivery in the last six months, food prescription and proscription, conformity to ANC and prayer sessions, husbands' roles and knowledge of causes of pregnancy complications and treatment modes (*See appendix* II). The researcher was present in all IDIs to extract this information. Although the study targeted pregnant women, inclusion of their husbands in the IDIs was in order because Ilesa is a patriarchal society, and husbands have the final say in pregnancy care and their attitudes can determine which caregiver the pregnant woman utilises. Discussions were allowed to flow naturally. The researcher did not insist on asking questions according to the order in the interview guide. The interview was conducted in an informal setting that enabled the interviewees to openly discuss their views on pregnancy care. The IDIs targeted health care providers and husbands of pregnant women. Thirty-four IDIs were conducted: 12 in faith homes, 12 in hospital/maternity centres, and 10 among husbands of pregnant women.

To supplement the data collected from the IDIs, the researcher visited faith based birth homes (FBBHs) and ANC centres. The heads of the faith centres and hospitals were fully aware of the mission of the researcher, but the pregnant women were not initially so that they would not alter their behaviour in any way. Many pregnant women were in attendance; they could not distinguish the researcher from other women. Therefore, the presence of the researcher could not influence the actions of the respondents by any means.

Twenty-four visits were made to FBBAs and orthodox caregivers to observe their prayer and clinic sessions. On twelve different occasions, the researcher was allowed to observe the entire ANC processes in private and government maternities centres. The

UNIVERSITY OF IBADAN

same numbers of visits were made to FBBAs. She participated in the prayer sessions and the health talks. As a result, she was informed on the prayer points as well as the content of the health talk. The content of the health talk included care of the breasts in preparation for lactation, HIV infection, and contraceptive, care of older children, husband and general hygiene. This provided her with opportunity of first-hand, on-the-spot information and clear picture of the respondents' activities in ANCs and FBBHs. The respondents could not, therefore, lie or mislead the researcher. The observation went in an unexpected direction that provided the researcher novel insights and ideas on the activities in faith clinics and ANCs.

3.5. Data collection process

In the process of collecting the data, the researcher visited the headquarters of CAC in Okesa, Ilesa to seek permission to visit their birth houses. The pastor-in-charge asked the researcher to come a week later when all the pastors would be around for zonal meeting. This was done and the researcher was introduced to the pastors meeting. The pastor-in-charge appealed to all the pastors and FBBAs to cooperate. He allayed their fears, adding that the researcher did not intend to expose their activities. Six secondary school teachers were trained as research assistants. The training was for a day. The training included manner of approach, filling the questionnaire appropriately as well as the probable problems envisaged. They were trained to maintain confidentiality and anonymity. The field assistants were fluent in Yoruba and English.

3.6 Ethical issues

This study was basically a social research designed for academic purpose only. Respondents were duly informed of the purpose of the study and were given the liberty to participate or not to. The questionnaire was interpreted to them and they were allowed to respond or not to respond to any of the questions.

The respondents' responses were made confidential. Strict anonymity was maintained, as neither name nor place of residence was captured. Information given could

UNIVERSITY OF IBADAN

not be used to identify the respondents. Verbal permission was sought and got from Supervisory Councillors for Health in the two LGAs. At each hospital and maternal centre, permission was sought and got from the heads of the sections. Permission was also sought from OAUTH authorities. Freedom of response was given to all respondents.

3.7 Method of data analysis

The questionnaire was checked for completeness and consistency. The independent variables -age, sex, education, marital status, income, and parity were measured against perception of pregnancy complications, perception of treatment of pregnancy complications, place sought for pregnancy, adherence to caregivers instruction, number of immunization taken and husbands' roles in pregnancy care. The quantitative data were analysed using descriptive and inferential statistics to show frequency distribution, chi square and cross-tabulation. The frequency distribution and chi- square and tests were used to explain association among the variables. Frequency distributions, means, percentages and multivariate analysis were used to analyze the quantitative data, which were processed using the Statistical Package for Social Sciences (SPSS17). The research objectives were used to categorize the data according to their themes. Similarities and differences in the data were analyzed.

The qualitative data emerged from IDIs and KIIs. The qualitative data were analysed through ethnographic summaries and content analysis. The data were translated from Yoruba to English where necessary and then manually analysed. The data were analysed according to the themes and objectives of the study. Verbatim quotations were also employed. This was triangulated with the results from the quantitative data.

Content analysis and ethnographic summary were employed to analyze the data from IDIs. Direct quotations were translated verbatim and transcribed.

3.8 Limitations to the study

The research assistants made many visits to the respondents before the questionnaire could be administered. Those copies that were found not to be adequately filled were returned and re-administered. Some FBBHs were uncooperative. For instance, FBBAs from Trumpeters Church and Holy Ghost Fire Ground were not included because

UNIVERSITY OF IBADAN

they did not volunteer to be interviewed. Efforts made by the researcher to visit or administer questionnaire there were practically unfruitful. A caregiver in one of them said, 'It is a secret, do not poke into it. God does His Work.' Traditional birth attendants could not be identified because all FBBAs claimed that they were Christians and were called by God. Fund was also in short supply; hence, the research could not cover more than two LGAs.

UNIVERSITY OF IBADAN

CHAPTER FOUR

DATA PRESENTATION AND DISCUSSION

4.1 Social and demographic characteristics of the respondents

This chapter presents analysis of data and discussion of the study. The data are presented in tabular forms.

Social demography explains the pattern and structure of social problems. A total of 500 pregnant women were surveyed so as to capture their current experiences. In this section, demographic factors are analysed and discussed under the following sub headings: age, marital status, educational qualifications of the respondents and their husbands'/partners', estimated monthly income, marriage type, religious affiliation and respondents' access to utilization and place sought for delivery. This is to give a general background picture of the respondents.

4.2.1 Age of the respondents

Table 4.1 shows that the respondents' ages ranged between 13 and 49 years. The mean age of the pregnant women was 29.54. The minimum age was 13 and the highest age was 45 years. The reproductive years fall within this period. Table 4.1 also shows that 21(4.2%) of the pregnancies took place among ages less or equal to 18 years; 160 (32.0%) of the pregnancies took place within ages 19-24 years; 183 (36.6%) took place within 25-29 years; 94 (18.8%) of the pregnancies took place within ages 30 and 34 years; 31(6.2%) of the pregnancies occurred between 35-39; and only 11 (2.2%) of the pregnancies occurred at 40 and above years of age. Most deliveries took place when the women were physically mature. The data revealed that few of the pregnancies and births took place within the teen ages and above forty. Adekoya (2012) reported that only 3.9 percent and 3 percent of his respondents were below 20 and above 40 years of age,

UNIVERSITY OF IBADAN

respectively. He found that the majority of his respondents were pregnant between ages 20 and 30. *Nigeria Demographic Health Survey* (2003) states that the best years for childbirth are between ages 20 and 30 years with the children evenly spaced. Neo-natal and maternal mortality (MM) are lowest among mothers within this age bracket. Women that are either too young or too old and those that have babies too close together are at high risk of death and pregnancy complications. Adolescent pregnancies have been associated with pregnancy complications (NDHS, 2003; Tinker and Ransom, 2002). Women with high parity are also at high risk of MM. Women above 35 years with more than four pregnancies are at an even higher risk of MM and morbidity and so they should be sensitized not to have children after 35 and not more than four children (Tinker and Ransom, 2002). Besides, many women have reached menopause and can no longer have children as from 40 years.

Table 4.1 Percentage Distribution of Age of the Respondents

Age Group (in years)	Numbers of Respondents	Percentage
≤18	21	4.2
19-24	160	32.0
25-29	183	36.6
30-34	94	18.8
35-39	31	6.2
≥ 40	11	2.2
Total	**500**	**100**

Respondents' mean age=29.54

Source: Fieldwork, (2009)

4.2.2 Marital status

UNIVERSITY OF IBADAN

Table 4.2 showed that most of the respondents −373 (74.6%) −were married; 65 (13.0%) were single; 51(10.2%) were co-habiting; 7(1.4%) were divorced; 3(0.6%) were separated; and only 1(0.2%) was widowed. The result showed that 51 (10.2%) of the pregnant women were cohabiting. High level of unemployed graduates and mature adults could be responsible for this. Those divorced and separated accounted for 4 (0.8 %) of the respondents.

Table 4.2 Percentage Distribution of the Respondents' Marital Status

Marital Status	Number of Respondents	Percentages
Single	65	13.0
Married	373	74.6
Cohabiting	51	10.2
Divorced	7	1.4
Separated	3	0.6
Widow	1	0.2
Total	**500**	**100**

Source: Fieldwork, (2009)

4.2.3 Educational qualifications of the respondents and their husbands/partners

Education has been found to play special roles in the utilization of health care services and has led to upward mobility of people. It is a major determinant of a people's socio-economic status. Education affects a people's perspective and determines whether or not a group of people will utilize hospital care services. The level of literacy of the couple should influence the wife to utilize hospital care. Studies have found that women's education is positively related to their awareness and utilization of hospital care. Education has been found to modify a people's belief system and make them receptive to modern health care services. Jegede (2010), in his study in Bomadi and Ika, found that

UNIVERSITY OF IBADAN

there is a significant relationship between mother's education and the use of immunisation.

Table 4.3 reveals that among the respondents, 30 (6.0%) had no schooling: 46 (9.2%) had primary education: 80 (16.2%) did not complete secondary education; 189 (37.8%) completed secondary education; while 153 (30.6%) had tertiary education. The table further reveals that 13 (2.6%) husbands of the respondents had no formal education; 35 (7.0%) had primary education; 59 (11.8%) did not complete secondary education; 204 (40.8%) completed secondary education; while 189 (37.8%) had tertiary education.

Since 1954 when Action Group of Nigeria launched its free primary education in south-western Nigeria, various governments in the geo-political zone have placed a lot of emphasis on acquisition of basic primary education. This may be responsible for the large number of literates in the state. Over 97% of the respondents had acquired one type of education or the other. Only 2.6% had no schooling. When men's education was compared with the women, the result revealed that 13 (2.6%) of the men and 30 (6.0%) of the women received no schooling; 7.0% of the men and 9.2% of the women had primary education, 11.8% of the men and 16.4% of the women did not complete secondary education; 40.8% of the men and 37.8% of the women completed secondary education; while 37.8% of the men and 30.6% of the women had tertiary education. The overall result on education revealed that more men than women had formal education.

It has been established in the literature that more men have tertiary education than women. Therefore, women are at a disadvantaged position when health decisions have to be made. Olubayo-Fatiregun (2009), citing Sen (1988), claims that, in many societies, women have less educational opportunities than men and receive unequal access to resources, such as food and income, all of which are strong predictors of health status. A study carried out in Kammu and Kashir, India revealed lower female literacy (43%) than men (67%). Even among literate women, the study revealed that women depended on their husbands for decision-making. The study further confirmed that, even in settings where women have acquired formal education, power relation in the household as well as social norms often prevent them from taking health and major decisions.

UNIVERSITY OF IBADAN

These inequalities have major impact on their health. Girls face disproportionate deprivation, lack of opportunities, and low level of investment in their health, nutrition, and education. Women receive unequal distribution of land and access to resources, like food and health care. The inequalities harm girls and women's health directly or indirectly throughout the cycles of their lives. The neglect of their health needs prevents many women from taking part in society fully. Bammeke (2001), quoted in Adebowale (2009), asserts that females are withdrawn from school into marriages or they are allowed access to education considered relevant for a good wife. Lauer and Lauer (2002) also quoted by Adebowale (2009) posit that the traditional roles assigned to women inhibit their commitment to higher education, which diminishes their prospects in formal labour participation. These restrictions are seen in early marriages and over-dependence on men, which weigh women down and constitute serious hindrances to improving their lots in life. These practices influence parents to think lowly of, and under- invest in females' education, regarding it as economic waste (Adebowale, 2009).

The occupational status of group of people reflects their social status as well as their ability to take certain financial and health decisions. A husband's occupation may determine his decision-making power and ability to provide for the needs of his pregnant wife and the incoming baby. The table reveals that 106 (21.2%) of the husband were civil servants, 9 (1.8%) were farmers; 14 (2.8%) were small scale traders; 317 (63.4%) were self-employed; 27 (5.4%) were unemployed; 20 (4.0%) were students; while 7 (1.4%) were clergy. About 80% of the respondents' husbands worked in the informal sector of the economy. Since the introduction of Structural Adjustment Programme, it has become glaring that the formal sector of the economy cannot absorb the majority of the working class.

UNIVERSITY OF IBADAN

Table 4.3: Percentage Distribution of Respondents' and Partner'/Husbands' Qualifications and Occupations

Educational Qualification	Number of Respondents	Percentages
Respondent's Educational Qual.		
No schooling	30	6.0
Primary	46	9.2
Secondary (Uncompleted)	82	16.2
Secondary (Completed)	189	37.8
Tertiary	153	30.6
Total	**500**	**100**
Husband's Educational Qual.		
No schooling	13	2.6
Primary	35	7.0
Secondary (Uncompleted)	59	11.8
Secondary (Completed)	204	40.8
Tertiary	189	37.8
Total	**500**	**100**
Husband's Occupation		
Civil Servants	106	21.2
Farming	9	1.8
Small Trading	14	2.8
Self-employed	317	63.4
Unemployed	27	5.4
Students	20	4.0
Clergy	7	1.4
Total	**500**	**100**

Source: Fieldwork, (2009)

UNIVERSITY OF IBADAN

4.2.4 Income of the respondents

Table 4.4 shows the estimated income of the pregnant women: 379 (75.8%) earned less or equal to 10,000 naira a month; 61 (12.2%) earned between 10,001- 20,000 naira a month; 25 (5.0%) earned between 20,001 and 30,000 naira a month; 19 (3.8%) earned between 30,001- 40,000 naira a month; 7 (1.4%) earned 40,001- 50,000; naira a month and only 9 (0.8%) earned 50,001 naira and above in a month. Thus most of the respondents were in the low income group. Although literate, they may not be able to access orthodox medicine because of user's fees. Therefore, there is need to upgrade women and make them have the financial impact of tertiary education. If women went to school but could not enjoy financial benefit of education, they might be discouraged to increase their knowledge. Economic empowerment of women in the community will result in empowering the women and ensuring their greater social standing.

Table 4.4 Percentage Distribution of the Respondents' Monthly Income

Estimated Monthly Income	Number of Respondents	Percentages
≤ ₦10, 000	379	75.8
10,001 - 20,000	61	12.2
20,001 - 30,000	25	5.0
30,001 - 40,000	19	3.8
40,001 - 50,000	7	1.4
Above 50,001	9	1.8
Total	**500**	**100**

Source: Fieldwork, (2009)

UNIVERSITY OF IBADAN

Poverty was so rampant among the women that seven FBBAs and the owner of a private maternity centre reported cases of pregnant women they had to give pants, clothes, food and even taxi fare to take them home. One said:

> Some husbands absconded on the day of their wives' delivery because of poverty. We pray for such husbands because we know that some of them want to be responsible but are very poor. (IDI Female Faith Care Provider, Ilesa West, October 2009).

One of the male Church founders/FBBAs buttressed this point when he cited a particular case in his church. The woman came to deliver with nothing, not even food. He took her delivery and fed her for three days. For her not to continue to be a burden, he took her to her house on the fourth day because she had no money for transport. She eventually became a member of the religious group and participated in their children's thanksgiving. The literature reveals that, among the traditional care providers, payment can be delayed to a later date.

Some FBBAs reported that procrastination and stinginess were some of the economic problems they encountered during processes of taking deliveries. On the day of delivery, FBBAs reported that some stingy husbands ran helter-skelter to buy the things they ought to have bought earlier and because it was an emergency, their power of bargain dropped and so they bought at expensive prices. Pregnant women and their partners kept postponing the day when they would buy delivery materials until the babies came.

To alleviate some of these economic hardships on pregnant women, the state and local governments provided free maternal care for pregnant women. Government also provides maternity kits (mama kit) that contained minimum materials women needed for delivery. This cost one thousand and two hundred naira only. Women are allowed to pay on instalment basis, starting from the first day of ANC. The midwives/community nurses opened registers of payments. When a woman completed the payment, the kit was given. But while the visits for this study lasted, most of the women kept postponing when they would buy. In addition to *mama kit*, all delivery centres had a list of other materials

UNIVERSITY OF IBADAN

which pregnant women were expected to buy. This list was given on the first day of attendance at ANC or prayer meeting but many partners were not financially able to afford them. Therefore, on the day of delivery, many women went to FBBAs empty-handed; in fact, even little as sanitary towels and babies' clothes had to be supplied by the church/FBBAs.

A private midwife recalled her experience with a pregnant woman whose pastor told her to come for special prayers, after telling her a vision of an impending danger. She was in the special prayer when labour set in. She ran to this midwife only for the caregiver to discover that the baby was breech with buttocks presentation. It was an emergency and she had nothing to deliver with. The baby was delivered eventually, but there were no clothes for the baby and the mother. The caregiver reported that she gave her clothes to the woman and her grandchild's clothes to the baby. When the husband came, he could not pay for any material. They already had many children whom they could not cater for. The caregiver advised them to go for family planning but they did not. The woman was pregnant again and died in the process of delivery. The baby survived, but the husband did not show up to take custody of the child, claiming that he had no one to help him take care of it.

Some maternity centres also reported cases where they had to use nylon bags as gloves to take delivery while they wrapped the babies with the mothers' headgears. Sometimes, they sent to the woman's house to get the clothes of the babies' siblings to cover them. Community nurses reported a case where the neighbours had to contribute money to buy clothes and other essential items for delivery.

4.2.5 Marriage type

There are two major types of marriages in traditional Africa societies: monogamy and Polygyny. In monogamy a man marries one wife, while, and in Polygyny a man marries more than one wife simultaneously. Table 4.5 reveals that monogamy was the prevalent type of marriage, among the respondents as 452 (90.4%) were in this type of marriage. Only 48 (9.6%) were in Polygyny. This may be due to the prevalence of Christianity in the community that encourages one man one wife. Although the 2003

UNIVERSITY OF IBADAN

NDHS reported that 36.0% of Nigerian women are in polygynous forms of marriage, adherence of the respondents to Christianity influenced their marriage pattern. It could also be as a result of general economic trend that makes Polygyny unrealistic, as men are finding it difficult to cope with more than one wife. Further, men previously married more than one wife so as to provide needed help on the farms. However, Polygyny is no more fashionable, as many men are no more farming and women are no more contented with following their husbands to farm.

Cohesiveness and strength of the extended kin group is waning such that the nuclear family is becoming dominant in decision-making. Ilesa women are predominantly traders and are not dependent on their husbands' economy. They are usually in full control of their finances. Jegede (2010) avers that Yoruba women distinguish their economic activities and products from those of their husbands. Orubuloye et al. (1991), quoted by Jegede (2010), reported that Yoruba women earn money from both farming and trading. They have access to land through their husbands and right to some produce. Sudarkasa's study in Awe, quoted by Orubuloye et al. (1990) and Jegede (2010), observes that a woman's income can be as high as that of her husband.

Table 4.5: Percentage Distribution of Respondents by Type of Marriage

Marriage Type	**Number of Respondents**	**Percentage**
Monogamy	452	90.4
Polygyny	48	9.6
Total	**500**	**100**

Source: Fieldwork, (2009)

4.2.6 Religious affiliation

The religion of a group of people influences their demographic behaviour and beliefs. It affects how an individual will act in a social setting and may decide whether

UNIVERSITY OF IBADAN

an individual will access health care services with one caregiver or the other. Table 4.6 indicates that 433 (86.6%) of the respondents were Christians 54 (10.8%) were Muslims, only 13 (2.6%) were in traditional religion. This explains why the researcher could not identify traditional birth houses. Among the Christians, 88 (20.3 %) were Protestants; while 299 (69.1%) were Pentecostals. Pentecostal for this study included all Aladura Churches and those that believe in speaking in tongues and white garment churches.

Table 4.6: Religious Affiliation of Respondents

Religious Affiliation	Number of Respondents	Percentage
Christianity	433	86.6
Islam	54	10.8
Traditional Religion	13	2.6
Total	**500**	**100**
Denominations		
Catholic	38	8.8
Protestant	88	20.3
Pentecostal	299	69.1
Jehovah's Witnesses	8	1.8
Total	**433**	**100**

Source: Fieldwork, (2009)

UNIVERSITY OF IBADAN

4.2.7 Percentage distribution of demographic characteristics of qualitative respondents

Table4.7. reveals the ages and marital status of the respondents. Among the FBBAs, 3 (25%) were 50-54; 55-59; and 60 years and above. None of the FBBAs was less than 50 years old. All the FBBAs had given births and had stopped childbearing and probably their children were already grown and could take care of themselves. This gives ample opportunities to these FBBAs to be easily available and accessible as they had a lot of time to themselves to take care of pregnant women. Conversely, orthodox caregivers were still within the childbearing ages and probably having children to take care of and were saddled with work and home responsibilities. FBBAs are usually elderly women. The literature reveals that TBAs are usually females that are elderly who acquired their skills generally by delivering babies themselves or by working with other TBAs (Eades, Brace, Osei and Laguardia, 1993).

The table further reveals that among orthodox caregivers, 3 (25%) were within 35-39; 40-44, 49-54 years; 1(8.3%) was within 55-59 years and 2 (16.7%) were in ages 60 years and above. Those within ages 39-49 were in government maternity centres or hospitals while the rest were retired nurses who started their own clinics after retirement. From personal observation, in these clinics, the last two were mostly patronized among orthodox caregivers. This could be as a result of their years of experience in the civil service and private practice. Pregnant women may have developed confidence in them due to years of experience. Thirty percent (3) of the husbands were 35-39 years old. These were fathers having their first and second pregnancies. Another 3 (30%) were aged 40-44 and 45-49 years and were fathers of third and fourth pregnancies. Only 1 (10%) was aged 50-54 years. This was a grand-multigravidal. Most of the men had stopped having children by this age bracket. The researcher tried to interview fathers in different age brackets to elicit husbands' contributions to pregnancy care in different gravidals.

All that participated in the IDIs and KIIs were married. This was because the majority of those that were interviewed were already above 35 years and many people struggle to marry on or before this age.

UNIVERSITY OF IBADAN

Table4.7. Percentage Distribution of Demographic Ages and Sex of Qualitative Respondents

Age		FBBAs	Orthodox caregivers	Husbands
35-39		-	-	3 (30%)
40-44		-	-	3 (30%)
45-49		-	3 (25%)	3 (30%)
50-54		3 (25%)	3 (25%)	1 (10%)
55-60		3 (25%)	3 (25%)	-
60-64		3 (25%)	1 (8.3%)	-
65+		3 (25%)	2 (16.7%)	-
Sex	**Male**	2 (16.7	-	10 (100%)
	Female	10 (83.3%)	12 (100%)	-
Marital Status		12 (100%)	12 (100%)	10 (100%)

Source: Fieldwork, (2009)

4.2.8 Percentage distribution of religion and educational qualifications of the respondents

Table 4.8 shows that all FBBAs reported that they were Christians; this was because the FBBHs were established by Christians and caregivers are supposed to be members of the establishing Churches that run them. Apart from that, the founders were Christians. A total of 12 (100%) of the orthodox caregivers were also Christians. The researcher interviewed heads of the maternities, clinics and hospitals. All the people she met were Christians. This could also reflect the predominance of Christianity in the study area.

Among the FBBAs, 4 (33.3%) had no schooling though they could read the Bible in Yoruba. Probably, they learnt it from the adult literacy classes of their churches. This is essential for them to be able to read Psalms of the Bible during their prayer sessions, vigils and on delivery materials; 6 (50%) of the FBBAs had primary level of education. One male FBBA stopped his education at JSS3, while the other male completed secondary level of education. All orthodox caregivers had tertiary education. They needed a minimum of Community Nurse Certificate to be able to qualify to work in hospitals, clinics or maternity centres. Two (20%) of the husbands had primary

UNIVERSITY OF IBADAN

education; another 2 (20%) attempted secondary education; and 2 (20%) completed secondary level education. The rest 4 (40%) had tertiary education. Among the husbands, 9 (90%) were Christians, while 1(10%) was a Muslim.

Table4.8. Percentage Distribution of Demographic Religion and Educational Qualification of Qualitative Respondents

Religion & Educ. Qualification		FBBAs	Orthodox Caregivers	Husbands
Religion	Christian	12 (100%)	12 (100%)	9 (90%)
	Islam	-	-	1 (10%)
	ATR	-	-	-
Educ. Qualification	No Schooling	4	-	-
	Primary	6	-	2 (20%)
	Sec. ncompleted	1	-	2 (20%)
	Sec. Completed	1	-	2 (20%)
	Tertiary	-	12 (100%)	4 (40%)

Source: Fieldwork, (2009)

4.3. Perceptions of pregnant women on aetiology of pregnancy-related complications

The first objective of this study was to find pregnant women's perception of aetiology of pregnancy-related problems. This was achieved by looking at the following items.

i) Perceived causes of pregnancy complications
ii) Perceived signs and symptoms of pregnancy complications
iii) Perceived means to avoid pregnancy complications
iv) Perceived treatment for pregnancy complications

4.3.1a: Pregnant women's perception of aetiology of pregnancy complications

The respondents were given a list of supposed causes of pregnancy complications and were required to select which of them they knew. Table4. 9 captures what they regarded as causing complications; 208 (41.6%) of the respondents attributed pregnancy

UNIVERSITY OF IBADAN

complications to witches and wizards; while 194 (38.8%) attributed them to infections. Infection is any kind of disease that can spread from one person to another and is capable of hampering the development and save delivery of the baby. Two hundred and seventeen (43.4%) of them attributed complications to adultery on the part of the woman, while 219 (43.8%) attributed them to woman's physique. The physique of the pregnant woman has to do with whether she is tall or short, whether she has well-developed pelvic that can accommodate the head of the baby at delivery or not.

Table 4.9: Perceptions of the Respondents on Aetiology of Pregnancy Complications

Cause of Complications	Yes	No	S.D
Witches and Wizards	208 (41.6%)	292 (58.4%)	0.46
Infection	194 (38.8%)	306 (61.2%)	0.48
Adultery	217 (43.4%)	283 (56.6%)	0.49
Woman's physique	219 (43.8%)	281 (56.2%)	0.50

Source: Fieldwork, (2009).

The study revealed inadequate knowledge of causes of pregnancy complications. Pregnant women who are not aware of causes of complications cannot work at preventing them. However, most of those with tertiary level of education attributed pregnancy complications to infection and physique of the woman rather than witches and wizards (primary 8 (44.1%); secondary 51 (66.2%); tertiary education (73.5%). Oke (1982) observes that Africans perceived diseases as natural, supernatural, and mystical. Jegede (2010) adds a fourth category, hereditary diseases. Although the classification can be overlapping, there is the belief that a disease that starts as natural may suddenly reflect supernatural symptoms; depending on the characteristic features of such disease.

Jegede's (2010) respondents in Ika and Bomadi also revealed that evil spirits were perceived as the causes of diseases. One of them stated that 'witches are the causes of diseases and if you go to the hospital you have gone there to kill your child.'

UNIVERSITY OF IBADAN

However, an FBBA reported that:

> Witches and wizards do not go about eating people but some pregnant women that were attacked had misused their tongues to insult some wicked people who waited for them till the day of their deliveries and ensured that they had complications' (IDI, Female, Faith Home, Ilesa West, Sept. 2009).

This FBBA asserted that when there were evidences of evil people at work, she told the pregnant women involved to apologize to those they offended. If the woman could not remember again, she told them to confess to God and ask God to intervene in their delivery.

Both the quantitative method and IDIs revealed that the respondents perceived extra-marital affair as a source of complication. When a woman gets involved and gets pregnant, it is believed she may have complications at delivery. Her husband would be called in and the woman would have to confess her unfaithfulness before she could have safe delivery.

To buttress the perception of adultery as a source of complication, an FBBA noted that a woman was brought by her husband and was having difficulty in labour. He claimed that he travelled and had no sexual relationship with his wife before December and the delivery was in June; he could not have fathered the child. While the woman was in labour, the husband and his mother came and said if the woman ever had safe delivery, the baby was not going to survive because the baby was not theirs. Eventually, the woman had a stillbirth and as the FBBA was trying to resuscitate the baby, the husband said:

> Don't worry or labour in vain. This baby will not survive. After delivery, this woman should relocate to her parents as I would not father a bastard child and I will not marry her again (IDI, Female, Faith Home, Ilesa West, Sept. 2009).

The husband and the mother-in-law refused to pay for delivery or give the woman food. The FBBA had to feed and clothe the woman and later paid for her transportation to her parents' house. Orji *et al.* (2001) assert that labour complications are blamed on labouring mothers, accusing them of being unfaithful to their husbands.

UNIVERSITY OF IBADAN

The number of pregnancies an individual has should affect her perception of pregnancy complications. Table 4.10 reveals that 94 (46.3%) of the *primigravidals* perceived that the physique of a woman can cause pregnancy complications, while 109 (53.7%) did not. Among the *multigravidals*, 119 (42.3%) believed that the physique of a woman can cause pregnancy complications, while 162 (57.7%) did not; 6 (37.5%) of the grand *multigravidals* perceived the physique of women as source of pregnancy complications, while 10 (62.5%) did not. The table further showed that there was no significant relationship between the respondents' parity and perception of the physique of a woman as a cause of pregnancy complication ($\chi^2 = 1.680$; df = 4; P > 0.05).

This study revealed inadequate knowledge of causes of pregnancy complications among all categories of pregnant women. In-depth interviews (IDIs) with hospital caregivers revealed that women with heights and weights below 1.5m and 40 kilogrammes respectively are perceived as high-risk women and as being predisposed to pregnancy complications. Nurses and community nurses claimed that they always referred them to the Teaching Hospital early. No FBBA mentioned these as indicators of complication. They need to be aware of this so that they can refer these categories of women early. When women with this nature are not aware, they may resort to being delivered at home or in faith homes.

UNIVERSITY OF IBADAN

Table4. 10: Influence of Number of Pregnancies and Perception of Woman's Physique as a Cause of Complication

Number of pregnancies	Perception of Body Size as Cause of Complication		Total
	Yes	No	
Primigravidals	94 (46.3%)	109 (53.7%)	**203 (100.0%)**
Multigravidals	119 (42.3%)	162 (57.7%)	**281 (100.0%)**
Grand Multigravidals	6 (37.5%)	10 (62.5%)	**16 (100.0%)**
Total	**219 (43.8%)**	**281 (56.2%)**	**500 (100.0%)**
$X^2_{critical = 9.49}$ X2cal =1.680 df 4 P 0.794			

Source: Fieldwork, (2009)

Table 4.11 shows that 84 (41.4%) primigravidals perceived infection as a cause of pregnancy complications, while 119 (58.6%) did not; 103 (36.7%) multigravidal perceived infection as cause of pregnancy complications, while 179 (63.3%) did not; and 7 (43.8%) grand multigravidal perceived infection as a cause of pregnancy complications, while 9 (56.3%) did not. There was no significant relationship between the respondents' number of children and perception of infection as cause of pregnancy complications (χ^2 = 1.838; df = 4; P > 0.5). When women have infections, they may not go for treatment; this is because they are ignorant. Besides, many sexually transmitted infections in women present no symptom and only laboratory tests reveal their presence. A woman may be infected and yet be unaware.

UNIVERSITY OF IBADAN

Table4. 11: Influence of Number of Pregnancy and Perception of Infection as a Cause of Complications

No. of Pregnancies	**Perception of Infection as cause of Complications**		**Total**
	Yes	**No**	
Primigravidal	84 (41.4%)	119 (58.6%)	**203 (100.0%)**
Multigravidal	103 (36.7%)	179 (63.3%)	**281 (100.0%)**
Grand-multigravidals	7 (43.8%)	9 (56.3%)	**16 (100.0%)**
Total	**194 (38.8%)**	**306 (61.2%)**	**500 (100.0%)**
$X^2_{critical}$ 9.49 X^2_{cal} 1.838 df 4 P 0.765			

Source: Fieldwork, (2009)

The in-depth interviews further revealed that FBBAs taught that pregnancy complications could result from consumption of sugary food items, like Bournvita and Milo. Pregnant women were advised to avoid them. They believed that sugary food could cause big babies that could result in the '*passenger being bigger than the passage*'. As the baby consumes out of the foods the pregnant woman eats, she is advised to eat less of sugary foods so that she does not end up having a big baby. When the baby is too big for the mother's pelvic, it is born through CS and most women dread it, not only because of its cost but also because of the general belief that it is abnormal, and that women whose deliveries are taken through CS have reproductive health problems. However, one of the midwives saw no reason why pregnant women should not take these beverages. According to her, some pregnant women could not tolerate solid food in the first trimester – only beverages can sustain them. She was of the opinion that solid foods, like e*ba* and a*mala* give more calories than beverages. Conflict of which to obey may occur to a pregnant woman that attends both the orthodox and FBBA delivery centres.

UNIVERSITY OF IBADAN

Some orthodox caregivers blamed pregnancy complications on the carelessness of nurses and care providers. Nurses and midwives in public hospitals in particular have been alleged of shouting or insulting pregnant women in labour but FBBAs have not been so alleged. FBBAs have been known to be supportive and caring with or without training. One wonders why nurses that were trained would be known for shouting and putting up actions that would put off pregnant women. A nurse reported the ordeal of a pregnant woman who was about to give birth and the nurse on duty refused to take the delivery because she was about to end her morning duty. She told the pregnant woman:

> Don't push now; if you push before people in afternoon shift come, I will just leave the baby on the table for them.

Another pregnant woman recalled how she was in labour and the midwife on duty went to shop for clothes which hawkers brought to the hospital and the midwife kept shouting at the woman in labour from where she was buying clothes.

> Madam if you won push call me o, if you no call me you go just push your baby for floor your baby go just die.

Actions like these can result in the loss of the baby or the mother or both. It may discourage such pregnant women from accessing health care delivery in hospitals in subsequent pregnancies. FBBAs do not talk or act like this. Jegede (2010) observes that workers' attitude constitute a great hindrance to health-care utilization. Read (1996), quoted in Jegede (2010) states that:

> Secret of unqualified practitioners is that they had learned by experience the proper approaches to their people; their sincerity, patience, perseverance, reassuring smiles, soothing words, pleasant attitudes, genuine understanding of the simple psychology of villagers, as well as their humane consideration of the weakness of people, their prompt response in time of need, their modesty all had contributed to their acceptance in the community as celebrated practitioners.

Another source of pregnancy complication, according to a caregiver, is when caregivers abandon their duty posts. She said:

UNIVERSITY OF IBADAN

> Many maternity centres are not functioning because the health providers abscond from duties. When pregnant women are not sure of meeting somebody at a maternity centre they are not likely going to patronize the place. Absenteeism is due to lack of supervision, basing nurses' appointment on political patronages rather than qualifications and experience. Nurses who are qualified and well-trained are shortchanged for those who have political connection, some of whom feel they are untouchable, irrespective of what they do.

The researcher confirmed this statement during the fieldwork. Some maternity centres were found under lock and key for reasons of weekends and public holidays. If a woman who registered at such maternity centres falls into labour on a weekend or a public holiday where does she turn to? This fear makes pregnant women to register for care in more than one place.

One of the caregivers noted that the care-giving job should be done by only those who are hard working and compassionate. She admonished that the work should not be assigned to careless people. There should be no dereliction of duty because lives of at least two persons are on the line. She, therefore, recommended that ANC should be daily not weekly, as done in other places, to be thorough, though it would be demanding on the caregivers.

The IDIs further revealed that the respondents believed in the existence of wandering evil spirits which torment pregnant women and drive out good babies and replace them. They also believed that there could be some spiritual manipulations by witches, wizards, and familiar spirits during delivery. This is believed to occur when pregnant women refuse to comply with instructions not to walk between 1-3 a.m. and 1-3 p.m. Therefore, pregnant women were instructed to avoid walking about around 1.00 p.m. or resting under big trees around the same time so that evil children walking around or staying inside the trees would not bring complications to them or drive out the babies inside them.

All the healthcare givers believed that non-attendance at prayer meetings or ANC could be a source of complications for pregnant women. All FBBAs said pregnant women that did not attend prayer meetings but just appeared for delivery would not be

UNIVERSITY OF IBADAN

entertained because they did not like emergency deliveries and did not know the history of their pregnancies. The majority of the FBBAs turned such pregnant women away. However, when FBBAs brought women who had been in labour many hours in faith homes to the hospital in morbid condition, they become agitated and ready to crucify teaching hospital staff for delaying to attend to unbooked patients.

4.3.1b Drug abuse as a cause of pregnancy complication

Data from IDIs revealed that drug abuse was perceived to be another cause of complication. A midwife reported that

> Pregnant women who have overworked themselves instead of going to eat good meal and rest go to drug vendors who gave them two paracetamol, 2 ampiclox, 2 tetracycline, 2 or more of other drugs and 2 B. complexes (‘*asape’* or ‘*saajo’* meaning complete treatment).They throw all down their gullets and that may result in complications and bodily resistance to drug (IDI, Female, Nurse, Ilesa East, Oct. 2009).

The FBBAs perceived and instructed that pregnant women who did not respect their husbands, fought, or stole could have prolonged labour. They instructed women to avoid these. This helped to preserve peace in the families. They believed strongly that the prayers they offered every week for the women would not allow any complications.

Another perceived cause of complication is the perceived source of the pregnancy. An FBBA said:

> I don’t know the foundation and source of their pregnancies. Some of them went to trees, rivers, or mountains to beg for babies; such babies as well as the pregnancies are problematic (IDI, Female, Faith Home Ilesa East, Oct. 2009).

The IDIs further revealed that pregnancy complications can arise because of too many deliveries. A health worker reported how two women’s uteri came out with their twelfth and seventh babies, respectively. She said this was because the uteri were already elastic and overblown with frequent pregnancies and deliveries. Ilesa people, like the rest Yoruba, do not believe in counting the number of children. Pregnant women may not tell

UNIVERSITY OF IBADAN

the truth about the number of pregnancies they had carried, especially if the babies were dead. The clerking officer would have to press hard to get the women to tell the number of their dead babies, probably because they were trying to repress painful experiences and memory. When nurses suggested family planning, they always refused because their husbands would not support. The husbands believed that their wives would engage in extra-marital affairs if they used family planning devices. However, recently, some husbands are becoming enlightened and are supporting the practice of family planning.

Another cause of complication mentioned by a caregiver is mixing and oscillating between traditional healers and orthodox hospital. A midwife noted that a woman was attending ANC in a maternity centre and the nurses were aware that she was going to have a set of triplets. The community health worker who was monitoring the pregnancy was not on duty when she fell into labour. By the time she arrived, the woman had delivered the first baby; the nurse reported that she delivered the second and went to put the baby in a cot. She did not know that the husband had invited a traditional healer. When she came in to check the woman for the third baby, she met a traditional healer who laid hands on the woman and was making incantations. She said she was surprised. She told the traditional healer that the woman still had a baby to deliver. The traditional healer was sorry and said he was not aware that a baby was still inside, that the incantation he made was for the placenta, and that if any baby was inside he would be a stillbirth because the incantation he said was to call on 'the foundation of the child'. Truly the third of the triplet was delivered shortly as a stillbirth with the placenta.

4.3.1c Influence of perception of witches and wizards as a cause of complications on place sought for pregnancy care

It is believed that when women attended ANC regularly, their knowledge about pregnancy care should increase. Table 4.12 presents the places women attended for care and pregnant women's perception of witches and wizards, as causes of pregnancy complication. Seventy-seven (50.3%) of the attendees at government hospitals, 34 (34.3%), and 97 (39.1%) of the attendees at private and faith homes, respectively, perceived the activities of witches and wizards as responsible for pregnancy complications. The table shows that there was a significant relationship between the place

UNIVERSITY OF IBADAN

sought for pregnancy care and respondents' perception of witches and wizards as causes of pregnancy complication (χ^2 = 7.573; df = 2; P< 0.05). This may be why many pregnant women preferred to deliver in faith homes where they believed that the activities of witches and wizards would be checked with prayers and other rituals. This explains why they prayed on mountains, bathed in flowing rivers and utilized anointing oil to ward off evil. Jegede's (2002) respondents also perceived witches and wizards as causes of children's diseases.

Table 4.12: Influence of Perception of Witches and Wizards as Causes of Complications on Place Sought for Pregnancy Care

Place Sought for Pregnancy Care	Perception of witches and wizards as cause of pregnancy complications		Total
	Yes	No	
Government Hospital	77 (50.3%)	76 (49.7%)	**153 (100.0%)**
Private Hospital	34 (34.3%)	65 (65.7%)	**99 (100.0%)**
Faith Homes	97 (39.1%)	151 (60.9%)	**248 (100.0%)**
Total	**208 (41.6%)**	**292 (58.4%)**	**500 (100.0%)**
$\chi^2_{critical}$ 5.99 χ^2_{cal} 7.573 df 2 P 0.023			

Source: Fieldwork, (2009)

4.3.1d Influence of perception of adultery as a cause of complications on place sought for pregnancy care

Table 4.13 shows that 81 (52.9%), 36 (36.4%), and 102 (41.1%) of respondents from government and private hospitals and faith homes, respectively perceived adultery as responsible for pregnancy complications. The table also shows that there was significant relationship between the place sought for pregnancy care and respondents' perception of adultery as cause of pregnancy complication (χ^2 = 8.137; df = 2; P< 0.05).

UNIVERSITY OF IBADAN

When significant others perceive that pregnancy complications occur because of adultery, women that have complications may not receive help on time. They might want her to suffer for her perceived 'sin'. Her situation might have got out of hand when help is eventually received.

Table 4.13: Influence of Perception of Adultery as a Cause of Complications on Place Sought for Pregnancy Care

Place Sought for Pregnancy Care	Perception of Adultery as a cause of Pregnancy complication		Total
	Yes	No	
Government Hospital	81 (52.9%)	72 (47.1%)	**153 (100.0%)**
Private Hospital	36 (36.4%)	63 (63.6%)	**99 (100.0%)**
Faith Homes	102 (41.1%)	146 (58.9%)	**248 (100.0%)**
Total	**219 (43.8%)**	**281 (56.2%)**	**500 (100.0%)**
$\chi^2_{critical}$ **5.99** χ^{22}_{cal} **8.137 df 2 P 0.017**			

Source: Fieldwork, (2009)

To corroborate these findings, causes of Maternal Mortality in OAUTH, Ilesa branch was got. Table 14 indicates that haemorrhage was responsible for 6 (40%), obstructed labour was responsible for 2 (13.4%) of maternal loss, and eclampsia contributed 2 (13.3%) to maternal deaths. The result showed that haemorrhage was the major cause of maternal loss, yet, 33.6% of the respondents were not aware of haemorrhage as a cause of maternal mortality. Ante partum haemorrhage is excessive blood loss before delivery, intra partum occurs during and post partum occurs after delivery. If the haemorrhage was prolonged it can result in the woman being brought in deeply unconscious. Globally, haemorrhage accounts for 34% of maternal loss (Salama, 2008). Adebayo (2013) states that haemorrhage accounted for 25% of maternal loss in

UNIVERSITY OF IBADAN

Nigeria. He notes that, if all maternity centres were well-equipped with facilities and manpower to control excessive bleeding during labour and after childbirth, MM will reduce by one quarter worldwide. Pregnant women's inadequate knowledge of haemorrhage may cause delay in seeking help. Even when help is sought, 159 (31.8%) of the respondents would not accept blood transfusion.

Table 4.14: Distribution of Causes of Maternal Mortality Recorded at OAUTH Ilesa from 2005-2008

Causes of Death	No of deaths
Abdominal malignity	1 (6.7%)
Ante, intra and post-Partum Haemorrhage (brought in deeply unconscious)	6 (40.0%)
Eclampsia	2 (13.3%)
Obstructed Labour	2 (13.3%)
Respiratory obstructed tress	1 (6.7%)
Retained Placenta	1 (6.7%)
Ruptured uterus	2 (13.3%)
Total	**15 (100%)**

Source: OAUTH, Ilesa, Secondary Data obtained November (2009)

4.3.2 Perceived signs and symptoms of pregnancy complications

A list of symptoms of pregnancy complications was given and respondents were required to identify the ones related to pregnancy complication. Table 15 shows that two hundred and eighty-seven (42.6%) of the respondents identified breech baby; 254 (50.8%) identified convulsion; 333 (66.2%) identified excessive bleeding; 308 (61.6%) identified high fever; 330 (66.0%) identified labour of more than 12 hours; 300 (60.0%) identified swollen legs as symptoms of pregnancy complications. Globally, 11% of MM was ascribed to eclampsia (Salama, 2008).

UNIVERSITY OF IBADAN

Table4. 15. Perceived Signs and Symptoms of Pregnancy Complications

List of Pregnancy Complications	Yes	No
Breech Baby	287 (57.4%)	213 (42.6%)
Convulsion (Eclampsia)	254 (50.8%)	246 (49.2%)
Haemorrhage (excessive bleeding before or after delivery)	333 (66.2%)	169 (33.8%)
High Fever	308 (61.6%)	192 (38.4%)
Labour more than 12 hours	330 (66.0%)	170 (34%)
Swollen Legs	300 (60%)	200 (40%)

Source: Fieldwork, (2009)

4.3.2a Perception of haemorrhage as symptom of pregnancy complications

Table 4.16 reveals that only 86 (56.2%) of the attendees at government hospitals, 73 (73.7%) of those who attended private hospitals, and 173 (69.8%) of attendees at faith homes recognized haemorrhage (excessive bleeding) as a sign and symptom of complication. Studies have shown that one of the leading causes of pregnancy complication is haemorrhage. The table shows that there was a significant relationship between the place sought for pregnancy care and respondents' perception of excessive bleeding as a sign of pregnancy complications ($\chi^2 = 10.765$; df = 2; $P < 0.05$).

UNIVERSITY OF IBADAN

Table 4.16: Perception of haemorrhage as a Symptom of Complications and Place Sought for Pregnancy Care

Place Sought for Pregnancy Care	Perception of Haemorrhage as a Symptom of Complication		Total
	Yes	No	
Govt. Hospitals	86 (56.2%)	67 (43.8%)	**153 (100.0%)**
Private Hospitals	73 (73.7%)	26 (26.3%)	**99 (100.0%)**
Faith	173 (69.8%)	75 (30.2%)	**248 (100.0%)**
Total	**332 (66.4%)**	**168 (33.6%)**	**500 (100.0%)**
$X^2_{critical}$ 5.99 X^2_{cal} 10.765 df 2 P <.005			

Source: Fieldwork (2009)

4.3.2b Perception of high fever as a symptom of pregnancy complications

Table 4.17 indicates that 83 (54.2%), 67(67.7%), 161 (64.9%) of attendees at government hospitals, private hospitals, and faith clinics respectively, perceived high fever as a symptom of complications. It also shows that there was a significant relationship between the place sought for pregnancy care and respondents' perception of high fever as sign of pregnancy complications ($\chi^2 = 6.158$; df = 2; P< 0.05). High fever could be a symptom of malaria or pre-eclampsia. The result of inadequate knowledge is that women would be applying home remedies (*aajo*), self-medication, and would not seek medical help on time. The literature has shown that 11% of pregnant women die as a result of malaria. As malaria is endemic in Ilesa, women may not perceive it as serious in pregnancy situation and many of them may not seek help early and delay may be dangerous.

UNIVERSITY OF IBADAN

Table 4.17: Perception of High Fever as a Symptom of Pregnancy Complications and Place Sought for Pregnancy Care

Place sought for Pregnancy Care	High Fever as a Symptom of Pregnancy Complication		Total
	Yes	No	
Government Hospitals	83 (54.2%)	70 (45.8%)	**153 (100.0%)**
Private Hospitals	67 (67.7%)	32 (32.3%)	**99 (100.0%)**
Faith Homes	161 (64.9%)	87 (35.1%)	**248 (100.0%)**
Total	**311 (62.2%)**	**189 (37.8%)**	**500 (100.0%)**
$X^2_{critical}$ 5.99 X^2_{cal} 6.158 df 2 P 0.046			

Source: Fieldwork, (2009)

4.3.2c Perception of labour of more than 12 hours as a symptom of pregnancy complications

It is expected that the number of pregnancies and the place pregnant women patronize for care should enhance their knowledge and perception of pregnancy complications. However, Table 4.18 shows that only 91(59.5%) of those who attended government hospitals perceived labour of more than 12 hours as a symptom of pregnancy complications; 73.7% of those that attended private hospitals perceived labour of more than 12 hours as a symptom; while 172 (69.4%) of those who attended faith homes perceived labour of more than 12 hours as a symptom of complication. The table reveals that there was a significant relationship between the respondents' perception of labour of more than 12 hours and the place where they sought for pregnancy care ($\chi^2 = 6.582$; df = 2; $P < 0.05$). This explains why some pregnant women would labour for 3 or 4 days in mission houses without trying to seek help. A gynaecologist reported that those who were transferred to the hospital and were advised to go for Caesarean Section (CS) would not give informed consent saying:

UNIVERSITY OF IBADAN

I believe God that I would deliver safely. I will not die. (IDI Female, OAUTH, March 2010).

Table4. 18: Perception of labour of more than 12 hours as a symptom of complication and places sought for pregnancy care

Place Sought for Pregnancy Care	Perception of long Labour as Cause		Total
	Yes	No	
Government Hospital	91 (59.5%)	62 (40.5%)	**153 (100.0%)**
Private Hospital	73 (73.7%)	26 (26.3%)	**99 (100.0%)**
Faith Homes	172 (69.4%)	76 (30.6%)	**248 (100.0%)**
Total	**336 (67.2%)**	**164 (32.8%)**	**500 (100.0%)**
$X^2_{critical}$ 5.99 X^2_{cal} 6.582 df 2 P .037			

Source: Fieldwork, (2009)

4.3.2d Perception of swollen legs as a symptom of pregnancy complications

Table 4.19 reveals that only 78 (51%), 66 (66.7%) and 152 (62.9%) of the attendees at government hospital, private hospitals, and faith homes respectively, perceived swollen legs as symptom of pregnancy complication. It also shows that there was significant relationship between the place sought for pregnancy care and respondents' perception of swollen legs as sign of pregnancy complications (χ^2 =7.891; df=2; P< 0.05).

UNIVERSITY OF IBADAN

Table 4.19: Perception of swollen legs as pregnancy complications

Place sought for Pregnancy Care	Perception of Swollen Legs As A Cause of Pregnancy Complications		Total
	Yes	No	
Government Hospital	78 (51.0%)	75 (49.0%)	**153 (100.0%)**
Private Hospital	66 (66.7%)	33 (33.3%)	**99 (100.0%)**
Faith Homes	156 (62.9%)	92 (37.1%)	**248 (100.0%)**
Total	**300 (60.0%)**	**200 (40.0%)**	**500 (100.0%)**
$X^2_{critical}$ 5.99 X^2_{cal} 7.891 df 2 P 0.019			

Source: Fieldwork, (2009)

When any part of a pregnant woman's body is swollen, in Ilesa it is believed that she carries multiple pregnancies. In pre colonial era, the birth of twins or triplets was regarded as a curse on families. Many people now cherish and highly esteem multiple births. They may be lost in the euphoria of expecting multiple births while danger looms in the corner. This may also cause delay in seeking help. The husbands, FBBAs, and significant others may be unaware of danger. Both high fever and swollen legs are signs of pre-eclampsia. The only FBBA that reported that she had MM claimed the woman had familiar spirit but in actual fact she had pre-eclampsia that finally degenerated to eclampsia.

Lack of or inadequate knowledge of convulsion as sign of complication would cause women and their husbands to seek help late. But as past researches have shown, all pregnancy problems are preventable and easily cured if identified and managed early (Ransome-Kuti, 1990). This would be possible if pregnant women attend ANC regularly and have freedom to discuss their problems with caregivers.

UNIVERSITY OF IBADAN

4.3.3 Perceived means to avoid pregnancy complications

It was widely believed that complications were the handiwork of malevolent spirits. In all the religious houses, prayer was perceived as means to avoid complications. In their weekly prayers, they prayed against wicked people who might be angry with or without cause. The prayers were said against

> Wicked people who will cause your family members to run helter-skelter on the day of delivery, who will not allow you or/and your child to survive (Female, Faith Care Provider, Ilesa East, Sept. 2009*).*

A lot of time was spent in praying against complications on the day of delivery.

Frivolity was perceived as a cause of complication and so secrecy was encouraged. A private nurse and FBBAs warned pregnant women not to display their babies' materials for others to see. They were instructed to buy the materials and keep. When they wanted to eat balanced diet, they must not make a display of it for others to see as people looking for children or those that could not afford to eat good food could be annoyed and harm them or their babies.

FBBAs further instructed pregnant women not to advertise their pregnancies by showing their tummies and complaining to people how they feel. They should not allow people to touch their pregnancies so as to prevent wicked people from having access to them and their babies. Pregnant women were instructed to be careful in the use of their tongues so that the evil ones would not catch them in their words. They were not to talk when they were not invited and should speak few words when they are invited to talk.

Respondents were further instructed that when they have headache, diarrhoea and vomiting, they should report in clinic/maternity centres immediately to avoid premature contractions. Whenever there were complications, FBBAs referred patients to a private hospital because the Teaching Hospital was often on strike. During the major part of collecting this data, the Teaching Hospital was on strike. If the doctors were on strike, the nurses would be on duty; when the doctors resumed, the nurses would go on strike; and the other paramedical staff would join at a later date.

UNIVERSITY OF IBADAN

4.3.4a Perceived treatment for haemorrhage

Respondents were asked if they would agree to blood transfusion if they were anaemic. This question was used to measure response to pregnancy complication and treatment choice. Table 4.20 captured the perceived treatment of anaemia: 341 (68.2%) of the respondents claimed that they would agree to blood transfusion, while 159 (31.8%) said they would not agree to blood transfusion if there was anaemia. This observation was statistically significant $\chi^2 = 84.534$, df = 1, N= 500, P< 0.05. If these women have reasons to be transfused, there may be problem of informed consent. One of the husbands during the interview vehemently disagreed that a woman should take another person's blood. Such husbands would not allow blood transfusion even if their wives had anaemia. The fear of contracting HIV/AIDS through infected blood causes women and their husbands to avoid blood transfusion like a plague. The solution is that pregnant women should ensure that they eat well and attend ANC on time to detect anaemia early.

The result revealed that at least two-thirds of the respondents would receive blood transfusion but the one-third that would refuse is high enough to be a source of concern and could result in high mortality rate. If these women have any reason to be transfused there may be a problem of informed consent.

Table 4.20: Percentage Distribution of Respondents' Perception for Treatment of Haemorrhage

Perceived Treatment of Anaemia	**Yes**	**%**	**No**	**%**
Would you accept blood transfusion if anaemic?	341	68.2	159	31.8

Source: Fieldwork, (2009)

UNIVERSITY OF IBADAN

As hospitals have their modes of treating complications so do religious houses.

From a Key informant interview conducted with a FBBA, he asserted that there were some complicated deliveries that needed various leaves for boiling or squeezing to make concoction. He said that when a pregnant woman was tired at the point of delivery and could push no further, he would add certain leaves with pap and give to the woman; the woman would have power to deliver.

One of the FBBAs averred that he treated haemorrhage with concoction:

"heaven delivers such women when I prepare concoction with pap".

According to this FBBA, the haemorrhage would stop. This FBBA claimed he never allowed pregnant women under his care to subscribe to blood transfusion. He emphasized that he had never sent anybody to Western medical facility for delivery because of complications. When he noticed that a pregnant woman was pale and might not have sufficient blood to undergo delivery, he usually prepared concoction made of leaves and stalk of guinea corn, coconut, lemon grass, and coconut shield which he boiled together and gave to the woman to drink. He claimed that the woman must have enough blood after taking the concoction.

4.3.4b Treatment of placental previa and breech presentation

An FBBA asserted that he had successfully treated eight cases of placenta previa or retained placenta. He said he usually cut a particular leaf to which he added salt and squeezed the juice for pregnant women to drink. He was confident that the placenta would come out. Jegede (2010) states that therapeutic management involves both herbal remedies and therapeutic rituals, like incantations, prayers, and sacrifices to appease the supernatural forces.

Some FBBAs claimed that they did manual removal for placenta previa and used hot water mopping to resuscitate stillbirths. These women reported that God taught them what to do on each occasion with different women.

The FBBAs believed that breech presentation is essentially the work of witches, wizards, and the devil. One of the FBBAs reported that whenever a woman went for

UNIVERSITY OF IBADAN

ultrasound and it was reported that her baby had assumed a breech position, he gave some leaves and concoction; and the position of the baby would change. He backed up his claim with the case of a breech presentation at a private hospital in Ilesa which he treated. The woman was to be operated upon, but the husband had no money. The doctor felt that the life of the woman was in serious danger and advised against self-discharge, but he pleaded with the doctor to allow him to take the woman. The doctor eventually agreed after they had signed discharged against medical advice (DAMA) papers. He said that he gave her some concoction and the woman had safe delivery. He claimed that afterwards the doctor gave him gifts and even offered that they be in partnership.

Belief system is an integral part of man and spiritual issues are difficult to explain scientifically. Care providers cannot just jettison this aspect if the lives of pregnant women would be saved. Life itself is a mystery. Interestingly, the very word mystery means the divine secret. It is from the Greek word *mustes,* which literally means close mouth; hence, as noun, an initiate into a mystery. The word means 'I shut my mouth and close my eyes'.

In one religious house, when complications arose, there were special works (*aseje)* concoctions to be made for the woman so that her ways might be through. An FBBA claimed that such complicated cases were always undertaken with no record of casualty after the special concoction had been administered. If the complications were the work of the enemy, the FBBA claimed that she would give the pregnant woman 'special water' which the founder had prayed upon and the woman would have safe delivery.

> If the complication was because the baby was too big for the passage, we refer the pregnant woman to hospital for CS (IDI, Female, Faith Home, Ilesa West, Sept. 2009).

The Founder of this religious house claimed that she had been taking delivery for the past fifty- six years and her spirit told her which delivery was natural and which had the hand of the enemy.

> Common pregnancy complications like haemorrhage and breech babies were usually sent to the hospitals but we make serious prayers for them. We believe that some mothers and mothers-in-law are witches who do not want their daughters and daughters-in-law to become pregnant. If

UNIVERSITY OF IBADAN

> they could not stop them from being married and becoming pregnant, they wait for them on the days of deliveries. Such women we encourage to be prayerful and not to have bitterness. They should take care of such mothers and mothers-in-law. (IDI, Female, Faith Home, Ilesa East, Sept. 2009).

Two male FBBAs and one female FBBA claimed that private hospitals always called them for assistance in complicated deliveries. One of them recalled two incidents where he was invited to the hospital to pray for two women who had complications. He said he gave them two tablespoonfuls of anointing oil and they were delivered safely. Both male FBBAs claimed they had never had any complication which they had to refer to hospitals; rather, hospitals referred complicated cases to them. This could be an exaggeration of their performances. No medical practitioners ever reported that they referred cases to FBBAs.

Whenever there were complications, an FBBA gave pregnant women native sponge and soap upon which he had prayed and read psalms. According to him, when they bathed with them, they would be relieved and have safe delivery. Usually no delivery charge was given but at the children harvest thanksgiving ceremonies all children delivered must come and invite people who would donate money and items to the religious house.

When labour prolonged, many FBBAs reported that they depended on God for direction as to what to do with each case.

> I have nothing other than the Name of Jesus. I pray in His Name and He is doing His work and only He can help me. I happily refer those who can give me trouble and pray God will send them away (Female, Faith Care Provider, Ilesa West, Sept. 2009).

This is in line with the findings of Orji *et al*. (2001). Prayers are often offered when complication ensues instead of transferring women early to hospital. The influence of religious beliefs was evident in the treatment of pregnancy complications as well as access to ANC at the point of delivery.

UNIVERSITY OF IBADAN

When pregnant women attend ANC, nurses encouraged them to patronize hospitals for delivery, but the nurses interviewed noted that the women usually preferred mission houses because of prayers. A nurse had this to say:

> but we pray for them here also throughout delivery and God answers prayers everywhere, evening, morning, house, mountain-top or valley, whether night or day (Female, State Hospital, Oct. 2009).

One of the FBBAs claimed that:

> There were instances of pregnant women who had been told in hospitals that their scans showed they would have to deliver by CS. When such women come and confide in us, we encourage them to go to hospital and we pray for them but when they insist that they have faith and believe that God will deliver, we give them 'blessed water' to bathe with and drink and God has been helping us. However, bleeding and placenta Previa are referred quickly to either Wesley or Adenle depending on the preference of the husband (which is usually Adenle). We prefer Wesley (OAUTH) for referral but they are insultive. They don't like us; even when women deliver without complications and go there for immunisation, they ask them 'where did you have your baby?' When they tell them mission, they are subjected to ridicule that we use only holy water; and many nurses from the Teaching Hospital also come here to deliver' (IDI, Female, Faith Home Ilesa East, Oct. 2009).

For all services FBBAs render, most FBBAs did not receive payment; only a few churches charged two hundred naira for registration and about one thousand naira for delivery. Such centres had more or less standard labour wards and practising nurses who were members of the religious organizations and who attended to pregnant women that might have complications. In most faith houses, there were no registration and consultation fees but the women gave free-will offering every week during prayer meeting. This was not compulsory unlike consultation fees in hospitals and one could give as little as one US cent or five to twenty naira. This may have informed why the religious houses are always full of people on their prayer days.

UNIVERSITY OF IBADAN

4.4 Influence of religion in pregnancy care

The general Yoruba belief is that pregnancy and childbearing are the works of God the Creator of the universe who has supreme control over His creation and does what pleases Him. He gives and takes life at His will. He controls all that happens in heaven and on earth. No one can query Him. Pregnancy, therefore, is perceived as a mystery that only God knows and understands; no one can query Him. He gives children to whomsoever He wishes. The respondents believed that God does not do evil and so breeched babies and pregnancy complications are the handiwork of the evil ones. If the orthodox medicine sees pregnancies as a natural or biological phenomenon, the pregnant women see it as spiritual. Half of the respondents patronised churches for care and a quarter delivered their babies there. They have much faith in mission houses and attend prayer meetings there religiously. Many caregivers in hospitals during the interviews confirmed that many pregnant women only come to them for ANC and immunisation but are delivered in mission houses. The researches carried out by Kisekka *et al.* (1992) and Ekanem *et al*. (1975) were in line with these findings. This is an indication that the people's religious belief system has great impact on maternal health-seeking.

Data from the IDIs revealed that a perceived cause of complication was belief in familiar spirits. The only FBBA that reported she had a maternal loss perceived it as the work of familiar spirits. She asserted that the woman complained that she dreamt and someone gave her injection in the dream. When she woke, she started losing fluid; she became swollen with oedema and had a fit. She was referred to the General Hospital and later to the Teaching Hospital but she died on the way. The FBBA said she learnt that the woman had familiar spirit and her time was up. The FBBA claimed that the woman was the cause of her own death. When a woman dies in the process of delivery, her mother, mother-in-law, or herself is always held responsible. When a woman dies, a woman is blamed for it; when a man dies a woman is blamed for it. When a woman dies owing to carelessness or poverty of the husband, no stigma is attached to the man. However, if this woman had attended hospital consistently, the oedema would have been detected early and treated and eclampsia that caused her death would have been prevented.

UNIVERSITY OF IBADAN

Although many women lacked scientific knowledge of causes of pregnancy complications, they were fully aware of their consequences and they dreaded them a lot. Many women resorted to FBBHs for solutions. Prayers in these homes illustrate this:

> It must not be hard for me o God. Even if days of delivery are hard for others, mine must be an exception in Jesus' name. O Lord, I take refuge in you. If they use knife to bring babies from other women; mine must not be so. O Lord, do not allow me to be rushed from delivery room to the operation theatre. O Lord, do not let them take the living out of the dead or the dead out of the living

Those prayer points mean that there should be no maternal or neonatal death /stillbirth. Both mother and child should be alive.

Another song is "O FBBA, please do not be disillusioned because of my pregnancy." It means that on the day of delivery, the work of the FBBA should be made easy because, the delivery will be easy.

They prayed a lot against forces and powers that would not allow the pregnancy and the baby to manifest:

> O Lord, do not let Satan succeed concerning me and my pregnancy. Ground, open up and consume all that would not allow this pregnancy to succeed, "In my husband's family, in my natal/orientation family, at my work place and market all those who are waiting to punish me on my day of delivery, who said I am too lousy and proud; all souls that have turned themselves into mighty battle for me during this pregnancy O earth, open up and swallow them, Let them be buried under the earth"

The women have absolute faith in the efficacy of prayers. They always prayed with enthusiasm.

> Other choruses include:
>
> Don't let me die with this pregnancy, have mercy on me. My voice and my baby's voice should be heard on the day of delivery. See me through, Father and Son. This nine- month journey, see me through O Father.

Songs and prayer points for pregnant women were compiled into a book by some FBBAs and were sold to pregnant women. Most of the pregnant women who attended the prayer

UNIVERSITY OF IBADAN

houses bought the book. They used it for personal and corporate songs and prayers. The researcher observed that when these women went to hospitals, they were always agitated and in a hurry to leave. They complained a lot that they were delayed unnecessarily; but, in the religious houses, they were more patient and did not complain of time wasting.

The beliefs of these respondents were further heightened by reported cases of activities of malevolent spirits they heard from FBBAs. Three of such cases are reported below.

4.4.1 Reported cases of malevolent spirits' activities in pregnancies care

Case 1:

A male FBBA described some spiritually manipulation experiences he and his colleague handled. He reported that the pregnancy was three years and 11days old. According to him:

> The woman had been operated and the baby could not be found for the evil ones hid it. After she was closed up and discharged from the hospital, she still looked pregnant and was having contractions. She was taken to a Celestial Church. The pregnant woman's mother-in-law came to me for prayer and I saw the pregnant woman in a vision during the prayer. I told the mother-in-law to bring her. I encouraged her that she would deliver safely. I will start to 'work' out her delivery in three days. Soon after she left, four women came to me physically and told me not to attempt to deliver the woman and that if I did I was going to pay dearly for it. I asked them who they were and the offence of the pregnant woman, one of them said she was the mother. They did not leave without reminding me of the warning not to attempt the delivery. I sang a song to them after the warning (Male caregiver, Ilesa LGA, Oct. 2009).

(The song means: He (the FBBA) is a living vineyard and that the Spirit of God in him cannot dwell with the devil.)

I told them that I would take the delivery because I was called of God.

After they left, I told the pregnant woman to be prayerful as some people (I did not declare their identities) would not want her to deliver safely.

UNIVERSITY OF IBADAN

He said that he went to a place he called 'Fonkoro' across a body of water to look for the materials to use for the woman and as he was returning with the material his vehicle was involved in an accident and he was the only one in the vehicle that was injured. He had a broken arm. (As at the time of interview, the hand was still in bandage). According to him,

> by the grace of God I saw the baby and the mother wrapped and after I administered the concoction, the woman gave birth to a maize cob and then a baby boy with a set of teeth (Male caregiver, Ilesa LGA, Oct. 2009).

He said he was to be killed as a result of this delivery but God saved him. When the baby did not urinate for five days he reported that he did another 'work' for the baby before he urinated and excreted on 8/2/2009. He said the baby was alive and well.

Jegede (2010) avers that the concept of healing among the three ethnics groups he studied is the totality of all steps taken physically and spiritually to bring health back to the afflicted.

Case 2:

This FBBA described another supernaturally perceived manipulated pregnancy his colleague took. According to him, the mother of the pregnant woman was going to all places with her and paying the bills, including Western medicine but the woman's delivery was elusive. The mother was pleading that they should help her to ensure that her first child was delivered safely. He said they told her mother to release the daughter by removing her "girdle". She refused and said she was not willing to remove the said girdle even if it resulted in the death of her pregnant daughter. The pastor claimed they forced the girdle loose. Before long, the pregnant woman was delivered safely while her mother wriggled in pains. He reported that when they set the girdle on fire, the elderly woman died.

Osunwole (1989) states that beliefs play important roles in traditional health care system because some steps taken to procure the medicine are sometimes directed towards supernatural beings, particularly the spiritual aspects, like prayers, sacrifices, charms, and incantations. Jegede (2010) states that traditional medicine is believed to be capable of curing all forms of disease and misfortune. Divination is used to diagnose the nature and prescribe cure for diseases. Barks, roots, leaves, and animal parts are often used to cure people of their diseases. Most of the steps taken to prepare and administer traditional

UNIVERSITY OF IBADAN

medicines are spiritual and cannot be explained by scientific reasoning. Yoruba medicine is spiritual in form and depends largely on the belief system of the practitioners.

The other male FBBA claimed he was given "power of the spoken word" (*afose*). He said when he commanded babies to come forth, they had to obey. He said he listened to spiritual directions before he attended to pregnant women. Sometimes a '*maleka*' (a spirit) told him to use coconut water for them.

Case 3:

The male FBBA narrated another complicated delivery he took. The woman involved insulted an elderly woman in the market. He reported that the elderly woman came to him to confess that she had planned that the woman's delivery would not be safe so that she might learn not to lash elderly women. He claimed that witches and wizards were everywhere but they could not prevail where the power of God was supreme.

FBBAs use various methods to care for pregnancies and deliveries.

This FBBA said he decided to handle only complicated pregnancies and to refer those without complications to the hospitals except the pregnant woman and her family decided that he should handle it. For such deliveries, he reported that he charged nothing "because the delivery gives me no trouble". If the family decided to show appreciation and brought gifts he took them. He said he knew that there were some families that were too poor to offer such gift. He reported that there were some deliveries he took and the families could not afford sponge and soap with which to bathe the baby and there was no cloth to put on the baby after bathing, yet, he bathed the baby for three days. From such families he took nothing; he usually used his money and material for them free.

When the researcher asked him on how he got to know all these things, he said they were by divine revelations:

> When I sleep, I see them and write them down. I do not forget any of the things I dream about and when I awake I follow the instructions given and try the concoction when such cases arise and they work.

UNIVERSITY OF IBADAN

He said that by merely looking at a pregnant woman he could discern whether the pregnancy was normal or devil manipulated**.**

These cases revealed the general beliefs of the people on pregnancy care. Women who perceive that their pregnancies have any supernatural influence may not patronize the orthodox health care system. They are likely going to patronize religious houses for care. They are likely going to pray on mountains and take spiritual baths. When such women go to hospital for its care, they are likely going to deliver in faith-based homes.

The result shows that during the respondents last deliveries, 189 (63.6%) delivered in hospitals, 73 (24.6%) of them delivered in FBBH, and 35 (11.8%) at home. The table further showed that in the current pregnancies, 211 (42.2%) hoped to deliver in hospitals, 179 (35.8%) would go to FBBH, 43 (8.6%) hoped to deliver at home, while 67 (13.4%) were yet to decide where to have their babies. About one third of the respondents hoped to deliver their current pregnancies in faith homes. Sixty-seven (13.4%) of them were not decided, on where to have their babies. They hoped God would decide for them. When such women fall into labour, they would not be able to take concrete decision on time on where to go. This causes Type I delay in seeking help; such women would also not be able to purchase the needed delivery materials. This is because there is little variation in the material to be bought from one caregiver to the other.

Respondents were requested to give reasons for the places they chose for delivery, the result reveals that 250 (50.0%) of them chose their caregiver because of religion (prayer); 182 (36.4%) did because of care, 44(8.8%) because of cost and 24 (4.8%) because of distance. Women were predominant in prayer houses because they claimed they believed the in efficacy of prayers.

The researcher observed that the FBB A centres were always filled. When questioned on how they advertised to bring the women, one of them said:

> We do not advertise, our work advertises us. Pregnant women inform one another and once they come they become my friends and they are the ones who invite their pregnant friends (IDI, Female, Faith Home, Ilesa West, Oct. 2009).

When women received appropriate treatment, and were happy; they would invite their friends and neighbours. However, in some of the churches, the FBBAs reported that

UNIVERSITY OF IBADAN

during church services and revivals, their pastors announced to the congregation that special prayers and delivery services were available in the church for pregnant women. They announced that intensive prayers would be offered when they came. These encouraged the pregnant women to come and also invite their friends.

4.4.2 Respondents' religious affiliation and places sought for delivery

Table 4.21 captures the distribution of pregnant women and their religious affiliations-67 (26.2%) Christians and 6 (15.8%) Muslims had their babies in religious centres, 159 (62.4%) Christians; 26 (68.4%) Muslims and 4 (100%) traditional religious adherents had their last babies in the hospitals while 29 (11.4%) Christians and 6 (15.8%) Muslims had their last babies at home. There were no religious barriers to places of delivery. Many Christians had their last babies in the hospitals probably because many of the hospitals such as OAUTH have Christian background. Further, there are sensitisation programmes that encourage women go to church for prayers but should go to hospital for delivery. It is interesting to note that all ATR members delivered in hospitals.

Table 4.21: Religious Affiliation and Places Where Respondents had their last Babies

Religious Affiliation	**Places Respondents Delivered their Last Babies**			
	Religious centres	**Hospital**	**Home**	**Total**
Christianity	67 (26.2%)	159 (62.45%)	29 (11.4%)	255(100%)
Islam	6 (15.8%)	26 (68.4%)	6 (15.8%)	38 (100%)
Traditional Rel.	-	4 (100%)	-	4 (100%)
Total	**73 (24.6%)**	**189 (63.6%)**	**35 (11.8%)**	**297 (100%)**

Source: Fieldwork, (2009)

UNIVERSITY OF IBADAN

Table 4.22 reveals places where women in different religious affiliations hoped to deliver their current pregnancies; 158 (36.5%) Christians, 16 (29.6%) Muslims and 5 (38.5%) Traditional Religion (TR) adherents hoped to deliver their babies in religious centres. One hundred and seventy-nine (41.3%) Christians, 29 (53.7%) Muslims and 3 (23.1%) TR adherents planned to deliver their current pregnancies in the hospital. On the other hand, 37 (8.5%) Christians, 2 (3.7%) Muslims and 4 (30.8%) TR adherents hoped to deliver their current pregnancies at home. Fifty-nine (14.6%) Christians, 7 (13.0%) Muslims and 1 (7.7%) TR adherents were undecided on places to deliver their pregnancies. The table also shows that there was significant relationship between religious affiliation and places where respondents hoped to deliver their current pregnancies (χ^2 =12.830; df = 6; P< 0.05).

Table 4.22: Religious Affiliation and Where Respondents Hoped to Deliver Current Pregnancies

Religious Affiliation	**Places respondents hoped to delivery their current pregnancies**				
	Rel. centres	**Hospital**	**Home**	**Undecided**	**Total**
Christianity	158 (36.5%)	179(41.3%)	37(8.5%)	59 (14.6%)	**433(100%)**
Islam	16 (29.6%)	29(53.7%)	2(3.7%)	7 (13.0%)	**54(100%)**
Traditional Rel.	5(38.5%)	3(23.1%)	4(30.8%)	1 (7.7%)	**13(100%)**
Total	**179 (35.8%)**	**190(38.0%)**	**43(8.6%)**	**67(13.4%)**	**500 (100%)**

Source: Fieldwork, (2009)

Muazu (1992) and Population References Bureau (2005) claim that 65% of Nigerians employ the services of traditional healers. Ekanem *et al*. (1975) aver that many women still prefer the services of TBAs even where trained midwives and physicians are available. Bourdillion quoted in Jegede (2010) states that spiritual healing churches attract a significant number of conversions even from Islam.

UNIVERSITY OF IBADAN

The result reveals that 179 (35.8%) of the respondents hoped to deliver their current pregnancies in mission houses. As many respondents were interested in delivery in faith homes, the researcher inquired from the FBBAs if they would like to be trained in obstetric care. The IDIs revealed that all FBBAs interviewed were ready to be trained. Therefore, government needs to spend some money to train them so as to save the lives of women and children. There is a need to observe treatment measures adopted by the faith homes that attracted the respondents.

4.4.3 Pattern of referrals of pregnancy complications

When complications occur and the health care provider patronized is unable to handle the case, they usually refer such patients to other care providers. In order to make referrals easy, a nurse suggested that ambulances be located near all delivery centres because many deliveries take place at night when it would be difficult to arrange for transportation. She observed that, in some emergencies, ten minutes of delay may be fatal. Pregnant women should be made to pay certain amount as contribution so that lack of fund would not be a reason why a woman in emergency would not receive care. This nurse reported an incident that happened earlier on the day of this interview:

> A woman came to deliver but passenger was greater than the passage (that means the baby was too big for the mother to deliver on her own). The lady was a student and had no money. Her parents and husband were hundreds of kilometres away; I called them but had to take ten thousand naira from my personal money to refer her to another hospital (female Faith Home, Ilesa West Oct. 2009).

Sometimes faith homes refer patients to each other before the patient is eventually referred to the Teaching Hospital. This results in Type 1 Delay described by Adelani (2008). A caregiver in one of the faith homes reported a pathetic case where a woman had been in labour for three days in another faith home. By the time she was referred to this faith home, serious sepsis had set in:

> Immediately she came and we examined her we sent her to the hospital. You see there are different assemblies that claim they have been called of God. But many are not called of God but nobody

UNIVERSITY OF IBADAN

> would claim that she was called by Satan. God knows those He called; He is helping them (FBBA. Ilesa East, Oct. 2009).

When complications arise in government maternity centres, health care providers refer the women to the Teaching Hospital or a prominent private hospital. However, care providers in maternity and FBBAs reported that they preferred the private hospital because of the receptive attitude of the care providers there. All religious houses except one claimed that they had never had any maternal mortality or stillbirth. One FBBA said:

> In the hospitals, deaths are common and expected; that is why they built mortuaries. Nobody is held responsible for death in hospital, and nobody has ever been punished for deaths that occur there. If any woman dies here, there will be a great outcry. I do not refer pregnancy complications to hospital. Rather, I help private hospitals out when they have complications *(*Male Faith Home, Ilesa East Oct. 2009).

When complications have reached critical stages, FBBAs normally advise the woman's family to take her to the hospital. If she arrives too late to be saved, death occurs in the hospital and not at the birth house and FBBAs could not be held responsible for death that occur in the hospital or on the way to hospital. Deaths that were orchestrated in FBBAs' houses are pushed to the hospital because of this wrong notion. The effect may be that pregnant women begin to associate hospitals to where MM occurs and FBBAs as where life is preserved without them being able to associate deaths in hospitals with handling in FBBAs' homes. Most FBBAs claimed that they referred complicated cases to the hospital but the big question is "how early?" Etuk *et al.* (1999) and Orji *et al.* (2001) note that late referrals from these untrained FBBAs and churches predispose women to maternal morbidity and mortality.

UNIVERSITY OF IBADAN

4.4.4 Modes of avoiding complications in faith birth homes

i) Prayers within the church

This result is derived from IDIs and the personal observation during the visits the researcher made to faith homes and hospitals. During church regular services, prayers were said for safe delivery for pregnant women. In the religious houses, pregnant women meet on a specific day in a week between 9 a.m. and 12 noons for prayer. The respondents made several of such visits during pregnancy duration. A typical meeting starts with a long time of dancing, singing and praise worship to God for sparing their lives, husbands, children, and homes; and that God in His mercies had averted many dangers from the women. The prayer items often included praising God that they were not involved in spending money on unplanned medical expenses, provision of food, and daily maintenance and God's goodness in their lives. Shortly after this, they would make rigorous prayers against maternal mortality and stillbirths. They would pray for easy and safe delivery and against evil imagination of wicked people; and that they would not be referred from one delivery house to another. They would pray that the evil ones would not follow them and that there would be no cause for maternal or/and neonatal deaths. Prayers were said also against breech babies and whatever would cause Caesarean Sections.

The influence of religion could also be seen in hospitals; when women attend ANC in hospitals, prayers were always said for safe delivery. One orthodox caregiver said "we encourage women to go to pray in the church but to come for delivery in the hospital as the two works hand in hand". Religious houses, however, spend more time in prayers than do hospitals. They ask God for mercies on their delivery. They sing songs like:

> *Baba saa nu mi bi e se sa nu fun obrin onisun eje. E saa nu fun mi. Ajaga yi wuwo mee le ruu. E maa se jeki esu fi iya je mi o. E saanu fun mi bi mo se nke pe yin o.*
>
> Meaning
>
> Father God, have mercy on me as you had on the woman with the issue of blood. Have mercy on me, this burden is heavy I cannot carry it alone. Do not allow the devil to triumph over me. Have mercy as I cry unto you.

UNIVERSITY OF IBADAN

At another time, the pregnant women kneel down and sing;

> *Ji se Re nde Jesu. Fi agbara Re agbara Re han. Fohun to le j'oku dide je ke niyan re gbo*

Meaning.

> Stand up to the task Lord Jesus. Show forth your mighty power and let it be manifest to everyone. Speak loudly that your people may hear.

Psalms 24 of the Holy Bible is commonly read in all mission houses.

1. The earth is the Lord's and the fullness thereof; the world and they that dwell therein.
2. For he hath founded it upon the seas, and established it upon the floods.
3. Who shall ascend into the hill of the Lord? Or who shall stand in his holy place?
4. He that hath clean hands, and a pure heart, who hath not set his soul unto vanity, nor sworn deceitfully.
5. He shall receive the blessing from the Lord, and righteousness from the God of his salvation.
6. This is the generation of them that seek him, which seek thy face, O Jacob.
7. Lift up your heads, O ye gates; and be ye lifted up, ye everlasting doors; and the king of glory shall come in.
8. Who is this King of glory? The Lord strong and mighty in battle.
9. Lift up your heads, O ye gates; even lift them up, ye everlasting doors; and the King of glory shall come in.
10. Who is this King of glory? The Lord of host, he is the King of glory (Full Life Study Bible, 1997).

Different Psalms were read for different stages of pregnancy; during the first trimester (1- 3 months) they read Psalms 1- 5. To those at the last stage of pregnancy (third trimester), they read Psalms 29:8 on water. They drank this water regularly and added some to their bath water. They believed this water to be sacred and that it would make their delivery easy. The Psalms they read reveal that the fear of the supernatural is prevalent. They were afraid of real and imagined enemies. They all believed in the supernatural intervention of God to deliver from the hand of the wicked. Pregnant women saw pregnancy as a burden which only God could help them to bear.

UNIVERSITY OF IBADAN

ii) Prayer on birth materials

In addition to these, as pregnant women bought the materials for delivery such as: baby clothes, mackintosh, pampers, napkins, candle or rechargeable lamb, sanitary towels, gloves, jik (an antiseptic liquid), razor blades, olive oil, cord clamp, salvon, needle thread, cotton wool, mentholated spirit, sponge and soap they were to bring them to Mission Delivery Centres where the items were prayed upon and kept. Each pregnant woman submitted a bag with all her delivery materials inside. She kept a key to the materials and left one with the FBBAs. The FBBAs reported that they continued to fast, pray and read psalms of victory on them until the women came for delivery. The prayer point was that the materials must be used for the purpose they were bought. Leaving the items with the FBBA for her individual and corporate prayers was believed to prevent evil ones from knowing when the woman was going to give birth. When contractions started, the pregnant woman would walked out of her house without carrying any load as if she was going to market or any other place. No one would know that she was in labour, as she would not have to carry any load so that perceived evil eyes would not follow her. Belief in secrecy of life is also manifest here. This practice compels the pregnant women to give birth with the FBBAs, as most women could not afford to duplicate the materials. If the materials were in the mission house, they would not be able to retrieve the materials even if they intended to patronize other caregiver at delivery.

UNIVERSITY OF IBADAN

Figure 1: Pregnant Women during a Prayer Meeting in a Church

iii) Vision and foretelling in Religious Homes

Qualitative data in some of the religious houses reveal that prophets and seers saw visions for pregnant women. Sometimes, they told the women that their babies had been tied several times by witches and wizards. In such visions, the women were instructed on the health caregiver they were permitted to visit. If anything goes wrong with a specified caregiver and the woman has to be referred to another hospital, fear is already created in the heart of the woman and they may not want to go to another hospital.

A pastor emphasized the importance of visions and prophecies as one of the reasons why pregnant women patronized faith homes. He said people had problems and they were looking for solution. They also wanted to know what the future held for them. These services are not available in orthodox medicine. The researcher observed that, in some of the faith homes, pregnant women knelt in front of their pastors/ prophets to hear "Thus says the Lord. There are 3 to 4 battles to be fought in front of you. God will

destroy all of them." Then the prophet/ prophetess would pray for them. A Prophet/FBBA said:

> You nurses and doctors in hospital are blind. You only open your eyes and could see nothing. You collect chalk and give people to swallow you cannot see the problems in their lives. As for me when a pregnant woman comes, and I look at her, *maleka'* (angel) would tell me the problems in her life and the '*maleka'* would tell me what solutions to proffer to their problems. (IDI, Male Faith Care Giver, C&S Church Ilesa East, 2009).

Jegede (2010), quoting Frazer (1911), corroborated this, stating that 'religion is a propitiation or conciliation of powers superior to man, which are believed to direct and control the course of nature and human life.'

Solutions include from bathing in flowing river or with water from the well within the church, going to mountain tops to pray, using anointing oil to rub the body, and fasting. The pastor provided the soap and the sponge as well as the anointing oil. He took those who were to go for prayers to their selected mountain top for whatever number of days the '*maleka'* stipulated. Jegede (2010), quoted Smith (1950), as saying that:

> "Full explication of religion involves complete exploration of social and political organizations, material culture, law and custom as well as the physical environment"

IDIs revealed that (what the researcher describes as) "pastoral authority" (though it may have some economic undertone) influenced choice of caregiver. In one church, the pastor instructed members of his church not to give birth in hospitals. Members were mandated to come to the mission delivery house to give birth. Children born outside would not be christened. Those who delivered outside were regarded as having no faith. Those who delivered in the church gave five tubers of yam, five measures of rice, and one gallon of kerosene to the FBBA. There was a register of all children born within the year and they were mandated to be present at the annual children's harvest where they donated money and other items to the religious house. Whatever proceeds came out of these would be shared between the FBBA and the pastor. Sometimes two or three women may be giving

UNIVERSITY OF IBADAN

birth at the same time in this place. Community health workers claimed that they paid visits to this religious house to see if they could be of assist to the FBBA in charge but the FBBA shunned them. They reported that on one of their visits, they met the FBBA and three women in labour at the same time. When they volunteered to help they were rebuffed. The FBBA was quoted as saying:

> I live on proceeds from the number of pregnant women that patronize this place and I would not allow anyone to block my source of livelihood. When I have four or more patients, I may refer one to you at maternity centre.

However, when complications arise in that religious house, they usually refer such patient to this maternity centre. The health workers asserted that when such patients were referred to them, they in turn referred them to the Teaching Hospital, contributing to Type 1 Delay (Adelani 2009). The community nurses claimed that when they visited the pastor of the church to tell him the happenings in his church, he told them that it was the policy of their religious group. On the contrary, the majority of the FBBAs claimed that they encouraged women that patronised them to visit hospital for care and referred difficult ones. Only three of the FBBAs said they never had causes to refer complications to hospitals.

UNIVERSITY OF IBADAN

Figure 2: A pregnant woman and a woman who had been delivered of a baby kneeling in front of a pastor

UNIVERSITY

vi). Prayers on mountain tops

Christ Apostolic Church, Cherubim and Seraphim faith caregivers took pregnant women to designated mountain tops for prayers regularly; every month or twice a month, where they prayed, read Psalms and held vigils. In two of the faith houses, the FBBAs said, when they looked at pregnant women, they could discern the position of the babies in the wombs. Those who were perceived to have problems had rigorous prayers said for them. If the babies were in breech positions, they claimed that they prayed to make the babies take the desired positions. Jegede (2010), quoting Frazer (1911) observed that religion enables man to cope with the natural environment and its effect on human activities.

v) Exclusive Prayer Camping (*Igbe 'le Adura*)

There was also exclusive camping for prayer for women who were perceived to have special problems for special prayers and God's protection. When the prophet/prophetess (FBBA) perceived in a vision that evil was looming for a pregnant woman, s/he ordered such a woman to come to church for special prayers. The pregnant woman would come to reside in the religious house for a whole day, three, seven, or more (usually odd numbers), depending on the seriousness of the perceived evil as directed by the '*maleka*' (angel). The pregnant woman would bring her food and other necessities to the religious house for the number of days. Prayers would be said for her at stipulated times such as 9a.m, 12 noon, 1p.m., 3 p.m., 6 p.m., 9 p.m., midnight and 3 am or on hourly intervals. This would be repeated as such if the *'Igbe'le'* lasted for more than one day. The following Psalms: 128, 91, 62, 35, 29: 5, 28, 24: 1-7 were usually read at '*Igbe'le adura*' and other meetings. All FBBAs believed in the efficacy of prayers,, saying: "Things prayers would accomplish physical exertion/energy/agility would not be able to."

The special prayer sessions served as bed rest and relaxation for these women. They slept, rested, ate, and prayed without having to bother about care of the husbands

UNIVERSITY OF IBADAN

and older children. They did not cook or do much running around. Food was brought for them or they bought food from vendors.

For all categories of pregnant women, vigils were organized by Faith Homes on a day in a week where pregnant women prayed throughout the night to allay their fears of witches and wizards and household troubles as well as whatever evil dreams they had. An FBBA said:

> We do not abuse or threaten them. Sometimes, visions are revealed concerning them and we take time to pray for them and we encourage them to come for special seclusion prayers for the troubled. The prayers encourage them a lot (Female IDI Faith House, llesa West, Sept. 2009).

Other women, apart from pregnant women, dominated prayer houses because when problems ensued, women tended to be more anxious in looking for solutions. Because they bore the brunt of pregnancy and its attendant risks, they always wanted to attend these prayers to give them spiritual and emotional comfort.

vi) Application of Blessed, Sanctified Water *(omi Iye)* and Anointing Oil (*Ororo Adu'a*)

All pregnant women came with kegs or bottles of water that they submitted at the altar of the church for prayers. Some FBBAs also use anointing oil. Book of Psalms from the Holy Bible were read into the water and the oil. One of the FBBAs averred that:

> I give Olive or Robot or Goya oil upon which I had prayed and read Psalms 3, 11, 24 to women to drink and rob on their bodies. I use it to make sign of the cross on their foreheads and tummy to ward off evil from them and their babies (IDI, Female, FBBA Sept 2009).

When the baby is eventually delivered, she used same Goya oil to clean the baby. The baby will be bathed with sponge into which Psalms 1-7, 11, 24 had been read. Anointing oil was also for pregnancies that were not developing as they ought. Women in such a situation were to drink two spoonfuls of the oil every week until their deliveries. Respondents that attended faith homes and collected 'holy water' for drinking and bathing were instructed not to boil the water or use it to take hospital drugs. The blessed water was believed to be more efficacious than drugs. They were to use fresh water for

UNIVERSITY OF IBADAN

drugs if they must take them. In some faith homes, to register in and attend hospital for ANC amounted to having no faith, and many members did not want to be seen as having no faith. Among some faith homes, civil servants attended ANC just to collect hospital paper to pursue their maternity leave form. This is in line with Emile Durkheim's Functionalist Theory. Durkheim claimed that the society sets apart some items as sacred while the rest are profane. In these religious centres, Psalms are read and prayer said on the oil, water, soap, sponges and delivery materials. The psalms read and prayers made the items sacred. The pregnant women believed this would drive evil far from them.

vii). Baths in flowing rivers and utilisation of sanctified soap and sponge (*Ose-Awebi ati Kainkain*)

Some of the religious houses especially CCC and C&S are located on the bank of a river that runs through the town. Those who were not near the river had wells in the religious houses. Pregnant women with perceived serious problems took spiritual births in this river. Pregnant women who came to these religious houses for prayers and care of their pregnancies took water from either the running water or the wells. They used that water to bathe there and took some home in bottles or kegs for bathing and drinking. The FBBAs and pastors prayed and read psalms over the water. The women were to drink this water until the next visit. If the water got exhausted, they were at liberty to come back to take more supply. However, the women were at liberty to bring their own water from home.

The health implication of drinking water from the flowing river is glaring. In Ilesa, like other town in Nigeria, a lot of people throw their wastes into this running water. It serves as toilets for many. While some bathe in it, others drink it as the river flows down. Women who take care of their pregnancies in some of these religious houses are at risk of water-borne diseases such as typhoid, cholera, dysentery and others.

In addition to bathing in flowing river, a faith home, gives '*ose awebi'* (soap for easy delivery). This could be any toilet soap upon which various prayers have been said and many Psalms have been read. This caregiver gives them this soap to bath with and oil to rob on their bodies. The researcher was in one of the prayer sessions where the FBBA

UNIVERSITY OF IBADAN

used the oil to make signs of the cross on all the pregnant women's foreheads and tummies. The women joyfully robbed this on their heads, their tummies and bodies. She bought and gave them this oil herself so that "they will not buy fake". Pregnant women who attended faith homes were bound to adhere to all instructions given in the place if their deliveries would be taken.

Another FBBA gave local black soap or special Lux or any toilet soap and sponge. Pregnant women must bath with the soap and sponge every Friday when they attended prayer meetings. There was a section of a river called *'Omi Ayo'* (water of joy) that passes through the town. Troubled people, pregnant women inclusive, go to bath naked in the morning, afternoon and night depending on the gravity of their perceived problems. It is believed that as rivers do not flow backwards, the problems they brought would flow away with the river.

Furthermore, to avoid pregnancy complications, all FBBAs instructed pregnant women that they should not be found outside between 1-3 p. m and 1-3 a. m daily. They believed that children with familiar spirits who move around at that time can drive out good children in pregnant women's wombs and replace them with bad ones.

> We tell the women not to go out in hot afternoon or at midnight between 1-3am and pm to avoid evil children who may take over their wombs (IDI, Female, FBBA Sept 2009).

viii). FBBAs and Counselling Services

Apart from care giving in pregnancy, FBBAs also provided counselling services for pregnant women and their spouses. Women were able to discuss their marital problems with faith caregivers freely. One FBBA recalled that a husband came to report that his wife always refused sexual advances from him and he had sent her away. The FBBA sent for the wife, advised her and reunited the family.

> We encouraged them to do family planning so that they would not send their husbands out (Female, Faith Home, Ilesa West, Oct. 2009)

One FBBA recalled the case of a pregnant woman whose last baby was less than one year. She was sick and was contemplating an abortion. The FBBA reported that she

UNIVERSITY OF IBADAN

encouraged her not to abort; and that God had special plans for them and would take care of them. She left the pregnancy and had a safe delivery.

FBBAs instructed pregnant women on how to live peacefully with their in-laws and husbands to avoid complications. Pregnant women were told to avoid arrogance, quarrelling, and fighting with their husbands so that he would buy maternity materials. The FBBAs reported that they usually invited husbands for progress report on the character of their wives. They tried to find out whether there was improvement in their marriage relationships. If any husband complained of misbehaviour of the wife, the woman would be reprimanded and advised to turn a new leaf. This was done to enlist the cooperation of the husband on the day of delivery.

Faith caregivers further instructed pregnant women to endure some hardship with their husbands and be grateful for whatever the husband could afford because of the prevalent economic crisis in the country. Women whose husbands were irresponsible were advised not to fight to avoid being kicked in the tummy, the damage of which might be incalculable. They were encouraged to be patient and avoid trouble. They were admonished never to quarrel because of pregnancy or children. Those in the early stage of pregnancies were advised to rest and avoid fighting to avoid miscarriage.

FBBAs warned pregnant women about other women outside who were ready to entice their husbands with money and materials so that they could go out with them. They were counselled that: if their husbands were having extra-marital affairs, they should not fight the man or the woman friend; if the husbands were members of FBBA's church, they would be called and advised to desist for the sake of their children so that the children would provide social security for them in future. This cautioned the men because they did not want to suffer at old age. Hospitals have no such services.

Some of these services endeared the hearts of pregnant women to the FBBAs. IDIs revealed preference for FBBAs as caregivers probably because of their attitudes. FBBAs were amiable, easily available and their phone numbers were given to all pregnant women. They were allowed to call them any time of the day. Worthy of note is the cordial relations the researcher observed among the religious caregivers and pregnant women. The women were allowed to sleep and sit anywhere they liked. The researcher

UNIVERSITY OF IBADAN

observed that some women went to lay full length on the altars of the churches asking God for mercy during their deliveries. This was different from what was observed in hospitals where the women sat on long benches and sleeping was not allowed because of space congestion or fear of the nurses.

Faith homes instructed their attendees not to bring advanced pregnancy of eight to nine months to them for delivery because they did not know the history of such pregnancies. As a result they did not take emergency deliveries. They sent such to the hospitals as captured below:

> When such pregnant women insisted on delivering with us claiming nothing was wrong with them and their last babies were easy, we educated them to know that no two pregnancies were the same; the fact that the last pregnancy was free of trouble and complication does not guarantee that complications could not show their ugly heads suddenly at the last minute. But those who come for prayers must have prayed off complications (IDI, Female, Faith Home, Ilesa West, Nov. 2009).

Women who did not conform to regular prayers were refused at labour because, according to the FBBA,

> We need the prayers; a woman who has not been coming for the prayers cannot be admitted because we are not aware of how her pregnancy had fared (IDI, Female, Faith Home Ilesa East, Oct. 2009).

It is interesting to note that the FBBAs rejected women who came for emergency delivery without attending their weekly prayer sessions. They claimed that they did not know the histories of their pregnancies and had not prayed through on such women and could not expose themselves to unnecessary stress if any complication arose. But they were quick to accuse the Teaching Hospital of not taking prompt care of unbooked patients they referred there.

Apart from spiritual help given by faith homes, they were more sympathetic to the cause of the pregnant women. A hospital caregiver reported an incident of a pregnant woman who tested positive to HIV. When she was in labour, she went to the hospital. The midwife on duty who knew her status told her to come back hours later because she

UNIVERSITY OF IBADAN

still had many hours to labour but actually it was to give the nurse time to finish her duty. The pregnant woman had no alternative but to resort to a faith home where she was delivered of a baby shortly on arrival. The FBBA did not use gloves. It was the pregnant woman who knew her status that insisted that gloves be used or that she be allowed to pack her blood by herself as she could not tell the FBBA her status and was not willing to spread the virus. FBBAs used bare hands to take deliveries and circumcise children. If FBBAs become infected, thousands of pregnant women and children are at risk because these FBBAs do not go for HIV test.

For all these services, FBBAs usually did not receive regular payment. During the interviews, some FBBAs confessed that they were not really happy with the financial returns of their work. Many complained that, sometimes, women vomited and passed stool on them and yet they were not able to pay. The FBBAs continued the work because they believed that God called them and they had to obey. In many religious homes, although deliveries were free, couples and their children were required to come to church that took their children's delivery during harvest and thanksgiving programmes in September or October of the year. The parents gave money and those that appreciated the FBBAs gave them personal gifts. Women who refused the invitation were regarded as ingrates and such women would normally come when they face another problem. To solve that problem they had to show gratitude for help rendered in the past. This is evident in the report of this FBBA:

> There was a woman who did not come back for thanksgiving. She had other problems and, where she went to pray; she was reminded that she did not give thanks where she received her baby. She had to return to me after many years with money and yams.

This indicates that, although there may not be immediate gratification, many pregnant women return at later dates to appreciate the FBBAs.

The belief that evil people can harm pregnant women pervades the study area. This may be responsible for the secrecy that attends pregnancy and deliveries. It may be the reason why pregnant women do not register in hospitals during the first trimester. Many women would not want people to know they are pregnant until their tummies

UNIVERSITY OF IBADAN

protrude and it becomes evident for all to see. However, secrecy is not limited to pregnancy alone; it is manifested in other facets of life. Many people hide successes in career, academia, business, and employment. They would not tell their neighbours and relations; they have gained admission to a university, or are travelling, or building a house. When they go to their villages, they go in public transport so that their people will not know that they own a car. They believe that people of darkness can overturn the good things of life that come to them. A common adage in Ilesa is "*bi isu eni ba ta, se ni a a dowo boo je*" (if your yam yields well on the farm, you should not expose it. You should cover it and eat it quietly, without allowing others to see.)

A few religious houses cooperated with hospitals and allowed nurses to attend their prayer meetings to give health talks to pregnant women on cleanliness, personal and environmental hygiene, immunisation, blood tests, and scan. Some FBBAs instructed women to go to hospital for scanning and blood examination to ensure that they were physically okay and there would be no complications. Women were free to do these tests in any hospital of their choice. During the following prayer meeting, they would give feedback to FBBAs on what the hospital discovered and it would become a basis for more prayers. Where these tests were done, and there were no signs of complications, the FBBAs would take the deliveries but when the result suggested complications, the FBBAs would allow nurses to direct the women to appropriate hospital, as seen in this except:

> But when the women insist that they would deliver here; I ask the heavenly spirit: If the spirit tells me to deliver her I will do; if not I send her away (Female Ilesa West, Oct. 2009).

The respondents had great faith in FBBAs being vested with more power through prayers to avert dangers than orthodox medicine. However, OAUTH records revealed that more maternal deaths are recorded from unbooked patients than those who booked in hospitals. Many of such women were brought in with their babies born before arrival (BBA). Maternal loss record at OAUTH Ilesa revealed that 73.3% were unbooked patients who were referred at moribund conditions. In fact, 33.3% had already delivered elsewhere and were brought when life was almost lost.

UNIVERSITY OF IBADAN

4.4.5 Maternal mortality recorded at OAUTH Ilesa from 2005-2008

Secondary data from OUATH reveals that the majority of maternal deaths recorded in the hospital were unbooked women that were referred to the hospital in critical conditions. Fifteen MMs were identified between years 2005-2008; 11 (73.3%) of them were unbooked women, while 4 (26.7%) were booked. Causes of death in five (33.3%) were post partum haemorrhage (PPH) whose babies were born before arrival (BBA); four (80%) of these were unbooked. Another two died as a result of eclampsia: one was booked and the other unbooked. Two died from obstructed labour; both were unbooked. One unbooked woman died from Ante-partum haemorrhage (APH); one unbooked from abdominal malignity; one booked from ruptured uterus; one booked died from respiratory distress; and the last was brought in deeply unconscious. Audu-Airede (2000) found that many women came to hospital as a last resort when complications had set in and "mother is on death road".

This buttresses the claims of Harrison (1997) that unbooked emergencies constitute no fewer than 70% of all hospital maternal deaths in Nigeria. The researcher found it so, even after 38 years of Harrison's study. The women received no ANC care and arrived at the hospital for the first time when their lives were already endangered by difficult labour, advanced pregnancy complications, or coincidental disease (Harrison, 1997).

Many of these women attempted to deliver outside the hospitals but when complications arose, there were delays in getting them to hospital on time. The women knew that, if they laboured for two days in hospital and could not deliver, CS would be done; but, in mission houses they could labour for four days or more before they would be referred to another place. This delay might be life-threatening and result in the women being taken to hospital in moribund conditions, which Adelani (2005) describes as Type I Delay. It may result in mortality of either mother or child or both.

UNIVERSITY OF IBADAN

Table4. 23 Percentage Distribution of Causes of Maternal Mortality Recorded at OAUTH Ilesa from 2005-2008

Causes of Death	Booked	Unbooked	Total
Abdominal malignity	-	1 (100%)	**1/15(6.7%)**
Ante-Partum Haemorrhage (APH)	-	1 (100%)	**1//15 (6.7%)**
BBA/PPH brought in Deeply Unconscious	1 (20%)	4 (80%)	**5/15 (33.3%)**
Eclampsia	1 (50%)	1 (50%)	**2/15 (13.4%)**
Obstructed Labour	-	2 (100%)	**2/15 (13.4%)**
`Respiratory Distress	1 (100%)	-	**1/15 (6.7%)**
Retained Placenta	-	1 (100%)	**1/15 (6.7%)**
Ruptured uterus	1 (50%)	1 (50%)	**2/15 (13.3%)**
Total	**4 (26.7%)**	**11(73.3%)**	**15 100%)**

Source: OAUTH, Ilesa, Secondary Data obtained in November 2009

4.4.6 Influence of denominations on places respondents delivered their last pregnancies

Table4. 23 shows that 19 (11.9%) Catholics, 38 (23.7%) Protestants, 101 (63.7%) Pentecostals and 1 (0.7%) member of Jehovah's Witnesses had their last babies in government hospitals. Six (9.0%) Catholics, 13 (19.2%) Protestants, 46 (69.2%) Pentecostals, 2 (2.5%) Jehovah's Witnesses had their last babies in FBBHs; while 2 (5.3%) Catholics, 5 (17.6%) Protestants, 21 (74.8%) Pentecostals and 1 (2.3%) member of Jehovah's Witnesses had their last babies at home. Altogether, 159 (62.3%) Christians had their last babies in hospitals; 67 (26.3%) Christians had their last babies in FBBHs, while 29 (11.4%) Christians had their last babies at home. NDHS (2003) states that, as at

UNIVERSITY OF IBADAN

2003 63% of the women received ANC from orthodox caregivers and 61% from urban centres received ANC from doctors and 23% from nurses and midwives (Giwa- Osagie *et al*., 1990).

Table 4.23 Influence of Denominations on Places Respondents Delivered their Last Pregnancies

Places of last Delivery	Denominations				
	Catholics	Protestant	Pentecostals	Jehovah Witnesses	Total
Govt. Hosp.	19 (11.9%)	38 (23.7%)	101 (63.7%)	1 (0.7%)	**159 (62.3%)**
Mission/FBBHs	6 (9.0%)	13 (19.2%)	46 (69.2%)	2 (2.5%)	**67 (26.3%)**
Home	2 (5.3%)	5 (17.6%)	21 (74.8%)	1 (2.3%)	**29 (11.4%)**
Total	27 (8.8%)	56 (20.3%)	168 (69.1%)	4 (1.8%)	**255 (100%)**

Source: Fieldwork, (2009)

4.4.7 Influence of Denominations on Places Respondents Hoped to deliver their Current pregnancies

Table 4.24 reveals that 22 (12.2%) Catholics; 33 (18.2%) Protestants; 123 (68.0%) Pentecostals and 3 (1.7%) Jehovah Witnesses hoped to deliver their current pregnancies in hospitals; 10 (6.7%) Catholics; 24 (16.0%) Protestants; 114 (76.0%) Pentecostals and 2 (1.3%) Jehovah Witnesses hoped to deliver their babies in FBBHs while 3 (7.9%) Catholics; 9 (23.7%) Protestants 24 (63.2%) Pentecostals; 2 (5.3%) and Jehovah Witnesses hoped to deliver their current pregnancies at home. Among all denominations, 3 (4.7%) Catholics; 22 (34.4%) Protestants; 38 (59.4%) Pentecostals and 1 (1.6%) member ofJehovah Witnesses were not decided on the caregivers to utilize at the point of delivery. The implication of this is that when labour sets in, this indecision may result to type 1 delay. There may be the problem of where to take the women to deliver; it may also mean that the needed delivery materials for any particular caregiver may not be ready because each of these caregivers has distinct materials they request pregnant women to purchase.

UNIVERSITY OF IBADAN

Table 4.24: Influence of Denominations on Places Respondents Hoped to Deliver their Current Pregnancies

Places Hoped to Deliver Current Pregnancy	Denominations				
	Catholics	Protestant	Pentecostals	Jehovah Witnesses	Total
Hospital	22 (12.2%)	33 (18.2%)	123 (68.0%)	3 (1.7%)	181(100%)
Mission/FBBHs	10 (6.7%)	24 (16.0%)	114 (76.0%)	2 (1.3%)	150 (100%)
Home	3 (7.9%)	9 (23.7%)	24 (63.2%)	2 (5.3%)	38(100%)
Undecided	3 (4.7%)	22 (34.4%)	38 (59.4%)	1 (1.6%)	64 (100%)
Total	38 (8.8%)	88 (20.3%)	299 (69.1%)	8 (1.8%)	433 (100%)

Source: Fieldwork, (2009)

Table 4.25 captures the number of deliveries in OAUTH, Ilesa from the year 2004 to 2008. Fifty-seven (2.3%) of them were assisted breech deliveries; 884 (35.4%) were CS. Forceps deliveries were 9 (0.4%). There were 1,514 (60.7%) cases of spontaneous virginal deliveries (self-deliveries), while vacuum deliveries were 28 (1.12%). The number of CS was high because when the women labour for two days in the hospital and delivery was delayed, hospital authorities would subject such pregnant women to CS to save the lives of the mother and the child. Besides, many women were referred to OAUTH in moribund conditions and only emergency CS could save their lives.

UNIVERSITY OF IBADAN

Table4. 25: Distribution of Types of deliveries at OAUTH, Ilesa from 2005-2008

Types of Deliveries	**Number of Deliveries**				
Year	**2005**	**2006**	**2007**	**2008**	**Total**
Assisted Breech (ABD)	6	16	12	23	**57 (2.3)**
Caesarean Section (CS)	161	201	242	280	**884(5.4)**
Forceps delivery	1	2	2	4	**9 (0.4)**
Induced	-	2	0	-	**2 (0.08)**
Spontaneous Virginal Deliveries (SVD)	264	393	380	477	**1514(60.7)**
Vacuum	5	16	3	4	**28(1.12)**
Total	**437 (17.5)**	**630 (25.3)**	**639 (25.6)**	**788 (31.6)**	**2494 (100)**

Figure in brackets are in percentages

Source: OAUTH delivery Records in Ilesa (2005 – 2008)

Three of the FBBAs assured pregnant women that if hospitals wanted to do CS and they came to them, they would deliver within one hour. Women who heard this constantly may refuse CS. This might cause delay that might be life-threatening and result in the women being taken to hospital in moribund conditions. However, hospital reports may not have the final answer at all times. An FBBA noted a supernatural intervention in a pregnant woman's case. The woman went for a scan and the baby was breech. The FBBA sent her to a hospital but she refused to go but started crying. The pregnant woman, according to the FBBA, looked through the window towards the sky and said:

> O God, you know my financial position. The money I owe in this hospital I have not paid it; one nurse stood in for me. Wouldn't you have compassion on me and deliver me safely without operation? (IDI, Female, Pregnant woman, Sept. 2009).

She said as she tearfully prayed, she sat and in 30 minutes the baby had turned so that in less than one hour she was delivered safely.

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Many studies have found that haemorrhage, eclampsia, obstructed labours, retained placenta and ruptured uterus were major causes of MM (Harrison, 1997). Although unbooked patients constituted 23.8% of hospital admission, they contributed 73.3% of maternal loss. Audu-Airede (2000) also claims that users' fees increased MM by 600% in University of Nigeria Teaching Hospitals beginning in 1987.

4.5 Factors that influence decision on care during pregnancy

4.5.1 Influence of formal education on place of pregnancy care

Education is perceived as one of the indices of economic status in Nigeria. It is established in the literature that literate men and women have access to information and are more likely to utilize hospital services. Table 4.26 reveals the respondents' educational qualifications and choice of place of pregnancy care. Ten (33.3%) of the respondents with no schooling attended ANC in government hospitals; 7 (23.3%) in private hospitals; 8 (26.7%) in church/religious centres; and 5 (16.7%) combined church and hospital.

Among the women that had primary education, 7 (30.0%) attended government hospitals, 12 (26.1%) went to private hospitals; 11 (23.9%) attended religious centre for pregnancy care and 6 (13.0%) combined the two. Thirty-eight (46%) of those who did not complete secondary education attended government hospitals; 16 (19.5%) attended private hospitals; 20 (24.4%) had the ANC in mission houses; 2 (2.4%) went to drug stores; 6 (13%) combined church with hospital. Among those who completed secondary education, 64 (33.9%) attended ANC in government hospitals; 47 (24.9%) went to private hospital, 47 (24.9%) attended churches; 1 (0.5%) visited drug shops; and 30 (15.9%) combined hospital and church. About 38% of those who had tertiary education went to government hospitals; 40 (26.1%) went to private hospitals; 34 (22.2%) attended mission houses; 1(0.1%) claimed herbal treatment; while 20 (13.1%) combined church and hospital. The result reveals that all levels of educational groups attended faith homes for pregnancy care and many have reasons for combining them. This is consistent with earlier studies. Jegede's (2010) respondents in Ika combined hospital treatment with church healing services, while others combined hospital treatment with traditional remedies;

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many members of Pentecostal churches were found not to believe in hospital medical care. 2008 NDHS also reported that 36% of Nigerian pregnant women received no ANC during the period of it study. There was no substantial change in proportion of women receiving no antenatal care between 2003 NDHS (37%) and 2008 NDHS (36%).

Table4. 26: Influence of Formal Educational on Place of Pregnancy Care

Highest Educ. Qualification	Therapeutic Choice for ANC/ Pregnancy Care						Total
	Govt. Hosp.	Private Hosp.	Mission	Church & Hosp.	Pharm Store	Herb	
No Schooling	10(33.3)	7 (23.3)	8(26.7)	5(16.7)	-	-	30 (100)
Primary	1 (30.0)	12 (26.1)	11(23.9)	6(13.0)	-	-	46 (100)
Secondary (Uncomp.)	38(46.3)	16(19.5)	20(24.4)	6(13.0)	2(2.4)	-	82 (100)
Secondary (Compl.)	64(33.9)	47(24.9)	47(24.9)	30(15.9)	1(0.5)	1(0.1)	189(100)
Tertiary	58(37.9)	40(26.1)	34(22.2)	20(13.1)	-	-	153(100)
Total	**187(37.4)**	**122(24.4)**	**120(24.0)**	**67(13.4)**	**3(0.6)**	**1(0.2)**	**500(100)**

Figure in brackets are in percentages

Source: Fieldwork, (2009)

4.5.2. Influence of formal education on knowledge of convulsion as a symptom of pregnancy complication

Table 4.27 shows that 11(36.7%) of the respondents fell into "no schooling" category, while 23 (50%), 38 (46.3%), 19 (52.4%) and 90 (54.2%) of them had primary, secondary uncompleted, secondary completed and tertiary education, respectively. Overall, only 254 (50.8%) of the respondents recognized convulsion as a sign of complications; no wonder 2 (13.3%) of MM in the Teaching Hospital was due to eclampsia. There was no significant relationship between educational qualification and respondents' perception of convulsion as a sign of pregnancy complications (χ^2 =3.979;

UNIVERSITY OF IBADAN

df=4; P> 0.05). There was a wide gap in respondents' knowledge of pregnancy complications. Pregnant women of all categories of educational qualifications were ignorant of convulsion as a symptom of pregnancy complications.

Table 4.27 Influence of Formal Education on Knowledge of Convulsion as a Symptom of Pregnancy Complication

Educational Qualification	Knowledge of Convulsion as a Symptom of Pregnancy Complications		Total
	Yes	No	
No schooling	11 (36.7%)	19 (63.3%)	**30 (100.0%)**
Primary	23 (50.0%)	23 (50.0%)	**46 (100.0%)**
Sec(uncompleted)	38 (46.3%)	44 (53.7%)	**82 (100.0%)**
Sec (completed)	99 (52.4%)	90 (47.6%)	**189 (100.0%)**
Tertiary	83 (54.2%)	70 (45.8%)	**153 (100.0%)**
Total	**254 (50.8%)**	**246 (49.2%)**	**500 (100.0%)**
$X^2_{critical\ 9.49}$ X^2_{cal} 3.979 df 4 P 0.40			

Source: Fieldwork, (2009)

4.5.3 Influence of formal education on perception of breech baby as pregnancy complications

Education is believed to enhance a person's knowledge and perception. Table 4.28 reveals the educational qualification of the respondents and perception of breech baby as a symptom of pregnancy complication. Fourteen (46.7%), 28 (60.9%), 44 (53.7%), 115 (60.8%) and 86 (56.2%) of respondents with no schooling, primary, secondary uncompleted, secondary completed, and tertiary education, respectively, perceived that breech babies were a symptom of complications. The rest were not aware. There was no

UNIVERSITY OF IBADAN

significant relationship between educational qualifications and perception of breech baby as sign of pregnancy complications (χ^2=3.116; df =2; P> 0.05).

Table 28: Influence of Formal Education on Perception of Breech Baby as Pregnancy Complications

Educational Qualification	Perception of Breech Delivery as a Sign of Pregnancy Complications		Total
	Yes	No	
No schooling	14 (46.7%)	16 (53.3%)	**30 (100.0%)**
Primary	28 (60.9%)	18 (39.1%)	**46 (100.0%)**
Secondary uncompleted)	44 (53.7%)	38 (46.3%)	**82 (100.0%)**
Secondary(completed)	115 (60.8%)	74 (39.2%)	**189 (100.0%)**
Tertiary	86 (56.2%)	67 (43.8%)	**153 (100.0%)**
Total	**287 (57.4%)**	**213 (42.6%)**	**500 (100.0%)**
$\chi^2_{critical}$ 9.49 χ^2_{cal} 3.116 df 4 P 0.539			

Source: Fieldwork, (2009)

4.5.4 Respondents' level of income and perceived place to treat pregnancy complication

A person's perception of causes of pregnancy complication will determine where she goes for treatment. The respondents were required to identify places where they perceived pregnancy complications should be treated. Table 4.29 contains pregnant women's perception of where to treat pregnancy complications: 230 (46.0%) of them believed that pregnancy complications should be taken to religious centres; 195 (39.0%) believed they should go to hospitals; 74 (14.8%) reported that maternities were right places for treatment of pregnancy complications; only 1(0.2%) would stay at home for

UNIVERSITY OF IBADAN

home remedies. This observation was statistically significant (χ^2 = 505,737 df =1, N= 500, P< 0.05). The table further reveals that 179 (47.2%) of those that earned 10,000 naira perceived that pregnancy complications should be treated in religious centres; 146 (38.5%) would treat complications in maternity centres 54 (15.2%) in hospitals; and none at home. Twenty-five (41%) of those who earned 10,001-20,000 naira would treat pregnancy complications in mission or religious centres; 24 (39.3%) of them at maternity centres; 11 (18%) in hospitals and 1(1.6%) at home. Among the respondents that earned 20,001- 30,000 naira; 14 (56%) would treat complications in religious centres, 6 (24%) at maternity centres; 5 (20%) in hospitals and none would stay at home. Among those who earned 30,001-40,000 naira, 8 (42.1%) would treat pregnancy complications in religious centres; 10 (52.6%) would treat them at maternity centres; 1 (5.3%) in hospitals; while none would stay at home. Among those who earned 40,001-50,000 naira, 2 (28.6%) would go to religious centres for treatment of pregnancy complications; 4 (57.1%) would treat complications at maternity centres; and 1(14.3%) would go to hospitals. Among those who earned 50,000 naira and above 2 (22.2%) would go to religious centre; 5 (56.5%) would treat complications at maternity centres and 2 (22.2%) would go to hospitals; while none would stay at home.

The table shows that there was no significant relationship between income and perceived places sought for treatment of complications (χ^2 = 8.137; df = 2; P > 0.05). Jegede (2010) posits that, in time of special stress, anyone may find attractive the support of the tight-knit and enthusiastic community of healing churches and accept confidence in the powerful symbols of their preaching and rituals. Bourdillion (1991), cited in Jegede (2010), argues that there are varieties of possibilities that people could choose from when they require relief from sickness. Modern medicine, in most cases, is combined with other sources of healing.

The overall result is that, there was no economic barrier in patronage of FBBAs. All categories of women patronized mission houses. Even those who patronized government hospitals still supplemented it with visits to mission houses.

UNIVERSITY OF IBADAN

Table 4.29: Influence of Respondents' Monthly Income on Choice of Place to Treat Complications

Income of Respondents	Place for Treatment of Pregnancy Complications				Total
	Rel. Centres	Maternity	Hospital	Home	
< ₦10,000	179 (47.2)	146 (38.5%)	54 (15.2%)	-	379 (100%)
₦10,001-₦20,000	25 (41.0%)	24 (39.3%)	11 (18.0%)	1 (1.6%)	61 (100%)
₦20,001-₦30,000	14 (56.0%)	6 (24.0%)	5 (20.0%)	-	25 (100%)
₦30,001-₦40,000	8 (42.1%)	10 (52.6%)	1 (5.3%)	-	19 (100%)
₦40,001-₦50,000	2 (28.6%)	4 (57.1%)	1 (14.3%)	-	7 (100%)
₦50000+	2 (22.2%)	5 (56.6%)	2 (22.2%)		9 (100%)
Total	**230 (46%)**	**195 (39.0%)**	**74 (14.8%)**	**1 (0.2%)**	**500 (100%)**

Source: Fieldwork, (2009)

4.6 Aderence of pregnant women to care providers' prescriptions and basic instructions.

It is one thing for pregnant women to attend hospitals for care in pregnancy, it is quite another for them to adhere to instructions given to them. WHO defines adherence as the extent to which a person's behaviour−taking medication, following diet and / or executing a lifestyle changes−corresponds with agreed recommendations from a health care provider. Non-adherence is common with negative consequences of failure to achieve the desired medical treatment. The level of adherence of pregnant women to hospital's instruction determines how much benefit accrues to them in hospital maternal

UNIVERSITY OF IBADAN

care. The researcher sought to know the level of women's adherence to instructions under the following sub headings:

i) Adherence to Focused Antenatal Clinic (FANC)

ii) Adherence to immunisation regimes

iii) Reason for non-adherence.

iv) Adherence to FANC by marital status

v) Adherence to sleep, food and exercise among respondents during pregnancy

vi) Adherence to drug administration

4.6.1a Adherence to Focused Antenatal Clinic (FANC)

Respondents were requested to indicate whether they ever attended ANC. Table 4.31 reveals the pregnant women's level of adherence to attendance at ANC: 398 (79.6%) attended ANC, while 102 (20.4%) did not attend any. Among those who attended FANC, only 258 (51.6%) did ultrasound diagnostic tests; 380 (76.0%) did blood tests; while only 52 (10.4%) attended hospital at other times apart from ANC when they were sick; 448 (89.6%) did not attend hospital outside FANC. This implies that only pregnancies force women to attend hospital. Most of the women attended hospitals only when they were pregnant. Jegede (2010) found that the majority of people first used traditional medicine before utilizing modern medicine after attempts at traditional medicine had failed.

Ultrasound diagnostic tests would enable caregivers to know early the positioning of the baby so as to know what management procedure to follow. But when women refuse or cannot afford the money for ultrasound, the caregiver may be unaware of impending danger. By the time he/she is aware of any complication; things may have gone out of hand or may require higher cost of management.

Blood test is to ensure that the pregnant women have adequate blood and prevent anaemia. This test is to be done often to detect anaemia, but 24% of the respondents did not subject themselves to this test. The IDIs reveal that some caregivers refused to do the test so that they would not expose themselves to other people's blood because of HIV

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infection. When this happens, anaemia may be detected late, when blood transfusion would be the only appropriate solution; but the IDIs reveal that pregnant women and their husbands dread blood transfusion. Researches have shown that early detection and management of diseases, like cancer ensures their cure. NDHS (2008) claims that early detection of problems during pregnancy leads to more timely treatments and referrals in case of complications.

Table 4.31 further shows that only 242 (48.4%) of the respondents took the immunisation at the appropriate time, while 258 (51.6%) did not. Not taking the immunisation as and when due renders the ones taken useless and ineffective and it can be counter-productive. The respondents that did not take immunisation on time would not be able to complete the doses as scheduled and the immunisation would not be able to prevent the diseases it is meant to prevent.

Table 4.30: Adherence to Focused Ante-natal Care

Adherence to Hospital Regimes	**Yes**	**No**	**Total**
Ever attended ANC	398 (79.6%)	102 (20.5%)	**500(100%)**
Undertook Ultrasound Diagnostic Examination	258 (51.6%)	242 (48.4%)	**500 (100%)**
Undertook Blood Sample Examination	380 (76.0%)	120 (24.9%)	**500 (100%)**
Immunisation taken as and when due	242 (48.4%)	258 (51.6%)	**500(100%)**

Source: Fieldwork, (2009)

Among those that did blood tests 155 (75.2%) of prim; 136 (62.4%) of multigravidals and 4 (50.0%) of grand multigravidals would accept blood transfusion if there was a need. There was significant relationship between number of pregnancy and decision to accept blood transfusion if there was a need. Among the three categories, most prims would accept blood transfusion. This may be due to fear on the part of the inexperienced primigravidals who would not want to leave their health to chance.

UNIVERSITY OF IBADAN

4. 6.1b. Respondents' access, utilisation and places sought for antenatal clinic service

Attendance at ANC is perceived to be a positive indication of maternal and child health. Attendance at ANC has been associated with positive pregnancy outcome. Table 4.31 reveals that 398 (79.6%) ever attended ANC; 309 (61.8%) attended ANC in hospital/maternity only, 182 (39.4%) attended ANC in FBBH only 61 (13.4%) combined hospital and FBBH; while 4 (0.8%) went to Pharmacy/ drug store. Among the respondents that ever attended ANC, 86 (17.2%) attended only once, 152 (30.4%) attended twice, 24 (4.8%) attended three times, while 199 (39.8%) attended four and more times.

Table 4.31: Percentage Distribution of Respondents Access to, Utilization and Places Respondents Sought for Antenatal Clinic Service

ANC Attendance Variables	Number of Respondents	Percentage
Ever attend ANC		
Yes	398	79.6
No	102	20.4
Where did you attend?		
Hospital/Maternity only	309	61.8
Mission only	120	24.0
Church & Hospital	67	13.4
Pharm/Drug Store	4	0.8
How many times did you attend?		
None	39	7.8
Once	86	17.2
Twice	152	30.4
Thrice	24	4.8
4 & More	199	39.8

Source: Fieldwork, (2009) (F= 500)

UNIVERSITY OF IBADAN

4.6.1c Age of Pregnancy at First ANC Attendance

Attendance of ANC at the right time is paramount to effective care. Table 4.32 revealed that 151 (50.8%) of the respondents attended ANC for the first time at the first trimester during their previous pregnancy; 92 (31.0%) at the second trimester and 54 (18.2%) at the third trimester. Among those who attended ANC during their current pregnancy, 274 (54.8%) attended ANC for the first time during the first trimester, 174 (34.8%) attended during the second trimester, and 52 (10.4%) attended at the third trimester. Nwokocha, (2006) reported late antenatal registration among Ibani people of Rivers State, Nigeria. The 2008 NDHS reported that only 16% of women had their first ANC at the first trimester and 36% did not receive any ANC. The result of late registration is that the respondents would not be able to take the right number of immunisations or undergo other required tests. This may also cause delay in early detection of pregnancy complications.

Many of the pregnant women went to hospital only when the pregnancies had developed considerably and could not take more than 2 out of the 3 compulsory Tetanus Toxoid injections. Many of them could not take more than one because of lateness to register. The lateness to register may be due to general secretive nature of pregnancy in the study area. Many women believe that if evil people get to know that they are pregnant early, they can attack such pregnancy. There is the tendency to hide the pregnancy until it can no longer be hidden. Although the respondents attended ANC, they could not adhere to immunisation regimes, despite the caregivers' emphasis on the importance of immunisation.

UNIVERSITY OF IBADAN

Table 32: Age of Pregnancy at First ANC Attendance

Trimesters	**1st** **1-3 months**	**2nd** **4-6 months**	**3rd** **7-9 months**	**Total**
Age at 1st ANC attendance Previous Pregnancy.	151 (50.8%)	92 (31.0%)	54 (18.2%)	**297 (100%)**
Age at 1st ANC attendance Current Pregnancy.	174 (34.8%)	274 (54.8%)	52 (10.4%)	**500 (100%)**

Source: Fieldwork, (2009)

4.6.2a Adherence to immunisation regimes

Respondents were requested to indicate the number of times they attended ANC. Table 4.33 indicates pregnant women's level of adherence to attendance at ANC Among the 398 (79.6%) that ever attended ANC, 27 (6.8%) attended once, 129 (32.4%) attended twice, 68 (19.2%) thrice, and 166 (41.8%) attended four or more times. Hospital authorities regard pregnant women as booked if they attend ANC at least 4 times and take all immunisations and other recommended tests. The table shows that only 166 (41.8%) attended up to the stipulated 4 times. Irregular attendance would not allow women to take all the immunizations, or complete other examinations that are necessary for the success of the pregnancy.

Immunisation regimes have been found to be effective in reducing maternal and child mortality as well as morbidity. Table 4.33 reveals the respondents' adherence to immunisation regimes: 91 (18.2%) did not take any immunisation, 173 (34.6%) took only one, 188 (37.6%) took two, 19 (3.8%) took three and 29 (5.8 %) took four. The majority (72.2%) of the respondents did not take more than two tetanus toxoid.

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Table 4.33: Percentage Distribution of the Respondents' Adherence to Immunisation Regimes

Number of Times	0	1	2	3	≥ 4	Total
Ever Attended ANC	102 (20.4%)	68 (19.2%)	129 (32.4%)	27 (6.8%)	166 (41.8%)	**500 100%**
Number of immunization	91 (18.2%)	173 (34.6%)	188 (37.6%)	19 (3.8%)	29 (5.8%)	**500 100%**

Source: Fieldwork, (2009)

4.6.2b Religious affiliation and number of immunisations taken

To adhere strictly to instruction, hospital authorities expect pregnant women to take at least three tetanus toxoid injection. Table 4.34 captures the respondents' religious affiliation and number of immunisations taken. Among the Christians, 84 (19.4%) took none, 151 (34.9%) took one, 153 (35.3%) took two, 45 (10.4%) took three. Among the Muslims, 6 (11.1%) took none, 16 (29.6%) took one, 30 (29.6%) took two, 2(3.8) took three. Among traditional religious worshippers, 1 (7.7%) took none, 6 (46.2%) took one, 6 (46.2%) took three. Only 48 (9.6%) completed minimum requirement of the immunisation while 91(18.2%) did not take any. There was significant relationship between religious affiliation and number of immunisation taken ($\chi^2 = 12.830$; df = 6; P< 0.05). NDHS (2003) reported that less than 50% of pregnant women took tetanus toxoid injections in Nigeria. Despite the great campaign in Ilesa on the radio, television and house-to-house campaign by community nurses on the need to immunize children, the result reveals that pregnant women did not learn from immunisation campaigns on children that they also needed to get immunized. The 18.2% that did not take immunisation is still high and there is need to continue the sensitization programme. The 2008 NDHS put Nigerian immunisation level at 64% in the South and 46% in the North.

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Some women augment their access to ANC with attendance in religious homes, while some depend solely on faith homes.

Table 4.34 Religious Affiliation and Number of Immunisation Taken

Religious affiliation	Number of immunisations taken				
	None	1 time	2 times	3 times	Total
Christianity	84 (19.4%)	151(34.9%)	153(35.3%)	45(10.4%)	**433 (100.0%)**
Islam	6 (11.1%)	16 (29.6%)	30 (55.6%)	2 (3.8%)	**54 (100.0%)**
Traditional Rel.	1 (7.7%)	6 (46.2%)	5 (38.5%)	1 (7.7%)	**13 (100.0%)**
Total	**91 18.2%)**	**173(34.6%)**	**188(37.6%)**	**48 (9.6%)**	**500 (100.0%)**
$X^2_{critical}$ **12.59 df 2 P 0.046**					

Source: Fieldwork, (2009)

4.6.3 Respondents' reasons for non-adherence to regimes

Table 4.35 reveals the respondents' reasons for not attending ANC; strike 1 (0.2%), engagement in other things, 117 (23.4%); no money, 9 (1.8%): religion, 131 (26.2%); and 133 (42.6%) forgot or had no reason. The table also presents the reasons for non-adherence of respondents to immunisation schedule. Two hundred and twenty (44.0%) of the respondents failed to adhere because of religious reasons; while 38 (7.6%) of the respondents did not because they forgot/had no reasons. The FBBAs asserted that to solve the problem of forgetfulness, they mandated husbands to remind their wives of when to come for the next prayer meeting. Strike actions were common in the Teaching Hospital. The respondents said that they had to register in other places to avoid being embarrassed on the days of delivery.

UNIVERSITY OF IBADAN

Table 4.35: Percentage Distribution of the Respondents' Reasons for Non-Adherence to Regimes

Reasons for Non adherence To	Strike	Engaged in other things	No money	Religious Belief	Forgot No reason	Total
ANC Attendance	1 (0.2%)	117 (23.4%)	9 (1.8%)	131 (26.2%)	133 (44.4%)	**301 (100%)**
To Drug	_	Do not like drug 45 (29.2%)	18 (11.8%)	42 (27.3%)	49 (31.8%)	**154 (100%)**
To immunisation regimes	_	_	_	220 (85.3%)	38 (14.7%)	**258 (100.0%)**

Source: Fieldwork, (2009)

4.6.4 Adherence to FANC attendance by marital status

It is expected that married women would be encouraged by their husbands to attend ANC more than the other categories of women. Table 4.36 shows that, among the singles 10 (15.4%), 20 (30.8%), 15 (23.1%) and 20 (30.8%) attended ANC once, twice, thrice, four and more times, respectively. Among the married, 69 (18.5%) attended once, 113 (30.3%) attended twice, 39 (10.5%) attended ANC thrice, 152 (40.7%) attended 4 times or more. Among the divorced/separated/widowed, 2 (28.6%) attended once, 4(36.4%) attended twice, 4 (36.4%) attended four or more times, while 1 (9.0%) went thrice. The table also shows that, there was no significant relationship between marital status and number of ANC attended (X^2 = 17.816; df = 20; P> 0.05). The result reveals that respondents of all categories attended FANC and that marital status did not affect attendance at ANC.

UNIVERSITY OF IBADAN

Table 4.36: Marital Status and Attendance at ANC

Marital Status	Number of Times ever Attended Ante-Natal Clinic				TOTAL
	1	2	3	4+	
Single	10 (15.4%)	20 (30.8%)	15 (23.1%)	20 (30.8%)	65 (100.0%)
Married	69 (18.5%)	113 (30.3%)	39 (10.5%)	152(40.7%)	373 (100.0%)
Co-habiting	5 (9.8%)	15 (29.4%)	8 (15.7%)	23 (45.1%)	51 (100.0%)
Divorced/ Separated/ Widow	2 (18.2%)	4 (36.4%)	1 (9.0%)	4 (36.4%)	11 (100.0%)
Total	**86 (17.2%)**	**152 (30.4%)**	**63 (12.6%)**	**199(39.89%)**	**500 (100%)**
X^2_{cal} 17.683 df 20 P 0.608					

Source: Fieldwork, (2009)

Attending ANC is not enough; it is imperative that pregnant women decide to deliver in hospitals. This is because a seemingly risk-free pregnancy can suddenly become risky at the point of delivery, needing experts' attention.

When the respondents were poor and could not afford delivery materials, they might result to mission houses for fear that they would be reprimanded in the hospitals. The respondents were aware that churches were given to charity and would come to their aid by providing for them when the couples had little or nothing prepared for delivery. Community nurses also asserted that women went to local government maternity centres without delivery materials and might be lucky to have leftovers from other pregnant women. The nurses reported that nylon bags were used as gloves for some women when they had no money for gloves.

Another factor that determines adherence to instruction is the problem of male preference. At one of the maternities, the caregiver mentioned cases of women who were abandoned by their husbands because all their previous deliveries had been girls, the

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women always believed that their current pregnancies would be boys. A gynaecologist mentioned similar cases of grand *multigravidals* who were advised to do permanent family planning to save their lives. They always refused because they believed that their next babies could be boys but, many times, the next pregnancies ended up being girls. They kept trying for baby boys to the detriment of their lives. This is in line with the claim of Isiugo-Abanihe (2003), that preference for male children encourage high fertility rate. Women are forced into having many pregnancies so as to have male children who would secure their inheritance at the demise of their husbands.

Generally, the respondents reported that they did not deliver by themselves at home. When this happened, the babies were usually wrapped and taken to the maternity, hospital or mission for care of the umbilical cord.

UNIVERSITY OF IBADAN

Figure 3: ANC Attendance at a Private Hospital

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Most faith caregivers instructed pregnant women to take all the necessary immunisation, precautions, and then pray; and that their prayers would be answered. An FBBA said the conclusion was "listen to instructions, accept what you are told and act on it" (IDI, Female, Faith Home Ilesa East, Oct. 2009).

FANC new schedule requires that pregnant women make their first visit at the end of 16 weeks, a second visit between 24-28 weeks, the third at 32 weeks and the fourth at 36 weeks. However, women who stand the danger of being exposed to risks are expected to pay additional visits (2008 NDHS). It is one thing to register in faith home or hospital; it is another thing to attend regularly. To ensure regular attendance, FBBAs kept registers of attendance to detect those who were irregular so as to know whether or not to take their deliveries. Most of the FBBAs commented that they did not accept to take deliveries of women who had not been coming to them for prayers as well as those who refused to adhere to instructions.

4.6.5 Influence of religious affiliation on places respondents attended for pregnancy care

Table4. 37 reveals that 255 (82.5%) Christians; 48 (15.5%) Muslims; 6 (1.9%) ATR members attended ANC in hospitals alone; while 113 (94.2%) Christians, 3 (2.5%) Muslims and 6 (1.9%) ATR members attended FBBHs alone for pregnancy care. However, 6 (1.9%) Christians; 3 (4.5%) Muslims and 3 (4.5%) ATR members combined church and hospital care-providers. The result showed that most of the respondents patronized hospitals and FBBHs for their pregnancy care. However, the majority of Muslims delivered in hospitals. NDHS (2003) notes that, the proportion of births attended by TBAs in North East, North West and North Central Nigeria, which in the northeast, which is predominantly Muslims, is far greater than that in the other geographical zones.

UNIVERSITY OF IBADAN

Table 4.37: Influence of Religious Affiliation and Places Respondents attended for Pregnancy care

Places attended for Pregnancy care	Religious Affiliation			Total
	Christianity	Islam	ATR	
Hospital	255 (82.5%)	48 (15.5%)	6 (1.9%)	**309 (100%)**
Mission/FBBHs	113 (94.2%)	3 (2.5%)	4 (3.3%)	**120 (100%)**
Church& Hospital	61 (91.0%)	3 (4.5%)	3 (4.5%)	**67 (100%)**
Pham. /drug store	4 (100%)	-	-	**4(100%)**
Total	**433 (86.6%)**	**54 (10.8%)**	**13 (100%)**	**500 (100%)**

Source: Fieldwork, (2009)

4.6.6 Adherence to FANC attendance by number of pregnancy

Table 4.38 reveals that of all categories of respondents, 106 (77.4%) prim attend antenatal clinics' followed by multigravidals 79 (50%) and grand multigravidals 2 (28.6%) at the early months. There is a significant relationship between number of pregnancy and early attendance of ANC. Most of all, primigravidals attend ANC most regularly. This may be because of fears and inexperience. They want to take precaution while grand multigravidals might take things for granted because of their past experiences. In actual fact, grand multigravidals are supposed to take extra precaution because of the health hazards of high parity.

Table 4.38: Number of Pregnancy and Antenatal Attendance

Age of pregnancy at first ANC	Number of pregnancy			Total
	Prim	Multigravidals	Grand mult.	
1-3 months	106(77.4%)	79 (50.0%)	2(28.6%)	187(61.9%)
4-6 months	26 (19.0%)	72 (45.6%)	5(71.4%)	103(34. %)
7-9 months	5 (3.6%)	7 (4.4%)	0 (0.0%)	12 (4.0%)
Total	137 (100%)	158 (100%)	7 (100%)	302 (100%)
X^2_{cal} 28.703 df 4 P 0.000				

Source: Fieldwork, (2009)

UNIVERSITY OF IBADAN

4.6.7 Influence of denominations on places Christians patronized for pregnancy care

Table 4.39 reveals places where different Christian denominations patronized for pregnancy care. The table reveals that 19 (7.0%) of Catholics; 69 (25.5%) of Protestants; 179 (66.1%) of Pentecostals and 4 (1.5%) of Jehovah Witnesses attended Government hospitals. Fourteen (13.6%) of Catholics; 12 (11.7%) of Protestants; 74 (71.8%) of Pentecostals 3 (2.9%) of Jehovah Witnesses attended FBBHs for pregnancy care. The following combined FBBHs and hospitals: Catholics 5 (8.9%); Protestants 5 (8.9%); Pentecostals 45 (80.4%) and Jehovah Witnesses 1 (1.8%). The results reveal that 271 (62.6%) of Christians patronized orthodox caregivers for ANC; 103 (23.8%) patronized FBBHs alone while 56 (12.9%) of Christians combined hospitals and FBBHs. The result shows that almost two thirds of Christians patronized orthodox care-providers for ANC. NDHS, (2003) reports that more pregnant women in Southwest patronized orthodox caregivers and that TBAS are more patronized in Northeast, Northwest and North Central than in other geo- political zones. NDHS, (2003) reveals further that 62.7% of pregnant women in the South received two or more tetanus toxoid.

Table 4.39: Influence of denominations on places Christians patronized for pregnancy care

Places of attended for Pregnancy care	Denominations				
	Catholics	Protestant	Pentecostals	Jehovah Witnesses	Total
Govt. Hosp.	19 (7.0)	69 (25.5)	179 (66.1)	4 (1.5)	271 (100)
Mission/FBBHs	14 (13.6)	12 (11.7)	74 (71.8)	3 (2.9)	103 (100)
Church& Hosp.	5 (8.9)	5 (8.9)	45 (80.4)	1 (1.8)	56 (100)
Pharm./drug store	-	2 (66.7)	1 (33.3)	-	3 (100)
Total	38 (8.8)	88 (20.3)	299 (69.1)	8 (1.8)	433 (100)

Source: Fieldwork, (2009).

4.6.8 Adherence to food, sleep and exercise regimes among women during pregnancy

To be healthy, all human need adequate intake of all categories of food; this is particularly important for the pregnant woman. She has to take enough for herself and the baby. Three hundred and forty-eight (69.6%) of the respondents took fruits daily;

UNIVERSITY OF IBADAN

104 (20.8%) took fruits weekly, and 39 (7.8%) seldom took fruits. For healthy living, daily consumption of all categories of food in adequate quantities is also essential. The respondents were requested to state the type of food and fruits they ate in the last two days. Those who indicated that they ate fruits and vegetables daily were categorized as having taken balanced meal, while those who did not take fruits were classified as having taken unbalanced meal. Four hundred and fifty-six (90.4%) indicated they ate balanced diet, while 46 (9.2%) did not. This, however, was different from what qualitative data reported. The IDIs revealed that many women wanted to appear gorgeous on the day of christening their babies. Instead of using their money for good food, they saved it to buy clothes that they would exchange for "show off" at their children's christening. In their health talks, FBBAs tried to discourage this tradition and encourage women to use such money for good food to avoid complicated deliveries. They were told that their children should be seen as their clothes.

Table 4.40 presents women's adherence to sleep, food and exercise prescriptions. Among the respondents, 52 (10.4%) slept only for 4 hours a day; 93 (18.6%) slept for 5 hours a day; and 355 (71.0%) slept for 6 or more hours a day. A pregnant woman needs a lot of rest and at least six hours of sound sleep to be healthy and carry the baby through. Lack of sound sleep can predispose her to hypertension and some pregnancy-related complications. Pregnant women need daily consumption of adequate quality food, especially protein, fruits, and vegetables to produce healthy babies. The researcher grouped women as having eaten balanced diet if they indicated that they ate fruits and vegetables daily. A lack of adequate consumption of these categories of food may result in food deficiencies that may result in pregnancy complications. To prevent complications, caregivers instructed pregnant women to take fresh fruits. The respondents were also instructed to eat fruits so that their babies' bodies would be neat and healthy. This is possible because Ilesa is blessed with different types of fruits and vegetables that are available all year round; therefore they are easy to come by.

To be healthy, daily exercise is necessary for adequate function of the heart. The respondents identified the type of exercises they did; 15 (3.0%) did none; 173 (34.6%) did some trekking, 195 (39.0%) did house work, while 117 (23.4%) drew water from the wells. The respondents were instructed in ANC and faith clinics to avoid strenuous

UNIVERSITY OF IBADAN

work. The FBBAs also instructed husbands to assist their wives in drawing water from the well. This could have accounted for the low number of women that drew water from the well.

The respondents were instructed to do some exercises like trekking to keep them strong and active. This is essential to make them strong and energetic during labour. However, itinerant hawking of wares from street to street that would subject pregnant women to kilometres of trekking was discouraged. This was perceived to be capable of exposing them to too many prying eyes, some of which could be evil. Pregnant women who were traders were encouraged to sell their wares in the same place with little exercise. All caregivers discouraged rigorous sexual activities during the first trimester of pregnancy to avoid miscarriage; but they instructed the pregnant women to allow their husbands to have access to them so that there would be no misunderstanding at home. *Primigravidals* were instructed to have sex regularly with their husbands to allow for easy passage of the baby at delivery.

Table 4.40 Adherence to Sleep and Food Regimes

Adherence to Regimes		**Number of Respondents**	**Percenta-ges**	**Df**	**Chi Square**	**Sig.**
Hours of Sleep	< 4 hours	52	10.4	1	399.809	.000
	5 hours	93	18.6			
	6 hours	355	71.0			
Quality of Food	Balanced Diet	456	90.4			
	Unbalanced Diet	46	9.2			
Fruits in take	Daily 348 (69.6%)	Weekly 104 (20.8%)	Seldom 39 (7.8%)	Don't like Fruits 9 (1.8%)		
Types of exercise	None 15 (3.0%)	Trekking 173 (34.6%)	House work 195 (39.0%)	Drew water 117 (23.4%)		

Source: Fieldwork, (2009)

UNIVERSITY OF IBADAN

An FBBA instructed pregnant women to take plenty of unpolished grains. Nutritionists have found this to be helpful to encourage bowel movement. Health talks in hospitals were similar to those in faith homes (although food proscription is not common in hospitals). Faith homes discourage pregnant women from eating plantain to avoid stomach upset and congenital skull deformities. Plantain contains a lot of calcium, iron and vitamins. This instruction could lead to iron deficiency, causing the woman to become anaemic if she cannot get alternative source of these nutrients. Wahab (2004) and Erinosho (2006) observe that banana, mango, gizzard, fish, egg, melon soup, antelope, grasscutters were proscribed for pregnant women in some societies. Both groups of caregivers prescribed taking a lot of water, protein, fruits, and vegetables for mothers and proscribed excessive carbohydrate that might lead to excessive weight gain which might precipitate pregnancy-induced hypertension.

The respondents that had swollen legs and bodies were discouraged from taking salt. Some caregivers instructed the respondents to eat melon, green vegetables, eggs, *moinmoin* and leguminous products. They were instructed to eat this food while pregnant and not keep them until after delivery. Traditionally, pregnant women keep melon soup and other attractive food till after delivery. The FBBAs said they discouraged over-eating or eating of fried food to avoid diarrhoea and prevent premature labour. Both groups of caregivers encouraged pregnant women to eat their breakfast on time. All caregivers advised pregnant women on absolute cleanliness in food preparation to avoid diseases and consumption of artificial spices. This advice is perceived to reduce complications in pregnancy and deliveries. They were instructed that their older children should eat well to avoid sickness and being hospitalized. Strict adherence to this will make them avoid unnecessary spending and the trouble of being hospitalized. When pregnant women adhere to all instructions, they still need adequate care throughout the duration of pregnancy because complications can occur at any point without warning.

As much as respondents would want to adhere to instructions from ANC or prayer houses, marital disunity was reported to be one of the reasons of non adherence to hospital regimes. A health officer noted that they had to take delivery of a woman with a nylon bag. The woman said she bought everything with her money and kept them with her mother, hoping that the husband would give her money but he did not. When

UNIVERSITY OF IBADAN

she fell into labour, she could not get to her mother to collect the materials. This illustrates role separation in the area. Even where women were capable of paying, they still expected their husbands to pay.

Many of the religious houses encouraged the pregnant women to go to the hospital for care, especially scanning and blood test. This encouraged the respondents to combine orthodox and religious houses. Some FBBAs employed nurses to assist them in taking delivery, especially if they envisaged complications; but a few of the FBBAs discovered that the nurses cheated them to make quick money. An FBBA lamented that she employed a nurse and was paying her from the altar to assist to palpate, administer drug, do blood test, scan, as well as assist her when she had many deliveries to take simultaneously. Unknown to the FBBA, the nurse had her own clinic and secretly, gave her phone numbers to direct pregnant women there.

4.6.9 Adherence to drug administration

Pregnant women are required to take routine drugs to prevent malaria and anaemia and to supplement their food intake to ensure they have enough vitality to cope with the stress of pregnancy, labour and delivery. The respondents were requested to state whether they got the drugs and took them. Table 4.41 reveals that 321 (64.2%) of them were given drugs, while 179 (35.8%) were not given. Among women that were given, 222 (69.2%) claimed they took the drugs as prescribed, while 99 (30.8%) did not. Those who got drugs but did not utilize them were not better than those who did not collect the drugs at all, if they were not worse, because the drugs would have been useful to some other people.

Table 4.41: Drug Administration and Utilization

Adherence to Drug	Yes	No	Total
Drugs Administered	321(64.2%)	179 (35.8%)	**500 (100%)**
Drugs Taken as prescribed	222 (69.2 %)	99 (30.8%)	**321 (100%)**

Source: Fieldwork, (2009)

UNIVERSITY OF IBADAN

The qualitative data also revealed that some respondents did not adhere to drug use. Some husbands noted that they reminded their wives to take their drugs and they did but a particular husband said his wife was an adult and should take her drugs without being guided. He, however, reported that there were lots of un-used drugs in their house. The cooperation of husbands, pregnant women and mothers-in-law and significant others is necessary to reduce non-adherence to drug use and, by extension, pregnancy complications. Drugs, immunisation and other tests should be adhered to. The quantitative data also supported this claim, as some of the respondents claimed that they did not utilize drugs given to them because they did not like taking drugs. When drugs are not taken as prescribed, they cannot be effective and may even be counter-productive.

Table 4.42 reveals that among the respondents, adherence to drug varied according to the number of pregnancy ever had. The study showed that 184 (88.9%) primigravidals, 152 (73.4%) multigravidals, and 3 (66.7%) grand multigravidals received drugs; while 178 (85.2%) primigravidals, 149 (68.7%) multigravidals; and 3 (42.9%) grand multigravidals adhered to drug prescription. There was a significant relationship between number of pregnancy and drug utilization. This could be because the primigravidals lacked experience and were not willing to leave things to chances, while the grand multigravidals might be over-confident owing to their past experiences. However, the grand multigravidals were ranked as having high-risk pregnancies in the literature and they are supposed to take precautions and adhere strictly to prescription. This study showed a significant relationship between number of children and adherence to drug prescription.

UNIVERSITY OF IBADAN

Table 4.42: Adherence to drug prescription and number of Pregnancies

Adherence to drug administration	Number of Pregnancies			Total
	Prim	Multigravidals	Grand multigravidals	
Drug Administered	184 (88.9%)	152 (73.4%)	4 (66.7%)	340(100%)
Drug utilized	178 (85.2%)	149 (68.7%)	3 (42.9%)	330 (100%)
X^2_{cal} 22.210 df 2 P 0.000				

Source: Fieldwork, (2009)

Health talk also included avoidance of drugs that were not prescribed and local concoction. The respondents were instructed not to drink alcohol. Orthodox health caregivers reported that wives to o*kada* (commercial bike) riders reported that their husbands gave them malaria and piles concoction that were made with alcohol. The women were advised not to take such. The respondents that refused to adhere to FBBAs instruction were referred to hospitals.

The qualitative data revealed that packed cell volume (PCV) and HIV tests were mandatory for all pregnant women; but some caregivers did not adhere strictly to this because of fear that they might contract HIV. According to one hospital caregiver:

> The less you puncture other people, the less the risk of exposures to their blood the less the risk of contracting the disease (Female, Private Maternity, Ilesa East, Sept 2009).

Retroactive or HIV/AID tests are compulsory in government hospitals and caregivers in such hospitals sometimes refused women who did not submit to the test because their HIV status was unknown and they might be at health risk. The most patronized private maternity centre in Ilesa did not do retroactive blood test. When the researcher asked the owner why she did not do the test, she said: "It will be adding other financial burden to

UNIVERSITY OF IBADAN

already impoverished women" (IDI, Female, Private, Maternity, Ilesa West, Oct. 2009). This revealed the ignorance of this caregiver too. She was not aware that the test was free. Some caregivers insinuated that high patronage of this maternity was because no premium was laid on HIV test there. The respondents were scared about the test.

Other instructions given at the FBBHs were that pregnant women should not bend over so that their babies would not have hiccups. This actually prevents falls. Respondents were instructed to take care of their bodies and environments.

Some orthodox caregivers complained that pregnant women did not adhere to instructions on maintaining their normal skin texture. They bleached and, when they had complications that needed surgery, suturing became difficult.

4.7 Men's roles in caring for the health of pregnant women

In every patriarchal society, men play significant roles in their families. Men are perceived as responsible when they are financially sound and could procure all or most of the materials for delivery and afford other bills related to taking care of their families. They are expected to take care of their pregnant wives by rendering different services to assist their wives. The researcher sought to identify the roles men play in pregnancy care. In ANC and prayer meetings, women were instructed to show their attendance cards with list of delivery materials to their husbands/partners so that they could help them pay and remind them of next appointment at ANC or FBBH as well as encourage them to adhere to instruction given.

4.7.1: Men's roles in pregnancy care

Table 4.43 indicates that 309 (61.8%) of the husbands paid for maternity materials; 102 (20.4%) wives paid, while 67 (13.4%) jointly paid. One husband in an IDI said proudly: "I paid for everything. I am the owner of my child" (Male, husband, Ilesa West Oct. 2009). However, three of the husbands reported that they did joint purse and the payment was from that purse. These husbands asserted that they jointly chose OAUTH for care giving. Those who claimed that they paid everything noted that they

UNIVERSITY OF IBADAN

single-handedly recommended caregivers for their wives. Two husbands averred that they allowed their wives to choose care providers for themselves because they knew how their bodies felt and who best could help them. A health officer also affirmed that "many husbands paid for their wives maternal care though they may rain curses on the wives". It was possible for women to pay because they also had their own sources of income distinct from those of their husbands. Many women were traders and were economically independent. Women that depended solely on their husbands were regarded as lazy. '*Ole a ji woo* video' (Lazy woman that wakes up early to watch films). Jegede (2010) observes that Yoruba women engage in economic functions, such as trading, and they have absolute control over their income. Only a few turn their income to their husbands and these do so in a situation where there are no competing co-wives.

Parents or in-laws paid for 11 (2.2%) teenagers whose partners probably denied the paternity of the babies or absconded. Eleven (2.2%) of the respondents reported their bills were paid by the church. In these days of a shift from extended to nuclear family system, many people find solace and comfort in their religious groups in time of crisis rather than in extended family ties. One interviewee confirmed this:

> I find that members of my church are closer to me than my blood relations because these are the people I see around me in times of crises (Female, Pregnant woman, Oct. 2009).

In every facet of life, choices are made and the choices we make determine our destiny. Some choices we made many years ago determined where we now find ourselves. Women are required to take decisions concerning childbearing. The pregnant woman's preferences will reflect the kind of decision she makes. These preferences are reflected in the places she patronizes for care of her pregnancy and these would also influence where she delivers present and future pregnancies. The choices she made of care providers may make or mar her pregnancies. This decision can be a herculean task, depending on the nature of her husband. In most instances, the man takes this crucial decision for her. Table 4.43 presents the decision-making patterns of the respondents: 140 (31.6%) husbands single-handedly decided on the number of children they were to have in the family; 90 (18.0%) wives decided on the number of children; 90 (18.0%) of the

UNIVERSITY OF IBADAN

respondents decided jointly 100 (20.0%) of them claimed that God decided; while 21 (4.2%) cases were unplanned. In about 25% of the deliveries, there were no concrete plans on family planning. They did not use family planning devices and hoped God would plan their families for them.

Table 4.43 equally reveals that 251 (50.2%) of the husbands chose health caregivers for their wives; 164 (32.8%) of the respondents chose for themselves; 51 (10.2%) were joint; in laws decided 23 (4.6%); friends (other pregnant women) invited 10 (2.0%); while cost determined only 1 (0.2%). This upholds the view expressed in earlier studies, that husbands were major decision makers in their wives' health-seeking behaviour (Kisekka et al. 1992; Ekwenpu, 1990). The literature reveals that men are the most influential decision makers in patriarchal societies. Cost was played down because the women could go to FBBAs where they did not necessarily have to pay.

Table 4.43: Percentage Distribution of Husbands' roles and Decision-Making Patterns

Roles in pregnancy care	**Who Takes Decisions?**							
	Husbands	**Wife**	**Jointly**	**In laws**	**God**	**Mission**	**Unplann-ed**	**Total**
Payment of Maternity material	309 (61.8%)	102 (20.4%)	67 (13.4%)	11 (2.2%)	-	11 (2.2%)	-	500 (100%)
Number of children	140 (31.6%)	90 (18.0%)	90 (18.0%)	59 (11.8%)	100 (20.0%)	-	21 (4.2%)	**500 (100%)**
Who chose Care giver	251 (50.2%)	164 (32.8%)	51 (10.2%)	23 (4.6%)	Friends 10 (2.0%)		Cost 1 (0.2%)	**500 (100%)**

Source: Fieldwork, (2009)

UNIVERSITY OF IBADAN

4.7.2 Influence of the respondents' marital status on payment for delivery materials

Table 4.44 shows the marital status of the respondents and payment for delivery materials; 35 (11.3%) single; 239 (77.3%) married; 30 (9.7%) cohabiting; 5 (1.4%) divorced / separated had their husbands/partners paid for delivery materials; 21 (20.6%) single; 73 (71.6%) married; 6 (5.9%) cohabiting; 2 (2.0%) divorced / separated and the only widow paid for themselves. Ilesa, the study area is a patriarchy society and there is role segregation in pregnancy care. While the woman is expected to bear the burden of carrying the pregnancy, the male partner is expected to pay for delivery materials and buy food and drugs. Any man who is unable to do this is regarded as *oku guro* or *oku aaye* meaning a standing corpse or the dead among the living. A widow of course bears her own burden and pays her bills.

Table 4.44: Influence of the Respondents' Marital Status on Payment for Delivery Materials

Payment for Delivery material	**Marital Status**					**Total**
	Single	**Married**	**Cohabiting**	**Divorced/ Separated**	**Widow**	
Husband/ **Partner**	35 (11.3%)	239 (77.3%)	30 (9.7%)	5 (1.4%)	-	**309 (100%)**
Self	21(20.6%)	73 (71.6%)	6 (5.9%)	2 (2.0%)	1 (1.0%)	**102 (100%)**
Jointly	6 (9.0%)	46 (68.7%)	12(17.9%)	2 (3.0%)	-	**67 (100%)**
In-laws	3 (27.3%)	8 (72.7%)	-	-	-	**11 (100%)**
Church	-	7 (63.6%)	3 (27.3%)	1 (9.1%)	-	**11 (100%)**
Total	65(13.0%)	373 (74.6%)	51 (10.2%)	10(2.0%)	1 (0.2%)	**500 (100%)**

Source: Fieldwork, (2009)

UNIVERSITY OF IBADAN

It is one thing to pay the bills; it is another to provide things that money cannot buy. Wives were required to state other things outside payment of bills that their husbands did. The result shows that 189 (37.8%) husbands did house work; 170 (34.0%) fetched water only; 32 (6.4%) gave money only; and 109 (21.8%) of their husbands did not care and did nothing to assist their wives in pregnancy. Thomas *et al*. (n.d) also found that only 27.3% sampled women claimed that their husbands helped them in household chores. They found that men played very limited role in supporting their wives in major reproductive events.

Some husbands also reported that they only gave money to their wives. They could not do household work, though they might assist their wives to draw water from the well whenever they were around. Drawing water from the well is a great assistance for pregnant women because there was no pipe-borne water in Ilesa and it could be quite stressful for pregnant women to draw water from wells that could be as deep as 40- 60 feet. Most husbands claimed that they gave money for delivery materials; bought food as well as encouraged their wives to take their routine drugs. Only two husbands mentioned that they took their wives to clinic on ANC days. The others said they waited for their wives to return and give report of the instructions given them at the clinic. A husband asserted that:

> 'To help my wife, I took my wife and children to clinic for immunisation. I used to be the only man among so many women but I was not ashamed because they are my children and I love them dearly. I followed my wife to hospital and stayed till she delivers. I left all my work because I love my wife but I cannot stand to witness labour real life. The pain would be too much for me to bear' (Male, husband, Ilesa West Oct. 2009).

All husbands, irrespective of their religious affiliation claimed they prayed intensively during the deliveries of their wives. Many of them reported that they wept when they heard cries of agony of their wives in the delivery rooms. A husband had this to say:

> When she started labour at home, when she stretched, I stretched, when she twisted I did the same. I was doing what she was doing until we got to the hospital I could not stand my wife to deliver in my

UNIVERSITY OF IBADAN

> presence, I may spoil things. I may misbehave (Male, husband, Ilesa West Oct. 2009).

In the qualitative study, some husbands claimed that they cooked, swept, washed fetched water and did household work when their wives were pregnant; while others claimed they brought in helpers, church members or instructed their older children to help their wives. Another husband allowed the wife's younger sister to stay with them to perform house work because he could not assist his wife. A husband reported that he could not do any house work but he did not complain about any food she prepared:

> I can't cook but I don't make any food demand. I eat whatever she cooks without asking for special type of food (Male, husband, Ilesa East Oct. 2009).

Another husband said:

> During the first trimester of pregnancy, my wife always had morning sickness. She would be feverish and vomit I helped her to bring water to wash her mouth and sprinkle it on her face. I encouraged her that she would soon overcome and talked to her to relax' (Male, Husband, Ilesa East, Nov. 2009).

Two husbands reported that their wives requested for strange uncommon food items during pregnancy and they searched and got them. One said:

> My wife could not eat well; she told me she wanted crabs soup. I did not know where to get crabs from. I started searching for fishermen. Fortunately, I met some boys who had some fresh fish to sell. I requested that they get me crabs and they had two. I took them to her and she was happy. She only took the stew and not the crab (Male, husband, Ilesa West Oct. 2009).

Another said:

> My wife wanted roasted groundnut and *ekuru* (beans pudding). I got her some groundnuts but she insisted it must be the type that Nupes (an ethnic in Nigeria that specialises in roasting groundnuts for sale) make. I looked for it but could not get. I had to persuade her to manage the type I got (Male, husband, Ilesa East Oct. 2009).

UNIVERSITY OF IBADAN

Another husband also claimed that:

> Whenever my wife is pregnant, she suffers from muscle pull at night. She wakes me up and I help her to stretch and massage the affected leg(s). Sometimes both of us do not sleep until day break (Male, husband, Ilesa West Oct. 2009).

All husbands affirmed that their wives gave them reports from ANC or FBBH. Their wives reported that they were instructed to take vegetables and fruits. They all claimed that their wives told then they should not drink Milo, Bournvita and milk to avoid big babies.

A husband also averred that:

> When my wife was in early stage of pregnancy, she could not eat well so I fed her and we ate together to ensure she took her food. Whenever, she was sick I called doctor or took her for consultation (Male, husband, Ilesa East Oct. 2009).

Another husband argued that:

> In the early stage of the pregnancy my wife spit saliva. I didn't like her to spit everywhere so I controlled it to one place. I encouraged her to do some exercises and not sleep all the time (Male, husband, Ilesa West Oct. 2009).

All husbands, irrespective of their religions, claimed that they prayed intensively during pregnancy and deliveries of their wives. Many of them said they wept when they heard cries of agonies of their wives in the delivery rooms. Some husbands said they went to mountain tops to pray for successful pregnancy and delivery. A Muslim husband reported that he made special prayers from the Qur'an into water for the wife to drink for safe delivery. According to him;

> There are special Qur'anic passages that I read into water to give my wife and I also did it for my friend's wife who was having difficulty in delivery. She was to be operated when the husband came to me. I made special prayer for her and she delivered without operation. Whenever my wife was pregnant, I prayed for safe delivery on money and give to the blind and beggars as *zaka* (Male, husband, Ilesa West Oct. 2009).

UNIVERSITY OF IBADAN

This he believed would make God have mercy upon her during delivery.

4.7.3 Husband's roles at delivery

Table 4.45 reveals that 247 *(*54.*8*%) of the husbands went with their wives to the places where their deliveries were taken and 269 (53.8%) stayed until their wives were delivered. This is similar to the findings of Thomas *et al*. (n.d) in Bangladesh that 54.8% of the women reported that their husbands accompanied them during pregnancy and check-ups and 63.6% claimed that their husbands gave them money for medicine.

Table 4.45: Percentage Distribution of Husband's Roles at Delivery

Husband went with wife to place of delivery	Yes	No
	274 (54.8)	226 (45.2)
Husband stayed with wife	269 (53.8)	231 (46.2)

Source: Fieldwork, (2009)

During the interview, most of the husbands claimed that they followed their wives to the place of delivery and stayed until they could hear the voices of mothers and babies.

In faith homes, husbands were not allowed to stay with their wives during delivery. They were usually sent to the church auditorium to pray but they must stay until their wives' deliveries had been taken. Those who were not around were called on cell phones.

Health care providers said that they did not allow husbands who wished to witness their wives' delivery to stay, because other women could be in labour at the same time and women could open up themselves and it would not be proper for a husband to be gazing at the nakedness of other women. This is at variance with happenings in developed nations where men are allowed to be with their wives during delivery. Another caregiver said that their clinic was isolated and some husbands might be problematic and harass the nurses sexually, especially at night. Sometimes ago, there were reports from

UNIVERSITY OF IBADAN

Lagos University Teaching Hospital (LUTH) that men harass nurses and female doctors sexually at night. At another maternity centre, husbands that came with their wives to deliver at night were kept with the night guards while some went to their homes to take care of older children. Others left their wives and their phone numbers to be called after their wives had put to bed. Some husbands ran away only to return whenever they were called because they could not stand birth pangs and the sight of blood or other body fluids.

All husbands asserted that their wives could not attend any caregiver without their permission. In fact, all claimed that their wives had to inform them weeks or days ahead of their intention to attend ANC or prayer meetings. Even when they travelled, the wives should inform them on phone. The husbands affirmed that their wives gave them feedback on ANC attendance; and that they bought drugs, food, fruits, vegetables, meat and fish for their wives during pregnancy because they believed that, if any problem arose during delivery, they were the ones to suffer. One of the husbands claimed that the parents of his wife also helped to buy fruits and vegetables. Most husbands said that they encouraged their wives to adhere to all instructions given by the caregivers. Most of the husbands interviewed said they reminded and encouraged their wives to attend ANC and to take their routine drugs.

A husband said:

> My wife did not like drugs so I brought water for her and encouraged her to take the drugs because if there was problem I would be in trouble (IDI, Husband, Ilesa West, Nov. 2009).

Another husband had this to say:

> As for me, I think my wife is an adult. If she is told to use drug for her health, I expect her to take it. She is not a child. However, there are lots of unused tablets at home which she did not take and she throws them away. Since she delivers safely I don't have problems (IDI, Husband, Ilesa West, Nov. 2009).

One of them said:

> I check her card so that I can remind her of next clinic day and prayer appointments; (IDI, Husband, Ilesa East, Nov. 2009).

UNIVERSITY OF IBADAN

Another husband averred that:

> Whenever any of the old children was sick I gave her money to take him/her to hospital and I carried the child to give the drugs prescribed. In this pregnancy, I reminded her to adhere to hospital regimes. I bought fruits for her and gave her money to buy some. I followed her to hospital during labour and whenever they sent me to go and buy something I did. I prayed a lot during her labour until she delivered. I was with her during the birth of the first child but during the second I was not given the chance though I loved to be there (IDI, Husband, Ilesa East, Nov. 2009).

While a husband was concerned about the welfare of his wife another husband (when the researcher was collecting secondary data at the OAUTH) was calling his wife who was in labour and shouting on cell phone saying: "Stop shouting now; are you the only one in labour in the whole hospital?" (Husband, Ilesa East, Nov. 2009). When the nurses told him to go and purchase more gloves he told them that he was not going anywhere; he said the nurses should know the number of gloves they needed for one delivery and should have told him to buy them at once; and that they should stop ordering him around. The next thing he did was to call the wife's elder brother to come and stay. The wife's elder brother came and continued the running around. These are individual differences, similar to the findings of Centre for Research, Evaluation Resources and Development (1999), which revealed that some men wanted their wives only for sex and care less after.

Another husband said he preferred his wife to go to government hospital because of adequate medical attention. No husband mentioned that he absconded on day of delivery or did not buy delivery materials. It seems that men accepted to cater for the wives' pregnancies but when they were unable they felt guilty.

Isiugo-Abanihe (2003) claims that the women sampled indicated that male partners should be actively engaged in the pregnancy, antenatal, and provision of adequate financial support for their wives. Research on promoting male responsibilities for gender equality from Bangladesh, India and Vietnam revealed that men were reluctant to play any significant role in reproductive health, child care, or household work; believing that their roles are mainly income-generation and social relations. The result from India revealed that men played limited role in reproductive issues and were more

UNIVERSITY OF IBADAN

likely than women to spend their money on themselves rather than the family members (Thomas *et al*., n.d). However, more recent study in Jammu and Kashmir in India revealed that men are willing to be involved in pregnancy care.

To buttress the important role which men play in reproduction, faith homes did not take deliveries that were not supported by husbands. Many faith homes did not take delivery for teenagers because "they have no root" that is, they were not married. There were no husbands to stand in for them. If there were complications, the FBBAs might be in trouble. However, where the teenager had no alternative, her parent would be made to sign an undertaking that they would make no trouble if any complication occurred. FBBAs' rejection of teenage pregnancy is a blessing in disguise because researches have shown that teenagers are prone to high-risk pregnancy complications. So, if they were rejected in faith homes, they might be forced to go to hospital where they would receive adequate care. Hospitals do not reject any pregnant woman on the grounds of marital status. As a matter of policy, FBBAs reported that husbands must give their consent before their wives could be allowed to attend prayers and deliver. Some faith homes insisted that husbands must bring their wives and register their phone numbers on the first day of visit. Husbands must append their signatures to the registration card and visit the FBBAs at least 4-5 times during pregnancy to assure the FBBAs of their support. If any complication arises on the day of delivery, the husband decides where next the wife should be referred.

Whenever a woman did not come for prayers on any of the meeting days, FBBAs called the husband to enquire why she was not there. The pregnant woman would also be called to find out why she was not at the prayer meeting. This strategy kept the women coming regularly. Hospitals do not have this strategy.

Where husbands proved to be irresponsible, and did not take care of their pregnant wives, some FBBAs devised methods of making them responsible. The FBBAs advised the women to give in sexually to their husbands so that they would be happy and supply their needs. They believed this would make the birth passage open up early for delivery. A faith caregiver said that, if she discovered that some husbands showed signs of irresponsibility because of ill behaviour of their wives.

UNIVERSITY OF IBADAN

> I advise the wives to be of good behaviour and admonished the husbands to endure with their wives (Female, Ilesa East, Oct. 2009).

The FBBAs invited the husbands individually if they noticed any irregularity in the wives' health. They advised such husbands to make their wives happy to avoid high blood pressure and provide balanced diet to avoid anaemia and blood transfusion that may predispose the women to being transfused with HIV-infected blood. Husbands usually dreaded the disease and took care of their wives. A particular FBBA said she told the husbands to surprise their wives with gifts and sweet words.

However, when any husband persisted and refused to take responsibilities for his wife, one of the FBBAs told the wife to fake illness, faint and pretend she was about to give up. The neighbours would be afraid and rush her to the church for prayer and care. The FBBA would call the husband to come urgently to the mission. The woman would be in the room for bed rest. When he arrived, the FBBA would demand for some money enough to do all tests and buy things urgently needed by the wife, which the husband usually provided in his panicky state. The FBBA said they might or might not do any test. She also ensured that the man went to buy milk and other food items. The FBBA would then give the money to the woman when the husband had left. Such husbands were warned not to allow their wives' health to deteriorate to warrant referral to OAUTH where they would have to pay more than ₦50,000 naira for CS. No husband wanted CS, so they always adhered. This FBBA said in situations where she was forced to use this strategy, it really worked.

Another FBBA gave her strategy of dealing with irresponsible husbands and relations. Whenever they brought any woman for delivery and she perceived that the woman had not been taken care of, she would tell them:

> For this delivery you are going to give me five tubers of yam, five measures of rice and beans, one gallon of kerosene and palm oil, large dried fish, pepper and melon. Before I finish with your wife let them be ready. The men usually looked for and got them (Female, Faith Care Provider, Ilesa West, Sept. 2009).

UNIVERSITY OF IBADAN

The FBBA said she kept the women after delivery for some days cooking the food items for them to make sure they recuperated well and whenever they were going back to their houses, she packed the remaining food items for them. These methods were not exploited by orthodox medical practitioners. These methods would only solve immediate problems. How long will the money or food items last? The best method is to make husbands see reasons for continuous care of their wives and encourage them to spend their money on their families. Fatubarin (2008) avers that Ijesa men who go to university to study Business or Economics have gone to do higher degrees because they already naturally had a Bachelor's degree from their upbringing. By training and upbringing, the Ijesa are scrupulous in spending money. They sometimes transfer this to their home management.

However, there were times when husbands would refuse to show up when they were sent for. A midwife mentioned a case of a pregnant woman who underwent a CS and was advised not to be pregnant again. She became pregnant again and when she had complications, the husband abandoned her and went to marry another person. A woman reported an incident of a woman who quarrelled with her husband so that he could take responsibility at home. The friend of the husband advised him thus:

> Why should you become a woman's apron and your wife will be quarrelling with you for soup and food money. Follow my example, marry a second wife and you will see both wives struggling to take care of themselves and their children None of them will worry you again and you will be free. (Female, Ilesa East, Oct. 2009).

While a few husbands refused to take care of their wives, others took their wives to ANC and prayer sessions in their cars and on their motor bikes and returned to pick them after prayer or ANC. A care giver said:

> some women are not working but are looking good because their husbands are taking good care of them (Caregiver, Female, Ilesa West Oct. 2009).

A Chief Nursing Officer affirmed that many of her patients were students who had unplanned pregnancies and the men-friends usually rejected the pregnancies. When pregnancies were unplanned and unwanted, and the partner refused to show up or provide

UNIVERSITY OF IBADAN

delivery materials the caregivers usually improvised materials that were needed. One said:

> They don't pay and yet treat their wives badly. Many are only responsible to contribute the pregnancies and ask their wives to take care of their children. They go ahead and marry more wives (Caregiver, Female, Ilesa West Oct. 2009).

CRERD (2001) reported similar attitudes among their respondents and FGD in Odeomu and Otan Ayegbaju in Osun State, Nigeria. Men refused to take responsibilities for their wives' pregnancies. However, in other places, credits were given to husbands for the care of their wives as husbands cooperated and even agreed to family planning suggested by caregivers.

Table 4.46 reveals that among categories of pregnant women, primigravidals (41.9%, 37.2%) received the most assistance from their husbands; followed by multigravidals (37.1%, 28.6%) and the least assisted were the grand multigravidals (22.2%, 22.2%). This could be owing to the fact that primigravidals' husbands were in their "first love" and are eager to become fathers but as time went on, their love began to wane or the husbands thought that their wives had enough experience than when they were pregnant for the first time. It could also be that the husbands thought that they have grown-up children who could assist their mothers. This is rather unfortunate because as grand multigravidals are getting old, they might be unable to cope with challenges and pressure of pregnancy. They, therefore, need encouragement from their husbands. The result shows significant relationship between the number of children and quality of assistance rendered by the husbands.

UNIVERSITY OF IBADAN

Table 4.46: Assistance Rendered by Husbands and Number of Pregnancy/ (ies)

Other things that husbands do to assist in pregnancy	Number of pregnancy/(ies)			Total
	Prim	Multigravidals	Grand multi.	
Housework	80 (41.9%)	79 (37.1%)	2 (22.2%)	**2 (22.2%)**
Fetch water only	71 (37.2%)	61 (28.6%)	2 (22.2%)	**2 (22.2%)**
Give money only	3 (1.65%)	0 (0.0%)	0 (0.0%)	**0 (0.0%)**
All areas	26 (13.6%)	52 (24.4%)	4 (44.4%)	**4 (44.4%)**
Prayers	3 (1.6%)	1 (0.5%)	0 (0.0%)	**0 (0.0%)**
None/ Does not care	8 (37.5%)	20 (9.4%)	1 (11.1%)	**1 (11.1%)**
Total	**191(100%)**	**213 (100%)**	**9 (100%)**	**413(100%)**
X^2_{cal} 23.654 df 12 P 0.023				

Source: Fieldwork, (2009)

4.7.4 Influence of marital status on other assistance husbands/partners rendered in pregnancy

Pregnant women were requested to state other things that their partners did for them in pregnancy. Only 35 (52.3%) singles got only money and the widow got nothing. This indicates the conditions of many widows in our society. At the demise of the husband, the widow is left in the lawns. She has to fend for herself and if she is lucky enough not to be shared along with the husband's properties. The married got the best assistance followed by the cohabiting.

UNIVERSITY OF IBADAN

Table 4.47: Other Assistance Husbands/ Partners Rendered in Pregnancy

Other helps paetners render	Marital Status					Total
	Single	Married	Cohabiting	Divorced/ Separated	Widow	
All house chores	-	167 (86.5%)	26 (13.5%)	-	-	193 (100%)
Fetch water	-	130 (91.5%)	12 (8.5%)	-	-	142 (100%)
Money only	35 (52.3%)	24 (35.8%)	8 (11.9%)	-	-	67 (100%)
None	30 (30.6%)	52 (53.1%)	5 (5.1%)	10 (10.2%)	1 (1.0%)	98 (100%)
Total	65 13.0%)	373 (74.6%)	51 (10.2%)	10 (2.0%)	1 (0.2%)	500 (100%)

The study revealed that even when a woman is sick or needs medical attention, the express permission of the husband must be sought in 282 (56.4%) cases before she could attend hospital. Jegede (2010) notes that male-headed household predominate. However, when a child is sick, more respondents−296 (59.2%) −would take their children to hospital, while they would wait for the permission of their husbands when they were sick. The respondents placed higher price on their children's health than theirs, although, in both cases, the husbands still took the higher percentage of decisions. Jegede (2010) observes that regardless of women's involvement in decision making, the final decision is still subject to the husbands'. According to him, Ibadan husbands often describe their wives as disobedient because they seek treatment for themselves and their children without consulting with them.

The IDIs revealed that husbands insisted that their wives take permissions from them before they went to hospitals. However, most of the husbands said that their wives

UNIVERSITY OF IBADAN

could go to hospital if they were not around or had travelled but they must inform them on phone. None of the husbands insisted that their wives should wait for them in case of emergency and none of the wives was ready to wait. Three hundred and nine (62%) women could decide to refuse sex when nursing their babies but when they are tired only 253 (50.6%) would decide to refuse. If the husband ran around with other women, only 193 (38.6%) would decide to refuse sex. Most of the respondents would not refuse so that he would not be lost completely to the other woman. The respondents reported that they would use sex to draw him from the other woman. However, when it is confirmed that the man has STIs, 304 (60.8%) would decide to refuse and wait for him to treat himself. They could not see the relationship between extra-marital affairs and STIs. They wanted to wait until the man manifested symptoms of a disease but by the time it became evident that he had a disease she too would have been infected. Yet, 196 (39.2%) of the women would not decide to refuse sex even if they were aware of the presence of STIs in their men. This explains why many women are plagued with sexually transmitted infections and HIV/AIDS. The literature confirms that women are powerless to negotiate sex or use of condom with their partners. When it comes to far-reaching decisions on sexual activities the woman becomes less able to make decisions.

Other people that play significant roles in pregnancy care are mothers-in-law as well as other pregnant women who introduce caregivers to their friends. The respondents were at liberty to bring other pregnant women to the place where they believed they received adequate care. The FBBAs allowed the respondents to guarantee their friends. All caregivers need someone to run errands and bring food during labour and after the pregnant woman has been delivered. All FBBAs have different occasions when women that delivered were abandoned. Apart from the fact that they had no money to pay, the FBBAs fed, clothed, and sometimes had to take them home or pay their transport fares. The FBBAs prayed for such people while hospitals retained them after delivery or refused to take them in at all. Of course, free facilities are not available in hospitals.

Men's role was reported to be significant when women intend to reduce the number of pregnancy; health caregivers instructed that women should take permission from their husbands. Many husbands usually refused, claiming that the wives would engage in extra-marital affair if she used family planning device. To be able to reduce

UNIVERSITY OF IBADAN

frequencies of pregnancies, women should be able to take independent decisions on family planning as they carry and nurse the babies and know the state of their health. Many men just want many children without corresponding care and support. More men than women desire more children (Isiugo- Abanihe, 2003).

The IDIs revealed that many husbands were ignorant about the dos and don'ts in pregnancy as well as signs and symptoms of pregnancy complications. However, they commented that if there was any complication, the woman should go to the hospital, while the men pray. Many husbands believe in the efficacy of prayers to solve such problems. A husband said he believed his wife should do all tests prescribed at the hospital while he prays. When husbands are ignorant of signs and symptoms of pregnancy complications, they may not be able to assist their wives at critical times; this may be a reason for delay in seeking help. CRERD (2001) also found husbands' knowledge of dos and don'ts in pregnancy inadequate.

The respondents recognised the roles men (husbands) play in pregnancy care. This was reflected in the extensive prayers they usually made for their husbands and their work during their prayer meetings, such as:

> Oh Lord, do not allow the crown of my head to be removed; Do not allow Satan to take my husband; O Lord, do not let me have ill luck To experience death of husband or /and children.

Husbands are regarded as the crowns, beauty, and dignity of women's heads. A woman is regarded as having ill luck when the husband dies. This belief does not hold if the woman dies. It is regarded as natural occurrence or at best an accident and the men are encouraged to remarry soon to be able to overcome the misfortune. But for the woman, she is shared out as part of the husband's property.

UNIVERSITY OF IBADAN

4.7.5 Discussion

Data on demographic and socio-economic profile revealed that the majority of the pregnancies occurred between ages 19-24 (32.0%) and 25-29 (36.6%). Only 4.2% of the pregnancies occurred before 18 years and only 2.2% occurred after 40 years. NDHS (2003) states that the best years for pregnancy and childbirth is ages 20 and 30 years when the children are evenly spaced. Pregnancy should be discouraged among adolescents and women above 35 years to avoid complications that are associated with these age brackets. Much as it is desirable and of a great socio-economic advantage to encourage girl education and delay of childbearing to a later age, so as to empower women, the risk of being elderly primigravidals should be considered along the line so as not to endanger the lives of the ladies in difficult and high-risk pregnancies. Delay in childbearing until a girl finishes higher institution should be considered alongside this risk, especially in Nigeria where students enter into tertiary institutions and one cannot be sure of when they would graduate owing to incessant strike actions in these institutions.

The result revealed that 74.6% of the respondents were married; 13.0% were single; while 10.2% co-habited. Both single parenthood and co-habitation are aberration to the norms and mores of traditional Yoruba settings. Both teenage pregnancy and co-habitation do not receive any positive social, economic and psychological supports and are totally discouraged in Yoruba society (Oyefera, 2005). In Yoruba society, conception and childbearing should take place within the institution of marriage. The prevalence of unemployed graduates and long stay in school due to incessant strike actions in the institutions could be an explanation for the high rate of co-habiting couples.

As for the educational status of the respondents and their husbands, 37.8% of the men and 30.6% of the women had tertiary education. Although both groups acquired some form of education, more men than women had formal educations. Women's education should be encouraged so that it can be at par with that of the men. This could be done if women could have their babies and still continue with their education. In addition, if day care centres could be established in all educational institutions so that nursing mothers could put their babies there. However, even where women acquire formal education, patriarchy and social norms make women depend on their husbands for

UNIVERSITY OF IBADAN

health and major decisions. Parent place less emphasis and less invest on female's education (Adebowale, 2009).

About three quarters (75.8%) of the respondents earned less than ₦10,000 a month, thus earning less than USD1 a day. This could be a hindrance to accessing orthodox medicine because of users' fees. Although, the respondents were literate, they could not enjoy the economic privileges of education. Economic empowerment should encourage women to acquire more education so as to be in the best standing to take care of their pregnancies. Poverty, procrastination and stinginess were some economical problems that encouraged the respondents to deliver in FBBHs and made some husbands to abscond on the days of delivery of their wives. The Ijesa people are known for austere financial management which some take too far into health management. Some couples kept postponing purchase of delivery materials until the babies arrived and these women entered delivery rooms empty-handed; delivery materials and baby clothes had to be supplied by churches or FBBAs or neighbours. In maternity centres, nylon bags where used as gloves to take delivery of some children, as the mothers could not afford hand gloves.

Monogamy was the prevalent (90.4%) marriage type. This could be due to the predominance of Christianity (86.6%) in the study area and the impact of ministers of God, like late Apostle Babalola, of CAC; Pastors E. A. Adeboye, of the Redeemed Christian Church and W. F. Kumuyi, of the Deeper Life Bible Church; and other religious leaders that are from this area.

The study revealed the knowledge of pregnant women on aetiology of pregnancy complications as follows: 41.6% attributed pregnancy complication to witches and wizards; 43.4% attributed complications to adultery; while 43.8% attributed pregnancy complications to women's physique. However, more women that had tertiary education (73.5%) attributed complication to infection and physique of women rather than witches and wizards. Orji *et al*. (2001) assert that labour complications are blamed on labouring women; they accused them of being unfaithful to their husbands. Hospital care givers revealed that women with heights and weights below 1.5 metres and 40 kilogrammes, respectively are perceived high risk and being predisposed to complications. Drug abuse and carelessness of nurses were also perceived as causes of complication. Oscillating

UNIVERSITY OF IBADAN

between caregivers was reported to be another source of pregnancy complications. The study further revealed that attitudes of nurses and orthodox care providers can hinder their patronage.

When complications, such as haemorrhage occur, 31.8% of respondents would not give themselves for blood transfusion. This should be a source of concern and people should be sensitive to the need to prevent anaemia. In religious houses, however, haemorrhage would be treated with concoction.

Breech presentation is believed to be essentially the machination of witches and wizards and such is treated with leaves, special concoction, blessed water, prayers and spiritual baths. Most of the services rendered by FBBAs were free but recipients were to attend annual children thanksgiving service in the church and make donations.

Prayers and secrecy were perceived to be means to avoid complications. Pregnant women were warned against advertising their pregnancies and to be careful in the use of their tongues. The respondents identified the following as symptoms of pregnancy complications: breech baby (42.6%), convulsion (50.8%), excessive bleeding (66.2%), high fever (61.6%), labour of more than 12 hours (66.2%), and swollen legs (60.0%). Data from OAUTH Ilesa confirmed that 40% of maternal loss in the hospital was due to haemorrhage, 13.4% was due to obstructed labour and eclampsia was responsible 13.3%. Adebayo (2013) states that haemorrhage accounted for 25% of maternal loss in Nigeria. He is of the opinion that if all hospitals were well-equipped, maternal mortality will reduce by a quarter worldwide. Lack of adequate knowledge of symptoms of pregnancy complications would cause pregnant women to seek help late. Ransome-Kuti, (1990) states that, all pregnancy problems are preventable and easily cured if identified and managed early.

Pregnancy is perceived as a secret which only God knows and understands. The respondents believed that God alone gives children to whomsoever he wishes. They viewed pregnancy from spiritual rather than from medical angle. Belief in malevolent spirit thrived and so the women patronized churches for care and delivery of their babies. They attended faith homes religiously and were engaged in rigorous prayers against maternal and neonatal mortality. Prayers were said against all types of enemies that would make delivery difficult. It was observed that these pregnant women were more

UNIVERSITY OF IBADAN

relaxed in mission houses but when they attended ANC, they were always anxious and in a hurry to leave, always complaining that their time was being wasted.

One fourth of the respondents had their last deliveries at FBBHs, 35.8% hoped to deliver their current pregnancies in FBBHs, while 13.4% were undecided on which care provider will deliver their current pregnancies. A total of 50% of these chose their caregivers because of prayers. When complications occur, referrals may be from one faith home to the other, then to a private hospital or the General Hospital and lastly to OAUTH, Ilesa. This kind of referrals causes delays in getting adequate help for women who may have complications. Some faith homes kept trying to help women in complications until things were almost out of control. Orji *et al*. (2001) note that late referral predisposes women to maternal morbidity and mortality. All FBBAs, except one, claimed that maternal mortality had never occurred among them. The only one that agreed to have had maternal mortality blamed the pregnant woman for it, claiming that she had familiar spirit. When complications have reached critical stage, FBBAs usually advise the woman's family to take her to any hospital of their choice. Some of such women die on the way or in the hospital before any help could be rendered.

There was no significant relationship between religious affiliation and delivery in FBBAs. All adherents of the three religions patronised FBBAs for care and delivery. Population References Bureau (2005) claims that 65% of Nigerians still employ the services of traditional healers.

The study revealed that different measures were put in place in faith birth homes to avoid complications:

Prayers were said by the whole congregation for safe delivery and pregnant women met one day every week between 9 a.m and 12 noon for rigorous prayer against any form of complications and evil imagination of wicked people. Prayers were accompanied with reading of psalms of victory into water they drink and use for bathing. The Psalms they read reveals their fears and believe that God's supernatural intervention can deliver from all forms of wickedness.

Anointing oil was also used to prevent pregnancy complications. Psalms were read and prayers said into oil. These were believed to be sacred and more efficacious than hospital drugs. Durkheim (1961) claims that society sets apart some items as sacred and

UNIVERSITY OF IBADAN

others as profanes. The Psalms and prayers made these items sacred and pregnant women had strong faith in them to drive away evil.

Pregnant women came to church with kegs of water to which pastors read psalms and upon which they prayed. They used this to bath and drink throughout the week. But pregnant women that were perceived to have serious problems took spiritual baths in flowing rivers and sometimes with special easy-delivery sponge, soap and oil which FBBAs had prayed upon.

Pregnant women submitted their materials for delivery at the mission houses for corporate and FBBAs' private prayers and fasting. This practice compelled such women to deliver in mission houses, as it was difficult to retrieve these materials at the point of delivery if the pregnant woman intended to utilize another care giver.

Vision and prophesies were used in religious houses. Sometimes, the prophets and seers in these religious houses saw visions for these women. They saw troubles in their lives and wicked ones trying to harm them. They also proffered solutions to these problems.

One of such solution was for faith care givers to take such women to mountain tops for prayers. This could be every month or twice in a month. There they read psalms, prayed and held vigils.

Another coping strategy was exclusive prayer camping for the weary. Pregnant women that were perceived to have problems were camped exclusively in the church for special prayers which would be said for them on regular basis as long as the prayer camping lasted. These prayers allayed their fears of witches and wizards and other evil imagination and gave them spiritual and emotional comfort.

The FBBAs took delivery and circumcised children with bare hands and also did no test for HIV. This way, FBBAs could be easy agents in spreading diseases. There is need to train FBBAs on the use of gloves.

The result further revealed that 73.3% of maternal loss were unbooked women who were referred to the hospital in moribund conditions. Also 35.4% of all deliveries in

UNIVERSITY OF IBADAN

OAUTH were Caesarean Section (CS). This could also be because pregnant women were referred to the hospital at times when only emergency CS could save their lives.

The result revealed that women of all levels of education attended FBBAs for care of their pregnancies. As for places where pregnant women perceived pregnant complication should be treated, 46.0% of the respondents would go to religious centres, while 39.0% would go to hospitals. Among the respondents that earned between ₦40,000 and ₦50,000 and above, 28.6% would treat pregnant complications in religious centres. Among those who earned ₦50,000 and above, 22.2% would treat complications in religious centres. This revealed that among all categories of earning, not less than 22.2% would treat their complications in religious centres. When there is stress, or anxiety, the income of the individual may not be taken into consideration. The foremost thing is where to get relief and many find religious centres as a place to find solution. In times of stress, anyone may find attraction in the support of healing churches (Jedege 2010).

Attending care giving centres is not as important as adhering to the instructions given. The level of adherence will determine the benefits that accrue to the adherents. Among the 79.6% that ever attended ANC, 51.6% did ultrasound diagnostic test and 76.0% did blood test. Among all categories of pregnant women 75.2% of the primigravidals would accept blood transfusion if there was a need and 50.0% of grand multigravidals would accept blood transfusion. The literature as shown that grand multigravidals are high risk pregnancies, yet half of them will not accept blood transfusion if there is a need. Women should be discouraged from having so many children. When they do, they should be ready to take appropriate health actions. The people should be sensitized on the health hazards of high parity and the need to take extra care when an individual is pregnant after the fourth time. Such women should be sensitized to deliver in hospitals so as to avoid complications. Further, 77.4% of the primigravidals attended ANC early, followed by 50.0% of the multigravidal and lastly by 28.6% of the grand multigravidal. Early attendance of ANC by primigravidals is commendable as they do not take things for granted. Delaying early attendance, like grand multigravidals, can be dangerous and costly.

Respondents also claimed to adhere to eating balanced meals, as 69.6% of them reported that they took fruits daily. When pregnant women eat balanced meals,

UNIVERSITY OF IBADAN

complications, like anaemia, are kept at bail. Health care providers would also have less work to do. Radio, television and other means of mass mobilization can be used to enlighten pregnant women and even everyone on the importance of healthy food. When pregnant women eat balanced meals, there will be low complications for mother and child.

Equally important is the need for good sleep and exercise. The majority (71.0%) of the respondents reported that they slept for at least 6 hours a day. Pregnant women and everybody need sound sleep to function normally. Sleeplessness can predispose pregnant women to hypertension and some pregnancy-related problems. Fortunately, most of these women slept well.

As much as respondents would want to adhere to instruction, marital disunity sometimes discouraged adherence. In a patriarchal society like Ilesa, men are perceived as heads of their families and are expected to pay for maternity materials. But when a man cannot afford it and the wife does, if there is no unity in the family, the woman may still not adhere. There is role segregation in pregnancy care. The woman is to bear the burden of carrying the baby while the man supplies the materials. A man that is incapable of this is regarded as '*oku guro*' (a standing corpse) or "*oku aaye"* (the dead among the living). He is regarded as dead, yet walking on the street. Lack of financial power erodes the social status of the man as the head of the family. Nwokocha, (2006) reported that "an Ibani woman feels very reluctant to pay for the cost of her prenatal care services". His respondent argued that "no matter how poor a man is, he should be able to to handle some family responsibilities".

Generally, FBBAs encouraged women that patronized them to combine FBBA with hospitals especially to do scan and blood tests. One FBBA even employed a nurse to assist in complicated delivery.

The result revealed that 64.2% of respondents got drugs from hospitals but 30.8% of them did not take the drugs as prescribed. Bosworth (n.d) asserts that non-adherence to prescription has grave consequences on public health, as it has enormous burden on the world health system. Quoting McCarty, Bosworth (n.d) states, that 125,000 died in U.S.A annually owing to non-adherence to medication. Osterberg and Blaschke (2005) aver that between 33-66% of medication-related hospital admission are due to poor adherence. The

UNIVERSITY OF IBADAN

total cost of non-adherence ranges from $100-300 billion each year. The study revealed that where the husbands encouraged their wives to take their drugs, there is less of non-adherence; but, where the husband is nonchalant, adherence is poor. There is need for husbands to encourage their wives to adhere. They should take it upon themselves to do this to reduce pregnancy related-complications.

The study further revealed that adherence to drug varies according to number of pregnancy ever had. A total 88.9% of the primigravidals, 73.4% of the multigravidals and 66.7% of grand multigravidals adhered to drug prescription. Generally, adherence to instruction is lowest among the grand multigravidals in all instances. Unfortunately, those that are most vulnerable are the ones that cared less. Grand multigravidals should be sensitized on their high risk status. During the visits to ANC in hospitals, the researcher noticed that many of the grand multigravidals were not happy with their pregnancies. Some complained that they made a mistake and were unwilling to have an abortion. This, however, should not make them expose their lives to danger.

Men as heads of their families are expected to be financially sound and responsible to procure all or most of the materials for delivery. They are expected to render other services to assist their pregnant wives. The result revealed that 61.8% of the husbands paid fully for maternity materials; 50.2%; chose health care providers for their wives. The wives paid for 20.4%; while 13.4% were paid jointly. The IDIs revealed that husbands who paid fully for maternity materials tended to dictate where care was received, while those that paid jointly seemed to decide jointly on care providers.

Paying medical bills is one thing, providing what money cannot buy is another. A total of 37.8% of the husbands helped their wives in household chores; 34.0% fetched water; while 21.8% were reported did nothing. Most of the husbands claimed that they prayed intensively during their wives' pregnancies and deliveries. Also, 54.8% of the husbands went with their wives to places where their deliveries were taken and 53.8% stayed until their wives were delivered. Thomas *et al*. (n.d.) reported that 54.8% of the women they sampled reported that their husbands accompanied them during pregnancy and check-ups and 63.6% of the husbands gave money for medicine. Similarly, 27.3% of the women sampled reported that their husbands helped in house chores. Many husbands reported that they empathized with their wives during stress of pregnancy and labour. To

UNIVERSITY OF IBADAN

make a pregnancy is the joint efforts of two people. It should follow, therefore, that the husbands should encourage their wives/ partners during the stress of pregnancy and delivery.

UNIVERSITY OF IBADAN

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The main findings of this study is as follows: This study provided insights into the relationship among social and religious factors, perception of aetiology of pregnancy complications, adherence of women to health caregivers' instructions and men's roles in pregnancy care. Health Belief Model (HBM) and Functionalist Theory were triangulated for the study. The study was descriptive and was conducted among pregnant women, their husbands and care providers. Both quantitative and qualitative approaches were utilised. Semi-structured questionnaire, IDIs and observations were used for data collection. This was to ensure that the weaknesses of one method were catered for by the strengths of the other.

The respondents were five hundred and ten pregnant women. Ten in-depth interviews (IDIs) were conducted among some of the women's husbands while 24 among Key Informants Interviews (KIIs) were done among their caregivers. The IDIs provided better understanding of data generated from the survey. These were corroborated with 20 sessions of observation in care-giving centres.

It is obvious that a lot of social and cultural elements work together to determine pregnancy care. People's belief and practice bear relationship with their decision on where to seek help. The people continued patronising FBBAs in pregnancy care because of religious influences, finance, as well as favourable treatment given to them. The results showed that availability and accessibility of health centres did not necessarily ensure qualitative utility. This study established that pregnancy in Ilesa, South Western Nigeria could not be divorced from the society's socio-cultural environment. The general finding of the study was that religion played dominant role in care seeking during pregnancy and that belief system dictated where the people sought and accessed health care delivery in pregnancy. Above all, the underlying factor for deliveries in mission houses is poverty. No pregnant woman would venture into standard hospitals without delivery materials and

UNIVERSITY OF IBADAN

money. The embarrassment would be too much. Apart from these general findings, the following findings were on specific objectives.

5.2 Summary of Findings

The main findings of the research are summarized under the basic objectives of the study.

5.2.1. Influence of Socio-demographic factors on decision on care during pregnancy

Respondents' ages were between 13 and 40 years. Their mean age was 29.54. The most productive age range was 25-29, where 36.6% of the pregnancy took place; the next prolific age range was 19-24, where 32.0% of the pregnancies occurred. Above 74% were married.

Respondents were a fairly literate group, as above 78% of the men and 68% of the pregnant women completed secondary level education and above. All levels of educational groups attended ANC in hospitals (61.8%) and FBBHs (24%). Some respondents were found to combine hospital care with FBBHs (13.4%).

Finance was a major determinant of Caregiver. Poverty was found to be rampant among the respondents and their spouses such that many could not afford delivery materials. It was a major hindrance to pregnancy care in hospitals. About 76% of the respondents earned less than ₦10,000.00 a month (less than one dollar a day) far below what was needed for daily survival, and could not afford materials required for delivery in hospitals. When finance was inadequate, FBBAs were found to be friendly and tolerant of pregnant women. When materials for deliveries were in short supply, the FBBAs reported that they provided for the women from their personal effects and materials from other pregnant women. Orthodox care providers also reported that they used nylon bags as gloves to take delivery.

The majority (86.6%) of the respondents were Christians and 57.4% of them were in the Pentecostal movement. Monogamy (90.4%) was the prevalent type of marriage.

UNIVERSITY OF IBADAN

There were no religious barriers to delivery in religious houses; 26.2% Christian, 15.8% Muslims had their last babies in religious centres. Further, in their current pregnancies, 36.5% Christians, 29.6% Muslims and 38.5% traditional worshippers intended to have their babies in mission homes. Thirteen percent of all religious groups were undecided on where they hoped to deliver their current babies.

5.2.2 Women's perception of aetiology of pregnancy complications

The respondents perceived activities of witches, wizards, familiar spirits (41.6%) infection (38.8%), adultery (43.8%) and women's physique as major causes of pregnancy complications. They perceived efficacy of prayers, anointing oil, blessed water, soap, and spiritual baths as solutions to such complications. Church and hospital were perceived to be places of treatment of complications.

The physique of respondents was perceived as dangerous to their sound health, 46.3% primigravidal; 42.3% multigravidals, and 37.5% grand multigravidals perceived that women's physique could cause pregnancy complications.

Above 41% of the primigravidals, 36.7% of the multigravidals and 43.8% grand multigravidals perceived infection as a cause of pregnancy complications.

FBBAs perceived consumption of sugary food as a source of complication; therefore, they instructed pregnant women to consume less of sugary food to avoid having big babies. Some caregivers blamed pregnancy complications on carelessness of some nurses who would not attend to pregnant women on time. For instance, while this research was on the researcher visited some maternity centres and found them under locks and keys for reasons of weekends and public holidays; while others were on incessant strike actions. The IDIs revealed that dereliction of duty of caregivers can occasion pregnancy complications. The IDIs also revealed that the respondents believed in wandering evil spirits that can cause pregnancy complication. Therefore, pregnant women were instructed to avoid being outside 1-3 a.m. and p.m.; pregnant women were instructed not to expose their tummies to those who might wish to touch them, as they were perceived to be a source of complication. To avoid complications, FBBAs instructed the

UNIVERSITY OF IBADAN

respondents not to advertise their pregnancy. They were not to allow people to touch them.

Non-attendance at ANC or FBBHs was perceived as a source of complication. The IDI revealed that oscillating between traditional and orthodox caregivers could be a source of complication, as there could be conflict of instruction.

Among the respondents, breech babies (57.4%), convulsion (50.8%), haemorrhage (66.2%), high fever (61.6%), prolonged labour (66.0%) and swollen legs (60.0%) were perceived as symptoms of pregnancy complications. Educational qualification was not significant in recognition of convulsion and breech babies as symptoms of complications. However, 31.8% of the respondents would not accept blood transfusion. When complications occurred 46.0% would treat them in religious houses. FBBAs would treat haemorrhage and other complications with concoctions, prayers, psalms and spiritual births. Maternal mortality in OAUTH Ilesa branch from 2004-2008 revealed that 40% of MM was caused by haemorrhage.

The respondents perceived pregnancy as the work of God. To avert pregnancy complications, respondents resulted to spiritual practices, such as vigils, praying on mountain tops, spiritual baths in flowing rivers, using anointing oil and blessed water, reading of psalms and prayers. These were perceived as efficacious means of warding off pregnancy complications. Visions and prophecies were common features in these spiritual places. The IDIs revealed that, when complication occurs, attitudes of nurses/midwives can discourage pregnant women from seeking help in the hospitals early.

Uniform reports from caregivers revealed that, when treatment failed among other caregivers, the final place of reference was the OAUTH, Ilesa. Many got there when they could be helped, while others got there in morbid conditions. If pregnancy complications will eventually end in the OAUTH, it would be profitable that women go to this hospital for care of their pregnancies from the outset.

UNIVERSITY OF IBADAN

5.2.3 Influence of religious belief system on pregnancy care

Religion was important and determined pregnancy care sought in the community. Beliefs in the supernatural were prevalent. Pregnancy was perceived as a mystery from God and, therefore, seen as spiritual rather than biological. Therefore, women did patronize faith homes for pregnancy care and delivery of their babies, though they attended hospitals to take immunization and had a card in case of emergency.

A quarter (24.6%) of the last deliveries was in mission houses; religious reasons, such as prayers, were given for such decision. In their current pregnancies, 35.8% hoped to deliver their babies in FBBHs, while13.4%were yet to decide where to deliver.

It was observed that the respondents made rigorous prayers in faith homes for safe delivery and against any form of complication and imagination of wicked people. Religious leaders and FBBAs reported that they fasted, prayed and read psalms on water, oil, sponge and soap as well as delivery materials. The women perceived 'blessed' items more efficacious than hospital drugs. These items were for bathing and drinking while the pregnancy lasted. Different psalms were read at different trimesters of pregnancy. These were perceived to bring about safe delivery and ward off evil.

As pregnant women bought their delivery items, they were encouraged to submit them to FBBAs for safe keep and prayers. The FBBAs claimed that they continued to pray and read Psalms on the items until the women finally came for delivery.

Visions and prophecies were common features with many religious caregivers. Women knelt before such care providers to listen to fortune-telling.

In religious centres, women were taken to mountain tops for prayers at regular intervals. Vigils were also held in religious centres for the women. Women whose religious leaders perceived as having serious problems and special needs were camped in the religious centres for special and exclusive prayers that might last for 1 to 21 days depending on the magnitude of the perceived problems. They may be taken to flowing rivers for ritual baths as well. Women patronised religious centres to allay their fears of witches, wizards and other household challenges.

Pregnant women submitted kegs or bottles of water on the altar for special prayers. They drank and used part of it for bathing. Spiritual influence was also manifested in

UNIVERSITY OF IBADAN

hospitals as songs of praises and prayers were said there for safe delivery, though more time was spent on prayer in religious centres than in hospitals.

Some faith based birth homes (FBBHs) cooperated with orthodox medicine. They allowed nurses to give health talks and deliver babies that the nurses described as high-risk pregnancies while those perceived to be at low risk were taken by FBBAs.

However, all was not always well at religious centres, as more MM occurred among unbooked patients than those that booked in hospitals. The study identified fifteen (15) maternal mortality (MM) in OAUTH, Ilesa between 2004 and 2008: 73.3% of the deaths were unbooked women, 40% of them delivered their babies elsewhere. Both Ante Partum and Post Partum Haemorrhage (PPH) were responsible for 45.5% of all MM.

Amiable relationship was observed to exist among FBBAs and pregnant women. The FBBAs did not only provide pregnancy care, but they also provided counselling services for pregnant women and their spouses and were more sympathetic to their causes.

The FBBAs instructed women on peaceful co-existence with their husbands and in-laws. They invited husbands for discussion to know whether their wives' characters and marital relationship were good and suggested improvement where necessary. If any husband complained about his wife's behaviour, such a wife was reprimanded by the FBBAs. This was to enlist the co-operation of the husbands and ensure peace of the pregnant women.

5.2.4 Adherence of pregnant women to basic instructions

The result revealed that 79.6% of the respondents attended ANC but only 39.8% attended up to the recommended four visits. Attendance of ANC at the right time is essential for effective care. About fifty one percent of the respondents attended ANC at the first trimester in their last pregnancy. At the current pregnancy, 34.8% attended ANC at the first trimester. Above 18% attended ANC for the first time at the third trimester in their last pregnancies and 10.4% in their current pregnancies. Those who attended only at the third trimester could neither complete all the immunization nor undertake all the tests. The result revealed that 18.2% of the respondents took no immunization, 34.6% took

UNIVERSITY OF IBADAN

only one, 37.6% took two, and only 5.8% completed the immunization. Among the respondents, 35.3% Christians, 55.6% Muslims and 38.5% traditionalists took two shorts of tetanus toxoid.

Only 51.6% of the respondents did ultrasound diagnostic examination and 24.9% did no blood tests. About 36% did not accept routine drugs and, among those who accepted, 30.8% did not take the drugs as prescribed. The IDIs revealed that women did not adhere to drug use because they did not like drugs and for religious reasons. Holy or blessed water got from FBBAs was perceived to be more efficacious than hospital drugs. In some faith homes, attendance at hospital for ANC was regarded as having "no faith". Civil servants in such assemblies attended ANC just to collect hospital paper to enable them to obtain maternity leave.

The result revealed that although women attended ANC, took immunization and take other precautions, at the point of delivery, 24.6% resorted to FBBAs, while 63.3% delivered in hospitals.

The respondents were found to adhere to sleep instruction. Seventy-one percent of them claimed that they slept for at least 6 hours a day. They also adhered to instruction on eating fruits, as 82.0% of them claimed that they ate fruits daily. Adequate consumption of fresh fruits and vegetables will enhance good health for mothers and babies.

5.2.5 Men's roles in pregnancy care

Men were found to play dominant roles in pregnancy care. Husbands took major decisions in their homes and single-handedly determined the health care providers for their wives. About 62% of the men single-handedly paid for maternity materials. Husbands who single-handedly paid for maternity materials claimed that they dictated their wives' caregivers. But where they had joint account, the husbands reported that they made joint decisions on caregivers. They also bought drugs, food, fruits and vegetables for their wives. Husbands that could not afford these or refused to pay for them were regarded as irresponsible. The IDIs revealed that such husbands absconded on days of their wives' delivery.

UNIVERSITY OF IBADAN

A few husbands reported that they took their wives to ANC and prayer meetings while others waited for the wives to return and give reports. The FBBAs saddled the husbands with the responsibility of reminding their wives of next ANC or prayer meetings. They were to encourage their wives to adhere to instruction at ANC and prayer meetings, especially those on drugs and food. All husbands claimed that their wives had to take permission from them to attend ANC or prayer sessions.

All husbands, regardless of the religious affiliation, claimed that they prayed earnestly for safe delivery for their wives. Some claimed that they wept bitterly when they saw their wives in labour pains. Some husbands said they went to mountain tops to pray for safe delivery of their wives.

Muslim husband asserted that he gave special offering to the needy to ensure his wife's safe delivery. One claimed that he read portions of Qu'ran into water for his wife to drink for safe delivery.

About 38.8% of the husbands did house chores while their wives were pregnant. And 34.0% helped their wives to fetch water from the wells, while 6.4% gave money only. The husbands had to append their signatures to the wives' cards before they could be fully registered in faith homes. They also had to visit FBBAs at least 4-5 times for progress report concerning their wives. The FBBAs did not attend to pregnancies that were not supported by husbands.

The husbands were found to be ignorant of signs and symptoms of pregnancy complications but believed in the efficacy of prayers when such occurred.

Whenever there were needs for referrals in FBBAs, the husbands determined places their wives were referred to. They usually preferred private hospitals to teaching hospitals because of promptness of attention and poor attitudes of nurses in teaching hospitals.

About 55.0% of the husbands went with their wives to places of delivery and 53.8% stayed around until their wives were delivered of their babies, giving them emotional and spiritual support.

UNIVERSITY OF IBADAN

5.3 Conclusion

This study provided information on pregnancy care in Ilesa, Osun State. It highlighted the social and religious background that determined pregnancy care. It brought to the limelight the influences of religion and patriarchy in family relationship on pregnancy care.

Finance was found to be constraining in accessing pregnancy care in hospitals, as many women were unable to afford maternity materials. The FBBAs were found to take a quater of all deliveries. When we understand the socio-cultural context of pregnancy care in the society, there is therefore the need to train FBBAs on better ways to manage women. A ban on mission houses would not bring the desired solution because the people are poor and cannot afford the cost of the materials that are demanded even in government hospitals and maternity centres where deliveries are claimed to be free. The reality is that the people find FBBAs more easily available and accessible when fund is in short supply. Although, the respondents and their husbands were literate, they could not access hospital care. It is imperative to upgrade the people's financial status and make them enjoy commensurate financial benefits of education. When people go to school but could not enjoy the benefits of education, they are discouraged from increasing their knowledge. To improve hospital deliveries, the economic status of the people should be raised and the cost of delivery materials in orthodox hospital reduced.

Pregnant women and their spouses were found to be ignorant of causes and symptoms of pregnancy complications. They attributed complications to activities of witches, wizards and adultery. Therefore, they sought spiritual solution to prevent and treat such complications.

Husbands' influences as heads of their families cannot be ignored. They paid for maternity materials and dictated caregivers to their spouses. Their financial and emotional supports were essentials for successful outcome.

UNIVERSITY OF IBADAN

5.4 Recommendations

The study has shown that pregnancy care among the people of Ilesa cannot be separated from the social and factors of the environment. Government and NGO intervention strategies should recognise the religious and social factors that are prevalent in Ilesa.

1. Education of adolescent girls and elderly mothers on risks associated with childbearing in their age brackets should be promoted.
2. It is, therefore, recommended that various levels of government should spend money on training FBBAs and sensitization programmes. Such training should be to educate FBBAs on referrals, hygiene, family planning, drugs and food prescription, prevention of HIV, prevention as well as signs and symptoms of pregnancy complications and early referrals. They would be able to know those they can handle and those they must refer urgently. Retraining should be organized from time to time.
3. Deaths that are orchestrated by FBBAs but take place at orthodox hospitals should be investigated and handled according to the law of the land. Whichever caregiver a pregnant woman opts for; there should be mutual cooperation among the caregivers.
4. Government and orthodox caregivers should monitor and inspect faith houses with the aim of making them more hygienic and less risky. Government should attach doctors and midwives to the FBBAs. There should be some conditions that birth houses should fulfil before they are allowed to take delivery. Failure to fulfil these conditions should make these birth houses culpable.
5. Church leadership should be sensitized on the number of maternal losses associated with activities of FBBAs. Churches with birth houses should be inspected and licensed by government before they are allowed to practise. It should be made mandatory for such churches to have trained health workers to manage pregnant women.
6. Referrals should be prompt and to the Teaching Hospital. Prayers can be offered while the pregnant women go to hospital. There is no barrier to prayer. Since the respondents see pregnancy from spiritual angle, they can be sensitized to pray in

UNIVERSITY OF IBADAN

religious houses but be determined to give birth in hospitals. There should be a way to sanction FBBAs or other caregivers that keep pregnant women unduly till life is wasted or almost wasted.

7. Society has to address the poverty level of its citizenry to reduce maternal mortality. Cost of maternity services should be reduced for the benefit of the poor.
8. Amiable disposition of caregivers in government hospitals will go a long way to encourage patronage and early referrals.
9. Husbands should give balanced diets, financial and emotional support to their wives.
10. Husbands need to be sensitized on the causes, symptoms, and signs of pregnancy complications. They should be sensitized to know how to prevent and detect complications, as well as the need to seek early help.

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UNIVERSITY OF IBADAN

APPENDICES

Appendix I

Sociology Department, University of Ibadan, Nigeria

Research Questionnaire

Dear Madam,

I am Mrs M.O. Ayanleke, a postgraduate student at the Department of Sociology of the University of Ibadan. I am conducting a research on the maternal health of pregnant women in Ilesa, Osun State. This research is purely for academic purpose. Please feel free to answer questions about your health. However, you are free to decline any of the questions you do not want to answer. Your answers will be kept strictly confidential. In addition, any information you give will not be used to identify you. Your willingness to participate in this survey will be appreciated.

Thank you.

Section A: Socio-demographic Profile of Respondents

S/N	Questions	Coding Categories
1	How old were you on your last birthday? (Give age in completed years.)	
2	What is your marital status?	
3	If married, what is your husband's educational qualification?	No Schooling……1 Primary…….2 Secondary (Uncompleted)…3 Secondary (Completed)……4 Tertiary (specify) …….5
4	What is your husband's occupation?	

UNIVERSITY OF IBADAN

5	What is your highest educational qualification?	No Schooling……1 Primary…….2 Secondary (Uncompleted)…3 Secondary (Completed)……4 Tertiary (specify) …….5 Other (Specify) ……..5
6	What is your estimated income per month?	Less than 10,000……..1 10,001- #19,999……...2 #20,000-#29,999……..3 #30,000 –#39,999…….4 #40,000 –#49,999…….5 #50,000 and above ……..6
7	What is your religious affiliation?	Christianity……..…..1 Islam…….….2 African Traditional Religion…..3 Other (specify)……..4
8	If a Christian, your denomination?	Catholic……1 Protestant……..2 Pentecostal……3 Jehovah's witness…….4 Other Specify……..5
10	What is your ethnic group?	

Section B: Pregnant Women's Compliance with Regimes and Husbands' Roles in Pregnancy

	QUESTIONS	**Coding Categories**
12	Did you ever attend an antenatal clinic?	Yes…….1……No……2
13	Where? (Tick as many as are applicable)	Govt hospital /maternity /clinic ….. Private maternity/clinic/ hospital…. Church/Mission……. Pharmarcy/drug store……..….

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		Stay at home.....….5
15	Who chose your centre for you?	
16	How many pregnancies have you had?	
17	How old was your last pregnancy when you first received ante-natal care?	
18	How old was this pregnancy when you first received ante-natal care?	
19	How many times have you attended?	
19	If not all, why did you miss out?	
20	Did you do ultrasound during this pregnancy?	Yes No
21	Did you do blood sample Examination?	Yes No
22	Apart from ante /post natal clinic days do you also go to hospital?	Yes No
23	Did you take immunisations?	Yes No
24	Did you take them at the time you were supposed to?	Yes No
25	How many did you take?	
26	If not complete, why?	
27	What types of exercise do you do?	
28	What type of food and fruits did you take in the last two days?	
29	How often do you take fruits?	Daily……1 Weekly……..…2 Once in a while….3 Seldom……..4 Never…….5
30	Were you always given drugs anytime you visit the clinic?	Yes No 1 2

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31	Did you always take the drugs as you were told?	Yes No 1 2
32	If no, why?	I forgot……1 I do not like drugs……2 I did not have money to purchase them……3 Religion.....4 Other specify ……..…5
33	Who pays for your maternity materials?	Husband only……1 Husband partially……2 Self fully……3 Self partially ……4 Jointly……5 In laws……6
34	When you had your last baby did your husband go with you to where you delivered?	Yes No
35	Did he stay with you?	Yes……1 No ……..2
36	If he did not, why?	Lack of time due to work…… Not interested…… Saw no need…… Not permitted by hospital authority.. Fear of the experience……
37	What other things does your husband do to help you in pregnancy? (e.g. domestic chores)	
38	Where did you deliver your last baby?	
39	Where do you hope to deliver this one?	
40	Why do you make that choice?	

Section C: Decision Making In Pregnancy

41	Who decides on the number of children to have?	Husband……..1 Self……..2 Jointly ……3 In laws……4 God……..5

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		Others Specify……..6
42	Can a woman go to hospital without taking husband's permission? Can a woman refuse sex with husband if: She has a new baby? She is tired? The husband runs after other women? The husband has sexually transmitted infection?	Yes No 1 2 1 2 1 2 1 2
43	Whenever your child is sick, can you decide alone to take the child to hospital?	Yes No 1 2

Section D: Women's Perception of Pregnancy Complications

44	Which of these will you regard as pregnancy complications? (Tick as many as applicable.)	Labour of more than 12 hours Yes No Excessive bleeding before or after delivery 1 2 High fever 1 2 Swollen legs 1 2 Bridged baby 1 2 Convulsion 1 2
45	What do you think can cause any of these above complications?	Infection Woman's physique 1 2 Witches and wizards 1 2 Adultery by the woman 1 2 (State others)
46	When a woman has any of these complications where should she go?	Go to church……..1 Go to Mosque…….2 Go for FBBAs……..…..3 Go to maternity……...….4 Go to hospital……..…5

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47	If there is need for blood transfusion in pregnancy or delivery, should one get transfused?	Yes 1	No 2
48	What are the other do's and don'ts for pregnant women that you know?		

Thank you for your cooperation.

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APPENDIX II

In-depth interview with Orthodox Health Workers and Faith Based Homes

Good day Sir/Ma,

My name is Mrs M.O.Ayanleke and I am a postgraduate student of the University of Ibadan. I am carrying out an investigation on pregnant women's maternal health in Ilesa East and West Local Government Areas. I will like to ask you some questions about your patients and operations. Your answers are strictly confidential and the information you give will never be used to identify you. The information you and others give will help us identify health related behaviour of women in this area. I will appreciate very much your willingness to participate in this survey. You are free to decline any of the questions you do not want to answer. Do you want me to begin the interview now?

Signature of Interviewer … Date……..

If consent is granted; the interview was conducted. If consent is denied interview ends.

In-depth Interview Identification No……..

Care giver Identification No……

Interview will be conducted in Yoruba or English where applicable

Probe for:

1 Demographic characteristics of respondents

2. When he / she started taking deliveries.

3 Number of deliveries taken per month in the last six months.

4. The basic instructions that she/he gives to pregnant women.

5. Types of food prescribed and proscribed for them.

6. Conformity to these instructions.

7. Whether women come for antenatal clinics / prayer meetings regularly.

8. Roles played by husbands of pregnant women during pregnancy.

9. The dos and don'ts handed over to pregnant women.

10. Common pregnancy complications that have been experienced in the course of duty.

11. Belief on causes of pregnancy complications.

12 What they do when such complications arise.

13. What they think can help pregnant women make the best use of their services.

14. Their opinions about other health care providers patronized by these women.

Thank you for your cooperation.

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APPENDIX IIIa

Husbands' In-depth Interview Guide

Good day Sir,

My name is M.O. Ayanleke and I am a postgraduate student of the University of Ibadan. I am carrying out an investigation on pregnancy care in Ilesa East and Ilesa West Local Government Areas. I will like to ask you some questions about your knowledge and care of your wife's pregnancy. Your answers are strictly confidential and the information you give will never be used to identify you. The information you give will help us to identify health- related behaviours of women in these areas. I will appreciate very much your willingness to participate in this survey. You are free to decline any of the questions you do not want to answer. Do you want me to begin the interview now?

Signature of Interviewer … Date……..

If consent is granted, the interview was conducted. If consent is denied interview ends.

In-depth Interview Identification No……..

Care giver Identification No……

Interview will be conducted in Yoruba or English where applicable

Probe for:

1. Who recommends health care delivery for their wives?
2. Whether husband will allow their wives to go to hospital without their permission.
3. Who pays for hospital bills and materials?
4. What husbands do to encourage wives to attend any care giver that the wives patronize?
5. What husbands do to encourage compliance to caregiver's instructions?
6. Whether they will like to follow their wives to hospital /mission /TBAs' house and actually witness the delivery process.
7. Who should determine the number of children to have in the family?
8. What they would do if their wives refuse sex because they have sexually transmitted disease/ she is tired.
9. Husbands' knowledge and perception of causes of pregnancy complications.
10. What husbands think should be done.
11. Husbands' knowledge of food prescribed and proscribed in pregnancy.

Thank you for your cooperation.

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APPENDIX III b

Itonisona fun iforowanilenuwo awon oko

Oruko mi ni Olaitan Ayanleke. Mo je akeko gboye imo ijinle ni eka imo ibagbe eka ni Fasiti ti Ibadan. Mo n se iwadi lori itoju awon aboyun ni ijoba ibile Ila-Oorun ati Iwo Oorun Ilesa. Mo nife lati beere awon ibeere lori itoju ati ilera iyawo yin. Awon idahun yin ni yoo je ki a mo ipo ilera awon obinrin ni agbegbe yi. Inu mi yio dun gidigidi si ijowo ara yin fun iforowanilenuwo. E ni anfani lati dahun tabi ko lati dahun eyikeyi ninu awon ibeere naa.

Ifowosiwe Oluwadi----------Ojo iforowanilenuwo----------

Bi o ba gba iforowanilenuwo n te siwaju

Numeri idanimo iforowanilenuwo

Numeri idanimo Olutoju

Iforowanilenuwo yoo je ni ede Yoruba tabi ti Geesi nibi ti o ti ye.

Iwadi lorii:

1. Taani o n yan eto itoju (ile iwosan) awon aya ninu ebi?
2. N je awon oko le gba ki awon aya won lo si ile iwosan lai gba aase lowo won?.
3. Tanni o n san awon owo itoju ati awon ohun elo?
4. Kini oun ti awon oko n se lati ru awon aya won soke fun lilo sibi itojuti nwon maa nlo?
5. Oun ti awon oko nse lati mu ki awon aya se bi liana ti awon Olutoju la sile?
6. Se awon oko yoo fe lati tele awon aya lo si ile iwosan/ Mission/ile itoju ati lati wa ni ibiti awon aya won ti nbimo.
7. Tanni o ye lati yan iye omo ti o ye ki ebi ni.
8. Kini awon oko yio se ti awaon aya won ba ko ibalopo nitori ti won ni asan ti nranni nibi ibalopo tabi ti o ba re awon aya won.
9. Imo awon oko nipa eko ati ero a won oko nipa awon okunfa awon isoro aaboyun.
10. Oun ti awon oko ro pe o ye ki won se ti alaboyun ba ni wahala.
11. Imo awon oko lori awon ounje ti a yan fun alaboyun.

E seun fun ifowosopo yin.

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