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MotherCare™

**MOTHERCARE NIGERIA MATERNAL HEALTHCARE
PROJECT QUALITATIVE RESEARCH**

WORKING PAPER: 17B

August, 1993

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**Public Opinion Polls, Ltd.
Lagos, Nigeria**

**MotherCare Project
1616 N. Fort Myer Drive, 11th Floor
Arlington, Virginia 22209 USA**

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MOTHERCARE NIGERIA MATERNAL HEALTHCARE PROJECT FORMATIVE RESEARCH

Public Opinion Polls, Ltd.

EXECUTIVE SUMMARY

by Deborah Gordis, MotherCare

The outcome of any pregnancy is influenced by a constellation of cultural, economic and physiological forces that may increase the probability of complications and death. In Nigeria where, according to the Nigerian research, between 800 and 1000 of every 100,000 live births results in a maternal death, these forces also vary from region to region, depending on a woman's ethnic origin, socioeconomic status, rural or urban residence, and health status. Any effort to treat programmatically the direct or indirect causes of maternal mortality must be informed by an understanding of the complex behavioral and environmental realities that shape women's lives.

Between August and November 1992, at the request of the MotherCare/Nigeria Maternal Care Project, Public Opinion Polls, Ltd., a private Nigerian research company, designed and implemented a qualitative investigation into the knowledge, attitudes and practices of Nigerian women, their husbands/partners and health care providers in the northeast state of Bauchi and the southwest states of Oyo/Oshun with respect to pregnancy, childbirth and postpartum care. The purpose of the study was to illuminate the substantive maternal health issues that motivate and inhibit safe motherhood and that may be amenable to programmatic or policy change. The results of the study are to be applied to efforts to reduce maternal mortality and morbidity ratios in Nigeria through the design of appropriate policy and management guidelines, appropriate clinical training programs for midwives and the implementation of a health communications campaign to improve maternal self care and to increase utilization of maternal health services.

The investigators conducted in-depth interviews and focus group discussions in both rural and urban locations of Bauchi and Oyo states. Participants were recruited from Fulani, Hausa and Yoruba communities and included pregnant women or those who recently delivered, their husbands/partners, community leaders, traditional birth attendants, traditional healers, nurse midwives and obstetrician/gynecologists.

The data obtained are organized according to the health and nutrition issues relevant to the different stages of pregnancy, labor and delivery and the postpartum period. Respondents were asked about the sources of health information available to them, such as radio, television, family and community members, health care workers. The study attempted to understand the flow of information within the community and the family decision-making processes that govern the utilization of traditional or formal medicine in the event of obstetrical complications.

The data reveal how cultural taboos and beliefs and socioeconomic forces often conspire to place a woman at a disadvantage from the start of a pregnancy. For example, among all three communities, pregnancy-related food taboos effectively eliminate several accessible, essential sources of protein from a woman's diet. The effects of nausea, diminished appetite and the enforcement of food taboos are not, however, compensated for by a reduction in the woman's

workload. Thus, many women are inadequately nourished and exhausted throughout their pregnancies. Husbands and in-laws help to maintain compliance with taboos.

Attendance at prenatal care clinics is not widespread. Transportation to these facilities and the cost of drugs and vitamins represent obstacles to clinic utilization for many of those who seek this care, especially among the rural Fulani. The belief among many Fulani that pregnancy is a private affair, and the concept of "shame" underpinning this belief, prevent many rural Fulani women not only from attending prenatal clinics but also from seeking help when they suspect something may be wrong.

However, interestingly, several Fulani respondents defended their decision to obtain care at the clinics despite cultural and economic barriers by invoking the higher costs--in financial and human terms--associated with treating complications at a hospital. Prenatal care is, unfortunately, seen by some as insurance against complications during delivery, which belief may ironically create an overconfidence about the prospects for a healthy home delivery. Among the Yoruba, receiving prenatal care did not seem to lessen the likelihood that, in the event of complications during labor, traditional medicine would be eschewed in favor of formal medicine. While several hospital-based physicians affirmed their belief that prenatal care would indeed prevent most of the complications they see in the hospital, the causal pathways of maternal morbidity and mortality are clearly more complicated.

Misperceptions of the early warning signs of obstetrical complications were found to be a serious contributor to delays in seeking out emergency care where available. Swelling of the face and hands, headaches, bleeding and premature rupture of the membranes are all considered normal. Even among the Yoruba, who tend to value hospital delivery far more than the Fulani or Hausa, transportation costs and logistics may preclude timely arrival at the hospital; once there, long waiting periods and lack of adequate personnel and equipment may preclude effective treatment. Nurses and doctors describe their irritation with this situation; community members protest their poor handling by health professionals, which may in fact be fallout from the frustration of trying to save women who arrive at the hospital too late or whose families cannot cover the costs of drugs and equipment that hospitals may require.

The gulf between traditional communities and western medicine is also illustrated by the underutilization of TBAs and the insufficient training provided to TBAs and traditional healers. While costs, feelings of shame and religious beliefs about exposing one's self may prevent many Fulani and Hausa women from seeking care at the hospital at the start of labor, women will sometimes be referred to the hospital at the eleventh hour when traditional treatments fail. However, TBAs among the Fulani and to some extent among the Hausa do not assist with labor and delivery but are only called upon to help with the newborn postpartum care. Those TBAs who have received clinical training express dissatisfaction with the lack of reinforcement training and links with the formal health care system.

Similarly, traditional healers, who use herbal treatments and Quranic verses in providing care, may also refer women to the hospital when their own methods are unsuccessful, but again, perhaps too late. Yoruba traditional healers who were interviewed did not see a conflict between traditional and western medicine and believe that the two systems can coexist. In fact, among the Yoruba, first-time mothers are considered high risk and often sent right to the hospital to labor.

Hospitals and clinics constitute an acknowledged important source of reliable information about pregnancy, delivery and infant care, despite the fact that hospital care is seen as inadequate. Respondents cited long waits, scarcity of drugs and equipment and the hostile

attitude of hospital personnel as reasons to avoid hospital delivery. Fulani from more remote villages felt that hospital personnel singled them out for particular ill-treatment and longer waiting periods because they are regarded as being "in a bush." Doctors' unwillingness to permit nurses to be trained to perform limited clinical procedures probably increases waiting time. That most hospital deliveries in some areas appear to be emergency deliveries undoubtedly contributes to the stressful atmosphere described by staff and patients.

In more urban areas of Oyo state, hospitals are able to impart to mothers, with some success, health information on maternal nutrition and self care. With respect to breastfeeding, however, hospitals in general appear to be doing little to change the widely held belief that colostrum is "dirty" and unhealthy for babies and that breastfeeding should be delayed until the "real" milk comes in.

The findings of the study describe a complex interaction of information sources, competing health care systems, cultural taboos, socioeconomic factors, decision-making hierarchies and client-provider relationships. At times, the opinions of the respondents and the analyses of the researchers seem difficult to distinguish from one another. But numerous direct quotations excerpted in the text shed light on the subject matter and provide an exceptional window into the minds and lives of the respondents. The direct and indirect causes of the region's high maternal morbidity and mortality ratios--which include poverty, illiteracy and women's low social status--shape the experiences described by the respondents, whose comments impart life to the statistics. The realities of women's lives described by the findings of this study present a challenge--and suggest solutions--to policymakers, health planners and program managers.

INTRODUCTION

BACKGROUND AND PROBLEM DEFINITION

Available information indicates that Nigeria, like any other developing country, exhibits high maternal mortality ratios and morbidity rates. In fact, experts say that at least 10% of all maternal deaths in the world occur here in Nigeria.

Studies, mostly hospital-based ones indicate that maternal mortality in Nigeria is caused by obstructed labor, sepsis, hemorrhage, eclampsia and the results of unsafe abortion. But these are direct obstetric causes. Other kinds of information point out the culpability of root causes in the social, economic and cultural environment such as poverty, illiteracy, ignorance, cultural practices, etc.

It is quite obvious that appreciable impression can only be made in the reduction of maternal mortality and morbidity ratios in Nigeria if women are educated as to the effects of the socio-economic and cultural practices and beliefs that expose them to health hazards. Not only this, by making women recognize early symptoms of obstetrical complications they can be made aware of their own health needs and thus take appropriate measures to prevent unnecessary maternal death or deformity.

The foregoing informed the client, MotherCare Nigeria Maternal Care Project to undertake a formative research to obtain information about the knowledge, attitude and behaviors of women, their families and their community support groups, and healthcare providers regarding self-care by women during and after delivery; as well as their utilization of maternal healthcare services and immediate care for the new-born baby.

The result of this study is expected to assist in the two other components of the Mothercare Project, which are:

- The training of midwives to increase their clinical knowledge and practice of maternal life saving skills and to enhance their practice of interpersonal communication and counselling skills.
- IEC campaign to promote self-care and new-born child care and utilization of maternal healthcare services among women.

Nigeria Maternal Healthcare Project Formative Research

KEY MATERNAL HEALTH ISSUES

The key community and clinic-based maternal health issues among the various audiences are to:

A. Women

- examine knowledge, attitudes and behaviors of women especially pregnant women, regarding self-care, recognition of risk factors, beliefs regarding their cause and treatment, and utilization of routine and emergency traditional and formal maternal health services (including family planning) during antenatal, intrapartum, post-partum and neo-natal phases of pregnancy.
- probe into the decision making process, roles of people and activities surrounding delivery, after delivery and healthcare seeking behavior, especially emergency referral.
- probe into the perception of women regarding pregnancy as a special condition needing special attention vis a vis a woman's daily routine of work, rest and nutrition.
- probe into recognition of complications and their treatment and referral.

B. Men

- examine men's knowledge, attitudes and behaviors regarding their involvement in health of pregnant women (including family planning); and the utilization of routine and emergency maternal health services.
- probe into involvement of men in the decision making process and activities surrounding antenatal care and delivery for the pregnant women.
- probe into the perception of men regarding pregnancy as a special condition needing special attention vis-a-vis a woman's daily routine of work, rest and nutrition.

C. Community Leaders

- examine community leaders' attitudes and practice toward the use and promotion of general health services and specifically routine and emergency referral for maternal healthcare.
- probe into recognition of complications and their treatment and referral.

D. TBAS

- inquire about TBAs' attitudes and practice with antenatal care, delivery management and referral of complications and experience with formal health services.

- probe into recognition of complications and their treatment and referral.

E. Village Doctors

- inquire about village doctors', attitudes and practice with antenatal care, delivery, management and referral of complications, post natal care and experience with formal health services.

F. Nurse - Midwives

- inquire about nurse/midwives' attitudes and practice with antenatal care, delivery, management and referral of complications, post-partum and neo-natal care, and experience with traditional health services.

- probe into recognition of complications and their treatment and referral.

G. Obstetricians/Gynecologists

- inquire about doctors' attitude and practice with antenatal care, delivery management and referral of complications and experience with traditional health services.

In addition, the study sought to obtain information about IEC activities addressing community-based self care, safe delivery and utilization of maternal health services in the areas surveyed.

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METHODOLOGY

RESEARCH METHOD AND GEOGRAPHIC AREAS COVERED

We addressed the information need areas through qualitative research, comprising a series of focus group discussions (FGDs) and In-depth interviews (IDIs) among three ethnic groups in two states in Nigeria.

For this study, a total of 68 FGDs and 128 IDIs were conducted among Hausa and Fulani in Bauchi State and among the Yoruba in Oyo/Oshun States. The target audience was segmented by: location (rural/urban), age, sex and all respondents were drawn from the C2DE socioeconomic classes.

Survey locations in Oyo/Oshun States included:

Urban: Ibadan

Rural: Sekona, Odeomu, Ikoyi, Edunabon, Ipetu modu, Ido-Osun ,
Moro.

In Bauchi State, among the Hausa;

Urban: Bauchi (Wunti Kobi, Wunti Dada, Zango/federal low cost),
Yelwa, Shekal, Kofar Dumi, Jahun Nassarawa, and Turun.

Rural: Gudum, Buzaye, Katsinawa, Gubi, Zaranda, Kagadama, Lushi,
Gwallameji.

And among the Fulani;

Urban: Azare, Bidawa, Magandala, Madara, Abbayayawo, Misau,
Sirko, Ajili and Darazo.

Rural: Bidir, Dagaro, Jarkasa, Jabdo, Zaḡawa, Sabon Gari Papa,
Sade, Bodado and Gabarin.

The details of the FGDs that were conducted among women and men among the three ethnic groups, in both urban and rural locations are as follows.

Summary of FGDs:

	Hausa	Fulani	Yoruba	Total
Women:	14	14	14	44
Men:	8	6	10	24
Total	22	20	24	68

WOMEN:

<u>Audience Segment</u>	<u>Hausa</u>		<u>Fulani</u>		<u>Yoruba</u>	
	<u>U</u>	<u>R</u>	<u>U</u>	<u>R</u>	<u>U</u>	<u>R</u>
Pregnant Women age 15-25 (or 13-17 for Bauchi state) and pregnant for the first time	2	0	0	2	2	2
Pregnant Women age 26-40 and pregnant for at least the second time	2	2	2	2	2	2
Women who delivered within the past two months in the home with or without the help of TBA.	2	2	2	2	2	2
Women who delivered within the past two months at the hospital or in health facilities	2	2	2	2	2	2
Total	8	6	6	8	8	8

MEN:

<u>Audience Segment</u>	<u>Hausa</u>		<u>Fulani</u>		<u>Yoruba</u>	
	<u>U</u>	<u>R</u>	<u>U</u>	<u>R</u>	<u>U</u>	<u>R</u>
Men whose wives are age 13-25 and pregnant for the first time	2	0	0	2	0	2
Men whose wives are age 26-40 and pregnant for at least the second time	2	0	0	0	2	0
Men whose wives delivered in the past two months in the home	2	0	0	2	0	2
Men whose wives delivered in the past two months in the hospital	2	0	0	2	2	2
Total	8	0	0	6	4	6

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Also, below are the details of the individual in-depth interviews (IDIs) that were conducted among women, village leaders, TBAs, village doctors, nurses/midwives and Obstetricians and Gynecologists.

Summary of IDIs:

Women:	72
TBAs:	18
Village doctors:	8
Nurse/midwives	12
OB/GYNs:	10
Village leaders:	8

<u>BAUCHI</u>		<u>AZARE</u>		<u>IBADAN</u>	
<u>U</u>	<u>R</u>	<u>U</u>	<u>R</u>	<u>U</u>	<u>R</u>

Audience Segment

Women who were pregnant for the first time and just delivered within 2 months and are age 13-19	4	0	0	4	4	4
Women who were pregnant for at least the second time and just delivered within 2 months and were considered high risk pregnancies (age 20-35)	4	0	0	4	4	4
Women who were pregnant for at least the second time and just delivered within 2 months and were considered to have had a complicated delivery (age 20-35)	4	4	4	4	4	4
Women who were are currently pregnant, are in their third trimester and considered high risk pregnancy (age 20-45)	4	0	0	4	4	4
Total	16	4	4	16	16	16

Overall total for women = 72 IDIs

Other IDIs: 56

TBAs: 6 Hausa; 6 Fulani; 6 Yoruba
(all in rural areas)

Village doctors/local
pharmacists (no formal training) 3 Hausa; 2 Fulani; 3 Yoruba
(all in rural areas).

Nurse/midwives: 3 urban, 3 rural in Bauchi; 3
urban, 3 rural in Oyo/Osun.

OB/GYNs/Medical Officers: 3 urban, 2 rural in Bauchi; 3
urban, 2 rural in Oyo/Osun.

Village Leaders: 3 Hausa; 2 Fulani; 3 Yoruba
(all in rural areas).

SAMPLING PROCEDURE AND SCREENING

Typically, qualitative studies including, FGDs and in-depth interviews are not designed to be representative of their respective population, but to represent certain sectors of that population. As such, our sampling for FGDs and in-depth interviews was purposive and no attempt at randomization was made. But all respondents were screened to meet the requirements of the group composition. In addition, respondents who have attended a group discussion in any health related matter in the last six months or those associated with the provision of healthcare services were excluded from the FGDs.

We also made use of birth registration and other records in local clinics and maternity centers in the recruitment of respondents for certain focus group discussions and in-depth interviews.

The knowledge of community leaders and other influential people in the area also come to play in constituting many other groups.

LANGUAGE OF INTERVIEWS

Because of the possible loss in meaning that may occur from translation, local dialects were used in conducting the interviews except for the professional audience.

PILOT STUDY

A pilot study of a selected FGDs and IDIs were done before the main study, to fine-tune the research plan and refine the discussion guides. A lot of changes were made in the discussion guides after the pilot study. Even then, the discussion guides were reviewed at various times during the conduct of the study to clarify and focus more attention on some areas based on the findings from the pilot

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exercise.

RESEARCH TEAM

The FGDs and IDIs were conducted by experienced and seasoned moderators and interviewers among whom were; Femi Odusi, General Manager with POP, Benson Olubodun, a Snr. Research Executive with POP, Mrs Dupe Oyedele, A Research Executive with POP, Ms. Alaba Simpson, a consultant to POP, Mrs Juliana Nathaniel, Ms. Joyce Dakun, Mrs Paulina Dogo, Mrs. F. Damara, Mr. Hassan John, and Idris Abdulahhi all Nigeria Family Health Services (FHS)-trained formative research moderators/interviewers. Technical assistance was also received from John Snow Inc, US and their consultants including Dr. Barbara Kwast, and Kim Winnard.

In addition, we also received considerable assistance at various stages of the project from Susan Krenn, Lola Payne, Data Phido, Mini Soyoola all of Nigeria Family Health Services Project and Nigeria Mothercare Project.

Dr. (Mrs.) Peju Olukoya of the Institute of Child Health and Primary Care, College of Medicine, Lagos also assisted in conducting the Literature Review for this study.

They were all assisted by local resource persons to recruit for the FGDs and IDIs. Most of these resource persons were also, FHS-trained.

In cases, where no trained persons was available, especially in the Fulani speaking area, moderators went through an FHS-designed and POP-adapted training program lasting a week to intimate them with the nitty gritty of formative research involving FGDs and IDIs. The training included lectures, mock groups, role plays, etc. At the end of one week we were convinced that the moderators were capable of using the discussion guides effectively in addressing the research needs.

TIME OF STUDY

The study was conducted between August and November, 1992.

ANALYSIS OF RESULTS

The results are presented by ethnic group. At the ethnic group level, the findings are presented in two parts.

The first part features findings from women, men and their community leaders. The community leader are represented by village leaders, religious leaders and market women leaders and traditional healers in Yoruba ethnic group while traditional birth attendants

are taken as women leaders, apart from the local health care providers role in the Hausa and Fulani ethnic groups. The findings are divided according to the stages a pregnant woman goes through from antenatal to post partum. The reason for combining the three audiences is because these audiences did not hold widely different views. In cases where differences exist, putting them together was very useful in analyzing what differences exist and has actually enhanced rather than limit the richness of the interpretation of findings.

The second part presents findings from the healthcare service providers, whether traditional or formal in a summary version.

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THE SITUATION IN BAUCHI STATE

**DETAILED FINDINGS FROM WOMEN,
THEIR HUSBANDS AND COMMUNITY LEADERS: FULANI**

INFORMATION

We found that in the communities studied, one form of health and pregnancy related information or the other is received.

The variety of information sources available to them ranges from those obtainable within the household/family including mothers and mothers-in-law, female elders, etc; to radio; tv; maternity/general hospitals; traditional community leaders and ward councilors.

However, a general trend is that those in rural area tend to receive less information from outside sources than those in urban areas.

Household Sources

Among the community studied, dissemination of information about pregnancy is believed to be the concern of the women. Thus, mothers and other female elders in the family are the first and most continuous source of information about health and practices to women during pregnancy, according to the respondents. Pregnant women are thus educated on; hygiene (clean themselves and their environment especially because of the child they are carrying), work habits (do not sit idle, work a little, walk around), nutrition (eat eggs, fowl, fruits and vegetables). They are also advised against eating certain kinds of food. We note that men are more knowledgeable about food taboos.

It was found that the household source is available to most women whether they make any conscious efforts to get it or not and tends to be the only source of pregnancy-related information available to a majority of women especially those in rural communities and many first-time mothers. In fact, many rural communities said they feel isolated because they are far from the towns.

"There are many information concerning pregnancy but we don't receive any and since we are villagers who will come to the village to tell us." -- Woman pregnant for at least second time, delivered within last two months, considered high risk delivery, Azare

I didn't receive any information about being pregnant because it is my first time, so I don't know anything about it." -- Woman pregnant for the first time and just delivered, Dagaro

It is clear that this source is the conduit for the myths, superstitions and misconceptions regarding pregnancy those of which rare simply attributed to how the 'forefathers' used to do it.

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We also note that the credibility attached to this source is high when it is the only source available and especially when the holders have not been exposed to contrary information.

Radio and TV

Outside the household, radio is unarguably the most common source of information about health -- and to a lesser extent, pregnancy. Respondents claimed that information that they normally obtain from the radio include those on hygiene, nutrition during pregnancy, immunization, ORT, EPI, etc.

However, research shows that the potential of this source is largely untapped among women. For even when there is a radio in the house, they are too busy with household chores to listen to it or they can't get at it because it is being used by their husbands.

"The radio is in the house but I have never cared to listen to the program attentively. I have a lot to do here." -- Woman with complicated delivery, Zadawa

The source tends to serve as a conduit for general information, and the credibility attached to this source is not so high. For instance, some respondents reported that they hear a lot of promises on the radio that never materialize making them suspicious of the veracity of whatever they hear on the radio.

We believe that this source could be more effective if reinforced by other credible sources.

Community Leaders

Community leaders constitute another information source to some of the Fulani, but mostly to the men. When there is information concerning immunization visits by health officials of the Local Government, ward councilors or other community leaders usually assemble the men to inform them. The men are expected to relay the information to their household members.

Some community leaders also inform men of the existence of nearby health facilities and try to persuade men to send their wives for care if need be.

It is also noted that this information-relaying function constitutes the community leaders' main and probably the most important role regarding the health of pregnant women in their communities. It is clear that this is one of the most credible sources of information to men in the communities studied.

Village Healers/TBAs

Though, they are not explicitly mentioned during many of the interviews, we suspect that many of the beliefs, myths and misconceptions about pregnancy are actively propagated and kept alive by village healers and TBAs.

One community leader mentioned that most TBAs inherit the job of caring for women during childbirth from their mothers and never undergo any formal training. They are thus, in our opinion part and parcel of the belief system in their communities, and because of their position in the healthcare system, they see themselves as the custodian of traditions and customs regarding care during pregnancy.

It is clear that this source is very credible where the health system is still mostly traditional like in remote rural areas without medical facilities and among even many of the more so-called urban Fulani communities.

Hospitals/Ante-natal clinics

We found that hospital/ante-natal clinics constitute another source of information for a few of the Fulani, mostly women, but some men through their wives. Again, information obtained from this source include those on hygiene, the kind of food to eat, work habits.

As a result of the perceived effectiveness of hospital care, most of the women that attend hospitals/clinics attach a high degree of importance to this source to the extent that they tend to discard information from other sources.

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PRENATAL CHANGES & ANTENATAL CARE

In many of the communities studied, pregnancy is viewed as a time of changes and great upheaval for the womenfolk, bringing with it many ailments and changes in their work and sex habits and nutrition.

Ailments

In all communities studied, certain ailments are claimed to afflict all pregnant women ranging from mild to serious and incapacitating vomiting, dizziness, nausea, tiredness, emotional distress, lack of appetite, oedema, etc.

"It reached a time when I will not be able to eat or drink or stand up or sit down. In short, I was not enjoying anything that time in my life." -- Woman pregnant for at least the second time and just delivered within two months and had complicated delivery, Zadawa

"I usually fight my husband in the first three months." -- Woman who delivered in the hospital, Zadawa

In recognition of this, many husbands, especially in the first six months, give their wives special treatment, though could be limited in the quality of care that they can give by lack of money. Some women however claimed that their husbands are at best indifferent to their condition or at worst actually not happy with them.

"If a woman is pregnant, she is equal to a patient who is on admission in the hospital." -- Man whose wife delivered in hospital, Sabon-qarin papa

"I really sympathize with her when she is pregnant due to some changes in which I am the cause." -- Man whose wife delivered in hospital, Sabon-qarin papa

"There was no change from my husband. He laughed at me." -- Woman who delivered at home, Jar-kasa village

"He is always shouting on me, frowning his face all the time, because I am pregnant now." -- Woman pregnant for the first time, Gabari

"Mallam, in the village, what rest will they get? They will do all kinds of work unless if they complain that they are not able to do so." -- Man whose wife delivered in hospital, Bodado

Sex

Sex is something that a lot of the men expect from their wives during pregnancy, especially during the first 4-5 months of pregnancy. This is based on the belief that women are actually more

sexually active during this period, and so need their husbands, though some try to avoid sex throughout the period.

However, the group concession is that a woman should make love with her husband provided she is healthy and willing.

"They need men but not in all women. There is a specific time for sexual contact with them although there will be a certain time you as a husband would not like to have sexual contact with her due to that pregnancy ." -- Man whose wife delivered in hospital, Sabon-garin papa

"At the stage of one to four months is a free time for having sexual contact with the wife. That one won't cause any problems in that stage, the pregnant women need their husband." -- Man whose wife delivered in hospital, Sabon-garin papa

"Some women when they are pregnant, they will hate the husband, until it reaches a certain stage whereas everybody knows that she is pregnant, and at that time, she will not even come to where your bed is, let alone have any sex with you." -- Man whose wife delivered in hospital, Bodado

Eating Habits and Food Taboos

It was found that pregnancy also plays havoc with the eating habits of most women. Except in a few cases, most women mentioned not being able to eat much, usually reducing food intake both in terms of quantity and frequency. Attempts to improve the quality of food at this time, in line with injunctions regarding nutrition, are mostly frustrated by frequent vomiting and the inability to afford richer food.

"I eat only 'tuwo' and 'buka' soup because I have no means of getting anything apart from it." -- Woman pregnant for first time and just delivered two months ago, Dagare

Research shows that food taboos exist among the Fulani during pregnancy. According to the respondents, pregnant women are expected to observe strict compliance with taboos involving the eating of sugar/sugar cane. This is the most feared food substance during pregnancy as it is believed to cause 'strong' labor.

Chicken is another no-go area among the communities studied. Chicken is believed to cause 'bayamma' (jaundice) to both mother and child.

The less often mentioned taboos included the eating of 'lolo' (a slimy soup like okra), any green vegetable, groundnut oil or oily food, eggs, bitter leaf (can cause abortion), pepper (will cause eye problem in the new born baby). Women who break these taboos are believed to meet with dire consequences, mostly difficult labor.

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"It is only sugar that we don't take because it causes long labor." -- Woman who delivered at home, Sirko

"If a pregnant women eats chicken she will suffer one kind of disease called 'bayamma' and such a disease will affect even the baby." -- Man whose wife delivered at home, Dagaro

"When a woman is pregnant, we don't allow her to eat chicken and eggs, and any protein diet. This is because if she eats the above food items, the baby will be too big in her stomach and during delivery she will find it difficult." -- Community leader, Sade

Apart from food taboos, we also found a long list of other 'don'ts' for pregnant women. Most of these are harmless and are of no particular disadvantage to the women.

Work Habits

The combination of inappetence and regular nausea and vomiting ensures that most women remain nutritionally unsatisfied, and feeling weak and tired at all times. Yet most of them still have to perform all or at least part of their household chores like washing, pounding millet, cleaning the house etc.

It was found that many women in this situation either never get any assistance or don't get enough of it. Assistance, if any are provided by mates (co-wives, mothers, mothers-in-law, and among a very few, husbands), or the husband can pay someone to help the wife -- if he can afford it.

"I couldn't work. It was my mother-in-law that did the housework." -- Woman who delivered in the hospital, Zadawa

"I work a lot. Even on the day I was to deliver, I pound millet and cooked my food." -- Woman pregnant for the first time and just delivered, Bidir

Our findings indicate that many women would actually welcome freedom from household chores when they are pregnant.

ANTE-NATAL CARE AND CARE PROVIDERS

Self Care

It was found that a majority of Fulani women studied do not get any form of routine care or attention during pregnancy from anybody. Nor do they expect any; they'll rather do everything by themselves. Some even avoid people, including their husbands at this time! At best they obtain assistance with household chores from their 'mates' (co-wives), mothers and mothers-in-law and expect their husbands to provide more nutritious food for them.

According to the respondents, the Fulani woman does not expect any care during pregnancy because it is considered brave to endure pain and bear any discomfort. To do otherwise is considered a 'shame' as you have let out your secret. Among the Fulani, pregnancy is considered the woman's own secret.

"I don't normally care about such things (care during pregnancy). I just stay as I am normally even if I am sick my husband will hardly know it, except when it is beyond my control. " -- Woman with complicated delivery, Abbayayawo.

"I don't want care from anybody, I just seek help from God." -- Woman in third trimester, considered high risk, Jabdo.

It is clear that 'shame' is very important to the Fulani. It is like a tradition handed down from the grandmother to the mother, and to daughter and one which is little understood by those that hold it sacred. 'Shame', as we found out, is much more than simple shyness, but shyness is part of it. As claimed in many of the groups, the Fulani are a shy people. Pregnancy is believed to be a very private thing or if you like, a secret and is considered shameful to discuss it with other people. Violation of this tradition is frowned upon in many Fulani communities, but the more urbanized Fulani are less likely to feel 'shame' when discussing their pregnancy, while first mothers are more likely to.

As will be seen later in this report, the concept of 'shame' is a very important one influencing the behavior of the Fulani during pregnancy and delivery.

Routine Care from Traditional Sources

A few women, however, claimed to seek routine care on a continual basis prior to delivery from traditional healers and/or religious leaders. Herbs for bathing and drinking and 'rubutu' (Quranic verses written on a slate and washed with water for drinking) are respectively the types of care provided. Respondents claimed that routine care is sought to make pregnancy and labor easy for the women. Cost and ease of obtaining this care makes some women prefer it to antenatal care from the clinics.

Ante-natal clinics

It was found that fewer still seek for routine care at the antenatal clinics mainly because of 'shame'.

Also, in situations where some women would have liked to attend antenatal clinics, they claimed that distance to health facilities, transportation problems, and the cost of drugs stand in their way.

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But there is a group of men and women who have embraced care at ante-natal clinics for their wives despite these obstacles. The belief is that, it is cheaper to incur ante-natal expenses rather than the expenses and difficulties of complicated delivery.

"If there is an emergency, you must hire the whole lorry and pay around N250 to the hospital. There you pay a lot of money at the hospital. All these we think about hoping that they deliver successfully at home. So to prevent all these complications, we always send our wives to hospital right from the time when the pregnancy is about two months for weekly check up." -- Man whose wife delivered at home, Dagara

"I want to deliver at home because if I go for clinic (ante-natal) in the hospital, I will be able to give birth successfully at home." -- Woman with complicated delivery, pregnant for at least the second time, Zaranda

So completely have some men embraced hospital care that we fear that they may forget or ignore useful traditional practices in their areas to their own detriment.

"In the old days when a woman is pregnant she usually continues thinking whether she will deliver successfully or die. But now as ante-natal clinic is recognized the old days are forgotten. All the customs and beliefs of the old days are no longer in existence." -- Man whose wife delivered in hospital, Sabon-garin papa

"Since the time we are aware with the effectiveness of the hospital medicine, we no more apply native medicine. Therefore, we always refer them to maternity where they give them some drugs and advice." -- Man whose wife is pregnant for the first time, Ailli

"We have now almost abandoned traditional medicine as regards to a pregnant woman." -- Man whose wife is pregnant for the first time, Jarkasa

According to the respondents, care obtained include monitoring for complications, weight and anaemia screening and treatment with multivitamins, counselling, etc. These many claimed to find useful, though some claimed ignorance of the need for some of the care. For instance, a woman in one of the groups wondered what weight monitoring has to do with treatment.

Knowledge and Treatment of Complications Prior to Delivery

When serious conditions occur during pregnancy, most Fulani women seek help within the household first, since this is the cheapest and most easily available treatment, according to the respondents. Herself (especially if she is an experienced mother), her 'mate', mother, mother-in-law, husband and elders are all possible people that are relied upon at this stage.

"I had severe headache, when I was pregnant, it pained me seriously but I didn't consult anybody. I only sent some children to buy 'Pengo' or 'Cafenol' for me from traders." -- Woman pregnant for first time and just delivered two months ago, Dagaro

"Some husbands have 2, 3 or 4 wives, any one among the wives can assist the sick one at any time. But when there is serious sickness, it is the responsibility of the husbands to get her drugs for treatment at all cost." -- Man whose wife delivered in hospital, Sabon-garin papa

Failing this, a traditional healer, who may also be a religious leader is called. Boiled herbs may be given for drinking or bathing by this person, while 'rubutu' may also be prepared for her.

If this fails, most then seek hospital care.

It was found mostly that, men's recognition of problems their wives could suffer during pregnancy is limited to those conditions -- vomiting, dizziness, pains, tiredness, etc -- that are normally associated with pregnancy and hence require no treatment. But their wives' knowledge though a little bit better was limited.

"In the first to third months, they suffer laziness (tiredness), some light headache, and they too much spit saliva, and of course constipation. So when they are suffering from all these kinds of things, we only see them, we don't do anything because we believe that it is normal for a pregnant within this period to have the observed changes and that she stops all these conditions when the pregnancy reaches at least 4-5 months, because at that time, pregnancy is fully developed." -- Man whose wife is pregnant for the first time, Sabon garin papa

Swelling of feet, hands and face, a condition that happens in almost all pregnant women is believed to be normal to pregnancy and hence require no treatment or occurs when one is expecting a female child or occurs due to lack of balanced diet. Use of boiled herbs is the traditional way of treating this condition when help is sought, especially by inexperienced mothers.

"Some swell up when their pregnancy is a female child while if it is male child, she will not swell up." -- Woman who delivered at home, Sirko

"In this village we have so many women who have swelling in their legs faces and hands and this is due to back of enough diet and protein in their body." -- Women delivered in hospital, Dagaro

Again, conditions like severe headaches ('hori nawai') and high fever ('jonte') though very common are mostly neither seen as pregnancy-related nor as serious. Thus, boiled herbs or analgesics are normally used to care for these ailments.

Respondents reported treating blood loss with tamarind water and sugar and not normally referring it to the hospital until excessive

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blood loss causes the woman to lose consciousness. In a few cases, if bleeding occurs very close to delivery time, it is normally taken as a sign that labor has started.

Respondents also claimed that breaking of water prematurely is not very common and again in many cases is not usually treated. When it occurs very close to labor, it is usually seen as a sign that labor has started, and is usually not treated at all or until it is too late. Traditional treatment though available, is perceived as ineffective and women almost always have to be taken to the hospital for treatment.

"Some women experience that (breaking of water more than 12 hours before labor starts). To us, it is not a sign of any sickness." -- Woman pregnant for first time and just delivered two months ago, Dagaro

LABOR & DELIVERY

Preparation for Labor and Delivery

It was found that little or no preparation is made concerning labor and delivery by both women and their husbands among the communities studied. For most women, no forward planning is made concerning pregnancy period as a whole including labor. This was explained to us as due to the need to keep the secret of being pregnant (the feeling of 'shame') and the uncertainty about the outcome of pregnancy.

"No preparation. I am shy about it and my parents will take care of everything." -- Woman pregnant for the first time, Madara

"No preparation. If I do, people will say that I don't respect my elders and I am not ashamed of myself." -- Women pregnant for the first time, Madara

"What if you die in the process of delivery. We want to see what will happen first." -- Women pregnant for the first time, Madara

"There wasn't any preparation, we just believe that things take care of themselves at the right time." -- Woman in third trimester, considered high risk, Jabdo

We also note that many men usually fail to make any financial preparation to meet delivery expenses, even those that prefer hospital delivery for their wives. In such situations, some men reported selling their animals or grains to meet emergency hospital charges during delivery. Most preparation hinge on buying foodstuffs, firewood, pepper, spice, etc to be used by the mother after delivery.

Labor Signs and Duration

We found that except for a few women especially inexperienced ones, most women claimed to know when labor is knocking. The pains, which are believed to be inevitable are claimed to usually herald labor. Signs normally taken as impending labor include; stomach pain, backache, breaking of water and bleeding from the birth canal.

"(I know I am ready to deliver) when I have pain which is different from sickness." -- Woman pregnant for at the second time delivered within two months and considered high risk, Azare.

"It (labor pain) is different from other sickness, you will experience back pain, stomach pain and so on." -- Woman who delivered at home, Sirko.

"I don't know what it is (labor) or how it feels." -- Woman pregnant for the first time, Madara.

It was found that there was no general agreement about when labor has gone for too long. Women reported that duration of labor differs for different people. For instance, young women especially those with their first births are said to experience a longer labor period than experienced women. Research shows that, it is normal for labor to be allowed to progress for more than 3 days before hospital care is sought. When labor is perceived to be prolonged traditional care is first sought, while the hospital is utilized as a last resort.

"I don't know how long labor should last. I myself spend two days with labor pains and I didn't do anything about it up till the time the baby came out." -- Woman with complicated delivery, Abbayawawo

"In my case, it was 3-4 days. I usually take Arabic writing ('rubutu') from the Arabic teacher to quicken it." - Woman who was pregnant for at least the second time, just delivered and considered high risk

"Labor period last sometimes four to five days and in some cases, it lasts up to nine days." -- Woman delivered in hospital, Dagaro

Places of Delivery

In most of the groups, it was found that women, including a few that attend ante-natal clinics, prefer and deliver their babies with little or no assistance at home. Very few women plan to deliver in the hospital. Most hospital deliveries are women that have been advised to deliver in the hospitals for one reason or the other or those rushed to the hospital because of life-threatening complications.

Women reported that on sensing labor, they go quietly into their rooms, alone, squat and deliver their babies. Rarely are other

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people, even close relatives called to assist until after delivery, except when in difficulty.

"When we are in labor, we don't say it out because it is a shame. It means you are not brave for revealing your secret and people will be gossiping about you." -- Woman pregnant for first time, just delivered with two months. Bidir.

A number of reasons favor home deliveries among the communities studied. Women reported home as being more familiar, less threatening than the hospital and more comfortable and does not expose one to 'shame' (Fulani). Again, it is thought that a woman that cannot by herself deliver is not brave and is thus gossiped about. Some women reported refusing hospital care in what was apparently life-threatening situations because of this belief.

"I want to deliver at home because people will be gossiping on you that you don't have the courage to deliver at home." -- Woman who was pregnant for the first time, Dagara.

"When we are pregnant and we want to go to the hospital, other members of the family will start abusing us that we are not ashamed of ourself in taking our pregnancy to the hospital, while our elders do not." -- Woman pregnant for at the first time just delivered last two months, Dagara.

"The most disappointing aspect of hospital, mallam, is that they insert their hand in the woman's private part." -- Man whose wife delivered at home, Dagara.

Second, among many of the respondents, the hospital is believed to be a place to go when you have problems. This was why some women who delivered in the hospital because of complications in a previous birth would rather deliver at home if no complications are present.

"We want them to deliver at home if the delivery can be successful. It is only when a woman stays long in labor without delivery that we refer them to the hospital instead of applying traditional treatment." -- Man whose wife is pregnant for the first time, Ajili

It was found that cost of care and transportation problems constitute the two most crucial impediments to hospital delivery for those that desire hospital delivery and in obstetrical emergency situations.

Women reported that hospital care is unaffordable to them. In some cases, the mere thought of the huge hospital bill was enough for many husbands to persuade their wives to continue in labor even when it was obvious that the woman needs emergency care. One of the community leaders interviewed confirmed that delivery at home is

preferred because it is cheaper.

It was found that difficulty and cost of getting transportation prevent many from thinking of hospital delivery, especially those in the more remote villages. A community leader of one of the villages under study mentioned that when the health committee of their village meets, the topic of discussion is almost always on how to ease the transportation problems in emergency cases, including during delivery.

Long waiting time, mainly due to lack of adequate personnel to man medical facilities, scarcity of drugs, attitude of hospital personnel, were also mentioned as reasons for decisions to deliver at home rather than the hospital.

"Because in the hospital they don't attend to us. They say we are villagers, they keep us waiting and waiting for a long time." -- Woman who delivered at home, Sirko.

"I delivered at home because the hospital is far away and even if we go there, there will be no medicine." -- Woman delivered at home, Jar-kasa.

"We have no objection towards our wives delivering at either clinic or hospital concerning their health because we know that they are delivering in a place where we are sure of their successful delivery. But our feeling is the cost of hospital charges and transport. In addition to that, we Fulani people are lowered to the lowest level by the hospital staff simply because we are in a bush. For examples, you take your wife to the hospitals, the hospital workers will first of all order you to stay under a tree or veranda. They will go away for a long time and later come back to tell you that the doctor is busy and that you cannot simply see him - unless if you can do something; that is you give money to him so that he can connect you with the doctor." -- Man whose wife delivered at home, Dagaro.

"We prefer our wives to deliver at home. As we are not used to the services of the hospital we usually face a lot of embarrassment from the hospital workers. For instance, if you are not from the urban area, you must find somebody who will act as a mediator between you and the midwives to attend to your wife. Don't think you are getting this service free. No, you must give him money. You then come and pay for the hospital services and buy drugs plus other materials." -- Man whose wife delivered at home, Bidir.

"You can be in the line to see the doctor, but the moment other patients see you in the front line they will start spitting, meaning that you are smelling. And this is really an embarrassment." -- Man whose wife delivered at home, Dagaro.

One of the traditional leaders that we talked to shed more light on the issue of attitude of hospital workers and explained that women who attend ante-natal clinics do not usually complain of

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embarrassment. He thus dismissed complaints of embarrassment as due to ignorance and lack of education.

It is clear that hospital staff are usually harder on cases of complications when such women have not been attending ante-natal clinics.

Many of the men reported that they would not mind hospital delivery for their wives, since delivery time at home is a time of uncertainty and upheaval for them. They explained that the man whose wife is about to deliver in the hospital is generally more peaceful as there is total submission to the expertise of the modern health facility. Again, their wives believe that hospital delivery is easier and better for them.

"When a wife is in labor, you as a husband don't have any peace of mind, you will be going up and down." -- Man whose wife delivered at the hospital, Sabon-garin papa

"To deliver in the hospital is of ease to both the husband and the wives." -- Man whose wife delivered at the hospital, Sabon-garin papa

"We don't have any belief which is against attending maternity or hospital in this village. But our religion prohibits a married woman to expose herself to the public, except if the circumstances warrants it like health (sickness) greeting parents, performing condolence." -- Man whose wife delivered at home, Bidir

"I want to deliver in the hospital because people who deliver in the hospital get injection which give them energy. The nurses also massage the uterus to remove the blood. So I want to deliver in the hospital and I want nurses & midwives to help me." -- Woman pregnant for at least second time, delivered last two months, considered high risk, Azare.

"In those days, we used to call some old women (TBAs) who are knowledgeable about delivery to assist. Now that we are aware of the services of the hospital we don't even waste much time in labor." -- Man whose wife is pregnant for the first time, Ajili

"It is generally good for the welfare of both the mother and her baby to deliver in the hospital because hospital people know how to cater for any oncoming problem or complication that may arise." -- Woman with complicated delivery, Azare

It is our opinion that the feeling of shame and religious beliefs about women exposing themselves in whatever degree, probably constitute some obstacle to the seeking of care at the hospital among the Fulani, but our suspicion is, that apart from high cost of care and transportation problems, much of the phobia against hospital care is due to ignorance, a fall out of the inadequate

number of the health facilities. This is supported by the suggestions given during all the interviews for the government to provide more health facilities.

Knowledge and Treatment of Complications During Delivery

Research indicates that, generally, knowledge of why a woman may have difficult delivery was poor among the communities studied.

Many of the respondents believe that it is God's will, while the men said knowledge of complications was a woman's secret that is unknown to them. Some also reported that complications are caused by failure to obey food taboos and disobedience to one's husband,

"Delivery is something that comes from God naturally. You can't foresee that this or that person will suffer difficult delivery because she has this or that. It just happens as God wishes." -- Woman in third trimester, considered high risk, Jabdo.

"This is a secret of pregnant women which we men would not know."-- Man whose wife delivered in hospital Sabon garin papa.

In cases where knowledge about causes of complications were better, young age and stature (many think of these two as one and the same) and anaemia were the main factors mentioned. Men defended the practice of early marriage as being done to prevent fornication.

"We have the custom of marrying our girls at the early age when they are not fully matured for fear of fornication from either sex." -- Man whose wife is pregnant for the first time, Jar-kasa

In an obstetrical emergency situation, the respondents claimed that close relatives, including the husband, the 'mate', the mother and mother-in-law and concerned neighbors and other community members all rally round the woman in trouble to provide any assistance that can be provided. In such a situation, most initially seek care from traditional healers or elders, but when this fails hospital care may be sought by the relatives of the woman, and mostly the husband.

It was found that the responsibility of finding and paying for transportation rests solely on the husband. We learnt that wheelbarrows and donkeys are often used when a vehicle is not available. Men reported that providing money and transportation is the major role of the husband at this time.

"What role can you play other than pray for her safe delivery. It is only when there is a problem as a result of labor that you the husband will play your role of transport and other medical charges." -- Man whose wife delivered in the hospital, Sabon garin papa

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Community help is also claimed to be available for needy families in terms of provision of vehicles, money for paying bills, blood donation, etc. This, according to one of the community leaders we talked to is mostly on an ad hoc level as there is no standing program in any of the areas surveyed to render this help on a continuous basis. He further added that people are willing to help each other even when there is no emergency, talk less of when there is a life at stake.

Blood Loss

Excessive loss of blood is a problem that many of the respondents identified as being common during labor. Women reported that this condition is identified by paleness, dizziness and fainting, but many claimed ignorance of the signs.

In most of the interviews, it was clear that the Fulani don't have any objection to taking blood transfusion, it is the giving that is the problem. When a woman needs blood during labor, there are, in theory, many who could help; the husband, relatives, neighbors, even other community members. This view cut across virtually all the male FGDs, and was corroborated by the community leaders. But in reality, most men end up buying blood in cases of need. Why is this?

Need for the blood themselves was mentioned the main reason for lack of enthusiasm to donate blood, which is a genuine excuse given the poor nutritional state that is prevalent among the communities studied.

However, many are influenced by the phobia that when they donate blood, their own stock may be exhausted! This is responsible for the belief that when you donate blood to someone with problems, you will acquire that problem.

The fear about blood donation is so strong that sometimes some men will even prefer to give out money to purchase blood instead of donating their blood.

"Her husband is the only one who can donate or his relatives or friends. In the absence of the husband or his relatives then people in the community will try to give money to buy the blood in the hospital, but mallam, in fact we cannot afford to donate our blood unless otherwise (absolutely necessary)." -- Man whose wife delivered in hospital, Sabon gari papa

"If she lost too much blood it has to be bought at the hospital. Nobody will agree to give her blood." -- Women with complicated delivery, Zadawa

In our opinion, purchase of blood at N300.00 (\$15) per bag at the time of interview, constitutes a major expense that most women in the communities studied can ill-afford.

Breech Presentation

In the communities studied, there was poor knowledge about the occurrence and causes of breech presentation.

Women reported that women who have their babies legs first, suffer much during pregnancy and deliver in the hospital.

Caesarian Section

It was found that delivery by Caesarian Section (CS) is also not well known. Only a few claimed that it is a necessary hospital procedure to end prolonged labor in underage women or those with small stature. In addition, they believed that any woman that had CS during a previous delivery, should not deliver at home but in the hospital.

Vesico-vagina Fistula (VVF)

In only a few of the interviews was VVF mentioned. According to respondents, VVF occurs in women married at a very young age and those with prolonged labor in a previous pregnancy. When it occurs, sufferers are unable to hold urine and the only cure lies at the hospital.

We also learnt that VVF sufferers are usually divorced and sent back to their parents, if the husbands cannot afford to cure them.

"The belief I have about VVF is a disease that will not be cured until she visits the hospital. The cause is early marriage. It will affect the woman during her next delivery if cured the first time." -- Woman with complicated delivery, Abbayawo

"If the husband can afford treatment, then he can do so in the hospital, but if he doesn't have the money to cater for her treatment then he can divorce her. If he have another wife it would be okay for her to stay in the husband house." -- Man whose wife delivered in hospital, Sabon-Gari Papa

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AFTER DELIVERY

In most of the communities studied, routine care is available to make newly delivered woman rest, eat and enjoy herself.

Hot Bath

We found that the hot bath period, the first 40 days after delivery, is a traditionally important period and is considered salutary to the health and well-being of mother and child.

During this period, relatives usually assist the newly delivered women in doing all her household chores during which time she takes hot baths, rest and eat rich food to get her energy back. Another function of the hot bath is to heal the vagina for resumption of sex.

Women and men reported that non-observance of the hot baths period is believed to be responsible for difficulties during the next pregnancy.

"If a woman delivered without enjoying all these things (fish, chickens, etc), then for the next pregnancy she won't be in a good condition of health throughout because you will see her with swollen body throughout that pregnancy. Because she lost that "bi'i" "Bi'i" means taking care of a woman who delivers." -- Man whose wife delivered in hospital. Sabon gari papa

"When a woman delivers the husband is expected to cut sexual relations with her until when she stops bleeding which could last for forty days. This is the essence of the hot bath." -- Man whose wife delivered at home. Dagaro

TBA Care

It was found out that TBAs do not actually help women get through labor. Women reported that they are only called to take care of the baby and assist them in cleaning up after delivery. The finding is consistent through most of the female Fulani groups.

"We don't call them (TBAs) when in labor. They are only sent for after delivery to come and take care of the baby." -- Woman who delivered at home. Sabon-garin papa

TBAs perform two additional functions after delivery. First, they assist in cases of retained placenta, which respondents claimed is common and in cord care.

It was found that retained placenta is treated traditionally in about four different ways. First, sneezing is induced by sprinkling

pepper in fire. The smoke from the fire is then inhaled by the women. Second, vomiting is induced by introducing an object (usually the stick used in stirring 'tuwo') into the throat of the affected person. Third, the affected woman is shaken vigorously. Lastly, the woman's abdomen is massaged. Women reported that in most cases, these traditional treatments work, otherwise, the woman is referred to the hospital.

"They put something in your mouth that can make you vomit and in the act, the placenta will come out." -- Woman who delivered in the hospital, Zadawa

"They usually give pepper mixed with water to drink or the pepper will be put in fire and the smoke will make the woman to sneeze and in the process the placenta will come out." -- Woman who delivered at home, Sabon garin papa

According to the respondents, cord care involves initially cutting off the cord close to the child's navel and burying the cut part.

The other part is then massaged with warm cloth, while salt and ashes are also used to rub the end. This is to make healing easier and faster.

Sometimes, only the placenta is buried and the cut part of the cord is burnt into ashes, mixed with local butter and used to rub the cord.

"The TBA comes in the mornings and evenings and bathes the baby, then make some fire and gives him hot compress with a clean handkerchief to the umbilical cord so that it will dry off and fall before the naming ceremony." -- Women with complicated delivery, Zadawa.

Treatment of Complications

Apart from retained placenta, chills and fever and pain in the area of the womb were also commonly mentioned. Women reported that unusually heavy or smelly vaginal discharge and very sore breasts are not common in their communities.

Virtually all the women claimed to have experienced pain in the area of the womb (called 'daci'). It is not normally seen as serious, and is usually treated through drinking of herbs. But some women believe that if left alone will go by itself.

Abdominal pain is believed to be the effect of 'bad blood' in the stomach and is also not considered serious. Some other women reported that the stomach was finding it difficult to believe that it has lost what was kept in its care, thus the complaint.

Some women reported that unusually heavy and smelly vaginal discharge was caused by failure to observe the hot bath period.

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Traditional care is normally applied though some women claimed that hospital care may sometimes be necessary.

Very sore breasts is treated locally by using burnt rubber (type used for getting water from the wells) mixed with oil or vaseline to rub on the sore breasts.

Child Care

The newborn child also attracts a lot of attention in terms of care. Women reported that they would know a sick child by mere looking.

Care includes those of the eyes, and most believe that something is wrong with the eyes if the baby fails to open them or if they are reddish or the baby cries all the time.

Warmth is provided by rubbing the baby with oil or local butter and then wrapping with thick clothes or giving them boiled herbs.

"A sick child is different from a normal one by mere looking at him. You will know whether he is sick or not. Smallness and largeness of a child is a gift from God." -- Woman in her third trimester and considered high risk pregnancy, Jabdo village

"Most children do have eye problem, but it is not something to worry about because it is believed that all new born babies must do it." -- Woman who delivered in the hospital, Zadawa

"During the raining season also they used to give their children boiled herbs to protect them from cold."-- Woman who delivered in the hospital, Zadawa

Some reported that premature children are treated at home. Traditional treatment involves bathing the child with warm water, after which honey is rubbed on the body of the child. Then they apply what they called traditional cotton wool that serves like incubator. This will continue for at least two months for those born in the seventh month of the pregnancy.

Women claimed to be able to identify abdominal pain by the continuous crying of the child, which to them indicates that the baby is not comfortable. They reported using a traditional powder for such pain.

Other less common complications are breathing difficulties, fits, and cord infections but all have traditional treatment though many claimed to prefer hospital treatment when case is perceived as serious.

Breast feeding

It was found that women, except for a few informed ones don't start breast feeding until after three days because of their conception about colostrum. During this time, women claimed that the child is fed with warm water, goat or cow milk, while the colostrum is squeezed out.

Colostrum (called 'kandi') is believed to be dirty, unhygienic, harmful and not useful at best. The belief about colostrum is widespread among women, their husbands, even their community leaders, and one that respondents claimed to have been handed down by forefathers. It is not questioned by most, just accepted.

"So before a new born baby is breast fed, the mother's breast must be washed, that sticky type (colostrum) must be withdrawn. The reason is for the health of both the baby and the mother. Although we did not ask from the women because they know the reason better than the men." -- Man whose wife delivered in hospital, Sabon-garin papa

"We call it (colostrum) 'kandi' our elders wash it out before giving breast to the new baby because they said that they first breast milk is not good for babies." -- Woman pregnant for first time, just delivered, Dagara

"I heard that when a baby sucks it (colostrum) it can tighten the stomach of the baby not to excrete faeces." -- Woman who is currently pregnant, in third trimester and considered high risk, Gabari

Those that reported feeding colostrum to their babies, clearly in the minority, were those that have been educated during ante-natal visits about the importance of feeding colostrum.

Family Planning

Research indicates that there is no deliberate attempt to limit number of children among the Fulani. Men and their wives reported that they would like to have as many as God will give them.

In fact, many women also showed a tendency for large families. According to them, they want their children to take care of them when they are old and the more children they have, the more care they get. In a few of the groups, men link a woman's worth with the number of children she is capable of having.

Again, it is largely believed that children come from God, and it is not good to interfere with what God has decreed.

"No, no, we don't plan our family. This is prohibited." -- Man whose wife delivered in the hospital, Sabon garin papa

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"We want as much as what God can give us if not a person who is heartless, who would want to limit the number of his children." -- Man whose wife is pregnant for the first time, Ajili

"And the most important of all is that whatever plan you make as to the number of children you want, God has already made the provision for you." -- Man whose wife is pregnant for the first time, Ajili

"You as a husband cannot convince them to have a limited number of children. Since in a village if a woman is not giving birth, it will be difficult for her to have a husband."-- Man whose wife is pregnant for the first time, Jarkasa

In most of the communities studied, traditional belief favors adequate spacing of children. Among the Fulani, normal spacing of birth is believed to be 2-3 years. Spacing that is less than this is called 'kunika' (irregular birth) and is frowned upon.

"There are those who deliver after every one and a half years. But that one is irregular birth we call it 'kunika'." -- Man whose wife delivered in hospital, Bodado

"We believe also those children of irregular pregnancy don't survive long." -- Man whose wife is pregnant for the first time, Ajili

Men reported that some women are more prone to 'kunika'. These are those that have better diet and have enough rest. 'Kunika' is very strongly resisted by men and women that are prone to 'kunika' and usually cut off sexually.

"In some cases, pregnancy will occur before the period of three years, especially those who eat better diet and have enough rest." -- Man whose wife delivered in hospital, Sabon-garin papa

"If we have those types of women who deliver after every one year, we look for traditional medicine, using traditional herbalists, religious mallams, etc to see that she resume normal duty. And if that does not solve the problem, we usually cut off sexual relations for a year from the date of their previous delivery. This decision is made with the knowledge of the wife because she know that such delivery is considered bad among the community and she will welcome it." -- Man whose wife delivered at home, Dagare

The wisdom behind the Fulani's 'kunika' is to properly wean a child before another one comes in, as noted by a few of the respondents. Many just saw it as a tradition to be observed.

It is our opinion that with the prevailing poor attitude towards family planning among the communities studied, which many see as a way to limit the number of their children, it is no wonder that

many women are 'prone' to 'kunika'.

DECISION MAKING

It was found out that the husband is the prominent decision maker concerning health in the household.

Women reported that decisions relating to their health, especially regarding where to obtain care are usually made by their husbands.

But research reveals that many people and circumstances influence this decision as is implicit from some of the findings presented earlier on. These include, knowledgeable female adults in the household and in the community; community leaders; TBAs; village healers and other health care service providers. Many decisions are also made for first time parents too.

We note that in one of the groups, the husband's decision not to take his wife to the hospital was overruled by the sister when the woman's life was in danger, but it was at the risk of the marriage of the woman.

Research indicates that the husbands' pre-eminence concerning decision making derives from his being the traditional head of the household. Another derives from the fact that since the husband will be responsible for incurring all the expenses of care, decisions about what type of care to seek and from where, will depend to a very large extent on the ability of the husband to pay for it.

COMMUNICATIONS

Radio is a very popular means of receiving news in both urban and rural communities. Respondents claimed that the popularity of radio derives from its longer broadcasting hours and because it features more programs in the local language instead of in English as is the case for TV. TV is precluded in many rural areas due to lack of electricity, while newspapers tends to be a feature of the town for reason of availability and of literacy.

Women reported listening to musical, cookery, children's, drama programs, while news, political and health programs feature prominently as programs that men claimed to listen to or watch.

Research indicates a paucity of songs, adages and proverbs relating to maternal healthcare among the Fulani in the communities studied.

In most of the Fulani FGDs and interviews, when respondents were asked to render songs, proverbs and adages that concern the issue of maternal healthcare, they generally said that they had no such things. Only in a few instances did women mention that they indeed

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have songs, or were taught songs during antenatal clinic, etc concerning the issue, but they refused to recite them. This was because it is not considered decent for married women to sing. In addition, they thought that singing is not appropriate when you have problems of survival (like hunger).

"How can you expect married women to start singing suppose the husband doesn't agree." -- Woman pregnant for a least second time, Jabdo

"Common eating is a problem, let alone singing song." -- Woman pregnant for at least the second time, Jabdo

Two songs were recited in just one of the many FGDs and IDIs conducted. The first one recognizes and sympathizes with the problems that a typical pregnant woman goes through. While the second one is more humorous, and imitates the awkward movement (gait) of a pregnant woman.

"Though you don't feel well during pregnancy, but after delivery you will feel happy." -- Woman pregnant for the second time, Sade

"Woman with big tummy; she moves like this, and moves like that" -- Woman pregnant for the second time, Sade

**DETAILED FINDINGS FROM WOMEN, THEIR HUSBANDS AND COMMUNITY
LEADERS: HAUSA**

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INFORMATION

Research indicates that in all the communities studied, there is no paucity of information on health and pregnancy, but the quality of information and sources differ among settings (urban/rural) and among men and women.

It was found that information sources include husbands, mothers, mothers-in-law, older females in the household, relatives, experienced mothers (especially co-wives) all constituting sources within the household; radio and TV; maternity/general hospitals; traditional community leaders and ward councilors.

Household Source

Women reported receiving some form of health and pregnancy related information from within the household and from mostly elderly females. This information revolve around hygiene (personal and environmental), work habits, nutrition. Additionally, women are warned about food taboos, and given a long list of behavioral don'ts such as; folding of legs, sitting down at the door steps, sitting on mortar, walking around in the sun, etc, which are mostly perceived to cause difficult delivery and problems of retained placenta.

"The kind of information I received from home about pregnancy are related to things that are forbidden and allowed a pregnant woman." -- Woman pregnant at least the second time with complicated delivery, Kofar Fada.

It is clear from research that this source is important to the more isolated rural communities; and first time mothers, even in urban settings; and women in purdah. Women claimed that this information is credible because of the experience of those who give it.

"Nobody will come to your house, until something happens, since you are in purdah." -- Woman who delivered 2 months ago, and had complicated delivery. Buzave.

"We believe what our old women told us because they must have experienced it." -- Woman delivered last two months high risk, Jahun

"If you are pregnant for the first time, it is preferable to be closer to the older women and those that have experience in child bearing so that they could tell you what is to be done." -- Woman considered high risk, delivered 2 months ago, Kofar Dumi

Radio and TV

Radio was also mentioned by most of the respondents as a source of pregnancy and health-related information in both urban and rural

areas. Research reveals that TV is a feature of the urban areas rather than the rural areas because of lack of electricity in most rural areas.

According to the respondents, information received from the radio and TV are many and include those on hygiene; nutrition; immunization; ORT; EPI; maternal care; and injunction to use antenatal clinics when pregnant.

Some women reported not having access to information from the radio because of household chores.

"I will like to listen to the radio at all times but the things I like is to know the schedule time so I either do my household chores before or after the program so as to enable me to watch my programs effectively." - Woman pregnant first time and delivered within 2 months, Zango.

"Even if you have radio, you can forget to listen to it because of (household) work." -- Woman pregnant for at least the second time, Gubi.

Village healers/TBAs

Some women mentioned village healers and TBAs as a credible source of health and pregnancy related information. Apart from being concerned with health/pregnancy as part of their job, respondents claimed that this also derives from the fact of their being elders in the community and thus experienced in issues relating to child birth. According to respondents, information from these sources revolve around food and other taboos; and hygiene, and especially need for some routine care to ease delivery.

Research reveals that the credibility of this source is high in the rural communities where health facilities are rarely used and lower among the more enlightened urban dwellers.

"As we are getting more enlightened, we don't follow such things (information from village healers) again." -- Woman in third trimester, considered high risk pregnancy, Kobi/Wunti.

Community Leaders

Research indicates the community leaders/ward leaders especially in the rural settings as the communities' main contact with the outside world, and they control to some extent, information flows to community members from health workers.

Men reported getting health and pregnancy related information from their community leaders to be passed down to their wives. Such information included those on the existence on health facilities and an injunction to use them; immunization and counselling visits by health officials of the local government and are subsequently pass down to members of their households.

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Research indicates that credibility of information from this source derives from the esteemed status of the community leaders in the community.

Hospitals and Antenatal Clinics

Many reported getting information on hygiene, nutrition, family planning including child spacing, need for immunization, work habits, need for rest.

However, some women reported being rebuked by nurses when they go to the hospital for a condition that they (nurses) considered dangerous but which the women did not know until then. They are then enjoined to come to the hospital immediately they see such signs.

Many respondents, especially those that have embraced hospital care extolled the usefulness of information obtained from this source.

PRENATAL CHANGES AND ANTENATAL CARE

Research indicates that during pregnancy, women go through a lot of changes that have implications for their work habits, rest, nutrition and sex.

Ailments

Female group members claimed that they are usually plagued by a variety of ailments, such as headache, tiredness, nausea, vomiting, loss of appetite, dizziness, back pain, stomach ache, emotional distress, etc. during pregnancy. According to them, sometimes these ailments are mild and bearable, but at times they could be serious, thus needing medical attention.

"Now that I am pregnant, every little thing get on my nerves" -- Woman pregnant for at least the second time, Kafar Dumi.

"This pregnancy did not allow me to trek a good distance, it keeps pulling me down and tired. I easily feel ache in my legs." -- Women pregnant for the first time, Shekal.

"I frequently have waist problem now that I am pregnant." -- Woman pregnant for the first time, Zaranda.

"When I was pregnant, there was no enjoyment again until the day I delivered. Food you will like to eat, but no longer can eat, Work, you can not do in high spirit the way you want it." -- Woman pregnant for at least the second time, delivered two months ago, had complicated delivery, Buzaye.

During this time, husbands take special care of their wives. According to the group members, it is an exception rather than the rule for husbands to be indifferent to the sufferings of the wife, except when he is limited by resources. It was also found that food is an area of particular attention for the husbands.

It is thought that pregnant women are erratic, prone to whims and have to be indulged. Men and women reported that pregnant women are given special care so that something bad might not happen to the baby. In addition, there were those who saw a pregnant woman as being in such a position to require special care for herself and not for the baby. These are in the minority, however.

"Husbands take special care of their wives during pregnancy because of the fear of losing their children." -- Woman who delivered within the last two months, at home, Buzave

"Our parents say that you should not deny a pregnant woman anything because such denial can cause miscarriage." -- Woman who delivered in the last 2 months, considered high risk pregnancy, Kofar/Dumi

"For us here, pregnant woman attracts sympathy." -- Woman, pregnant for at least the second time, delivered two months ago, and had complicated delivery, Buzave.

"He may want to do something for me, but if he doesn't have the means, he can't do it." -- Woman who delivered for the first time, Shekal.

Sex

Research indicates that sex is not taboo during pregnancy among the Hausa. Men argued that sex is desirable during pregnancy since it is not against Islamic injunctions and furthermore, a man may sleep with his wife at any time during pregnancy for he has the right to.

Some group members note that not all women want sex during pregnancy and that the husband should be understanding regarding this. In addition, they warned that sex may not be advisable at certain stages during the pregnancy period especially very close to delivery, because it could create problems for the baby, or the mother, a feeling shared by many women.

"As the Quran says, a man can have sex with his wife even when she's about to deliver and nothing will happen. Even if she will deliver that same day or the next, nothing will happen. Nothing will protect their health except God." -- Man whose wife delivered in the hospital in the last two months, Yelwa

"Sex with a pregnant woman depends on the month of the pregnancy. When it is almost time to deliver, it is not good she may be on it and just deliver." - Man whose wife delivered last 2 months in hospital, Zango

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"During late pregnancy, if a woman sleeps with the husband, she will experience pains and weakness in her body in the morning." -- Woman who delivered at home in the last 2 months, Buzaye

"It varies from one woman to the other. Another as soon as she takes in she becomes disinterested in a man while another even the day she delivers she wouldn't mind sex." - Man whose wife delivered last 2 months in hospital, Zango

Eating Habits and Food Taboos

Women claimed to experience changes in their eating habits during pregnancy; avoidance or desire of certain foods and lack of appetite were most common.

It was found that when some women experienced increased desire for food, their husbands tend to support in the belief that pregnant women eat for two, while elderly women discouraged them because it was thought that this could lead to big babies and prolonged labor.

Some food items are taboo among the Hausa communities studied. In practically all the groups, sugar/sugar cane (especially) and other sweet things such as cocoyam, sweet potatoes, and mango were mentioned as being taboo for pregnant women. It is believed that eating of such sweet things cause 'zaki' or sweetness. Respondents claimed that 'zaki' is responsible for prolonged labor and abdominal pain. According to them, during delivery, all the body sugar comes out first before the baby; so the more sugar in the body, the longer the labor.

"All the body sugar has to be removed before delivery." -- Woman who delivered at home, Buzaye

"If the sugar is too much, it will have to come down before delivery, so the more the sugar, the longer the labor period." - Women pregnant for the second time, Wunti Kobi

Chicken is another food taboo that pregnant women are required to observe. According to a few of our respondents, babies of women that eat chicken during pregnancy are believed to be afflicted with jaundice and respiratory difficulties.

*"If a woman eats chicken during pregnancy, the baby may have breathing difficulties, his stomach or respiratory system will be moving slowing."
-- Man whose wife was pregnant for the second time, Yelwa*

Eggs (causes prolonged labor), oil (causes prolonged labor), pepper (causes eye infection in babies), and some fruits like 'aduwa' (causes miscarriage) were also mentioned as being taboos.

Work Habits

Respondents claimed that pregnancy affects the desire and ability of the women to work due to the ailments previously mentioned. Many of the women reported getting assistance from their relatives, including their husbands and sometimes neighbors, especially when it comes to strenuous work that they have been enjoined to avoid. Some women, especially those in rural areas and small households, however, reported having to do all the work themselves with little or no assistance, sometimes leaving some household chores undone until help comes.

ANTENATAL CARE AND CARE PROVIDERS

Many women seek routine care during pregnancy from a variety of sources in preparation for easy delivery.

Household Care

It was found that the first and the most consistent source of care for pregnant women is from the household. Most women reported getting a lot of care from relatives and neighbors during pregnancy. Such care are usually in form of assistance with household chores and provision of more nutritious food (according to what the husband can afford).

"He prevents me from doing any hard job, so he brought my junior sister to come and stay with me so that she can be helping me" -- Women pregnant at least the second time and delivered last two months considered high risk. Kofar Dumi

"Neighbors come in to help you when you are pregnant" -- Women pregnant for the first time and delivered last two months. Sheka

Routine Care from Traditional Sources

Some women, especially those in rural areas, claimed to seek routine care from traditional healers and sometimes religious leaders to prepare them for easy delivery. Care includes boiled herbs and roots for bathing and drinking and 'rubutu' (quranic verse written on a slate and washed with water for drinking).

It was found among the communities studied that women are expected to undergo the treatment for sweetness or 'zaki' at about the seventh month till delivery.

"As soon as the pregnancy is about 7 months old, there is a medicine that we give them that helps with the sweet and oily things they have eaten. And we in our living as Hausa, sweet things and oil are some of the things that will make a woman suffer when she is about to deliver. So we do find this herb and give them, and which they drink and pour out all these sweet things and oil just before they deliver, which I myself can go and fetch

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them for you to try on your wife." -- Man whose wife was pregnant for the first time, Kofar/Dumi

Antenatal Clinics

Women reported obtaining a variety of useful routine care such as blood and urine tests, weight gain monitoring, blood pressure measurement, medication (multivitamins), counselling, etc. In addition, attendance also makes it possible for complications to be identified and treated very effectively early. A special advantage of clinic attendance according to both the men and women was that those who want to deliver at home can do so without fear.

"I want to deliver at home because if I go for clinic (antenatal) in the hospital, I will be able to give birth successfully at home" -- Women with complicated delivery, pregnant for at least the second time, Zaranda

Research indicates that knowledge about the need for antenatal care is good in many of the communities studied, but women are prevented from attending because of factors such as; distance from clinics; cost of obtaining care; transportation problems and waiting time at the clinic.

Many women reported having to travel long distances, sometimes trekking to reach antenatal clinics for care.

"We are far from the hospital and if you don't have any money for taxi or motorcycle, it becomes difficult." -- Woman in third trimester, considered high risk pregnancy, Jahun/Nassarawa

Clinic attendance is further hindered by the cost of obtaining care. When women live far from clinics, considerable money is spent on motor transportation in addition to drugs and payment for some routine tests at the clinic.

"Before, if you go to the hospital, we get drugs free, but now all responsibilities have been shifted to us. If you are pregnant, you have to buy drugs yourself." -- Woman in third trimester, considered high risk pregnancy

Women also complained vociferously about the length of time it takes to obtain care as being too long, which some explained this as being due to the large number of women turning up for antenatal care and the limited number of staff available to attend to them. Some women report that there is usually conflict between the need to do housework and antenatal clinic attendance. It was found that when such conflicts exist, housework usually wins. Women reported being turned back at the clinic for being late.

"Where I go, we sometimes finish by 3pm because there are so many people. We normally start at 7.30am." -- Woman who delivered two months ago in the hospital, Jahun/Nassarawa

"If you come late, even if you could not come on time because you were busy at home, they'll ask you to go back. They won't even pity you for spending taxi fare (to come)." -- Woman who delivered two months ago in the hospital, Jahun/Nassarawa

In many areas, roads are in poor conditions and vehicles are scarce. Women reported that when they think of the effort of getting involved in getting transportation to the clinics, they simply seat tight.

Men complained about the their wives being scantily dressed and singing during antenatal days. Lack of understanding of why this is so makes some men prevent their wives from going for care.

Knowledge and Treatment of Complications

When complications arise during pregnancy, many women expressed the desire to go to the hospital immediately. They claimed to have lost faith in traditional medicine which is a hit-or-miss affair. They expressed the belief that traditional care providers do not really understand the cause of complications and can thus not provide accurate cure for them. This view was expressed more significantly in urban than rural communities and were borne out of experience with both traditional and modern healthcare.

"Traditional medicine may cure, and it may not cure. If it does not, they simply change the treatment." -- Woman, who was pregnant for at least the second time, delivered 2 months ago, and had complicated delivery, Buzaye

"The people at home (traditional care) always say something for saying sake. It's not that they have acquired the full knowledge like the nurses." -- Woman who delivered in the last 2 months in the hospital, Katsinawa

"Like at home, when my legs were swollen, they said I will deliver twins, but when the delivery comes, I had one child, not two as they said." -- Woman who delivered in the last 2 months in the hospital, Katsinawa

Despite these problems, many still continue to seek traditional care due to obstacles in the way of modern healthcare delivery system and simply use modern health care as last resort.

It was found that traditional care for complications start from the household through older women, experienced mates, and if no cure is forthcoming, progressing to a traditional healer or 'Ngozoma' or religious leader.

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"If it is what one prefers, of course one will prefer the hospital, but that of the hospital is not forthcoming because if you go to the hospital they will just waste your time. But lack of help from the hospital is new. We used to deliver, even free with no problem, but now, you have to pay, and even with your money, it is trouble." -- Woman, who was pregnant for at least the second time, delivered 2 months ago, and had complicated delivery, Buzave

Research indicates that knowledge of the causes of complications during pregnancy is poor among the communities studied. For instance, swelling of feet, and hands, face, a common occurrence is attributed to a variety of factors including, lack of exercise, failure to have hot bath after previous delivery, consumption of salt and multiple births. A traditional preparation called 'ayayagi' is claimed to be a common treatment for this condition.

"If one sits in a particular place, blood will gather in one place and not circulate." -- Woman who delivered in the last 2 months, Katsinawa

Headaches and high fever are also common but are not seen as serious nor pregnancy related.

"Since I got pregnant, I started having headaches. Since I know the treatment for headaches, I went ahead with the medication myself. I used Hedex." -- Woman who was pregnant for the first time and delivered within the last 2 months, Sheka

It was found that bleeding from the birth canal is not seen as serious. Some women claimed that a little bleeding now and then is normal during pregnancy. In situations where bleeding from the birth canal was paid any attention, the color determined what was done. Dark red was thought to be a sign of infection, while color of fresh blood meant sweetness disease ('zaki').

It was found, however that persistent bleeding is seen as a cause for concern and promptly referred to the hospital in many cases.

LABOR & DELIVERY

Preparation for labor and delivery

Among the Hausa studied, there is no traditional preparation for child birth, but women claimed to engage in buying clothes and other things that the baby will need, while the men prepare by getting firewood, spices, food items and all the things that will be needed by the mother after delivery.

Labor signs and duration

Most of the women interviewed except primips claimed that they could identify the time when labor would start. They claimed that stomach ache, back ache, breaking of water and bleeding from the birth canal were signs that labor has started. These signs according to them tend, to be more severe than those observed during pregnancy, and tend to occur together.

"The first thing I usually experienced is breaking of water, followed by severe and consistent pain, then I know labor is on hand" -- Women who delivered at home, Zango.

"When I was in labor, it took me one day before I knew I needed help in the hospital, because it was my first delivery." -- Woman pregnant for the first time, delivered within last two months, Zango

"Mine (labor) started with the flowing of water. When I stand, I will notice that the wrapper is wet. It took the whole day like that. The next day, I went to work to harvest rice. While harvesting, I saw water flowing down and later blood followed. I came home and that lasted the whole afternoon. I took my bath and bathed the children. I went into the room and stomach ache started, before 7pm, I had given birth." -- Woman who delivered at home two months ago, Zango

"Labor pains came to me on a Friday morning. It continued like that up to evening and through the night to Saturday morning. You know, I was not used to such a thing. On Saturday, I endured it to evening time. Then I said something should be done. I did not know what was happening then. It was in the hospital that they informed us that it was labor pains. My husband then returned and collected my things for me." -- Woman who was pregnant for the first time, and delivered within two months, Shekal

How long should labor last? It was found that there is no clear indication. Women reported that it will vary from one woman to another, and from one pregnancy to another even in the same person. Some women reported a labor period of a few minutes to 2 weeks! This indicates that some women do not know when actual labor commences.

"I was in severe 'labor', but when I got to the hospital, I was told that it was not a true labor for delivery." -- Woman who delivered in the hospital within the last 2 months, Katsinawa

"It is better to stay home and suffer it out until such a time you feel the child is near then you go to hospital." -- Woman pregnant and delivered for the first time, Shekal

An abnormally prolonged labor is usually a signal for hospital care, says many of our respondents.

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However, in the more remote villages, prolonged labor is treated traditionally through incision to widen the birth canal by traditional healers or TBAs. When labor is prolonged because of 'zur zur', a collection of blood that blocks the birth canal, women reported that cure is provided by cutting open the 'zur zur' for the blood to flow and free the birth canal. One respondent also reported witnessing a case where a traditional healer manually removed a baby from the womb.

"The man put his hand inside 'karkashi', put his hand inside the birth canal and pulled the baby out by force, and then the woman just died." -- Woman who delivered 2 months ago, considered high risk pregnancy, Zango

Places of delivery

Research indicates that many Hausa women deliver their babies at home assisted or unassisted. TBAs, relatives and elderly women who are experienced in childbearing were mentioned as providing assistance with childbearing. Those providing assistance hold and encourage women in labor and decide when they need additional assistance. Delivery involves the woman being in a squatting or kneeling position before pushing.

"I delivered at home alone. While kneeling, I held the leg of the chair and pushed and the baby came out." -- Woman who was pregnant for at least the second time, delivered 2 months ago, considered high risk pregnancy, Zango

"Even if you call her (TBA), she'll just close the door and tell you to deliver. There is nothing to do. It's like you are travelling to a distant place, they can only wish you safe journey, but no one can help you." -- Woman who delivered at home two months ago, Zango

Research indicates that various reasons influence the decision to deliver at home.

Some respondents claimed that there is better and adequate care at home. According to one of the community leaders, the home is believed to be the natural place to deliver because of the amount and quality of care available at home.

"My liking and everyone's liking is that a woman should give birth at home. This is because they will be taken care of as if they are at home. If a woman is giving birth at home, she will be adequately taken care of. This practice is still with us, we have not abandoned it. We still practice which has been with us for long. A woman will give birth and you provide her with the necessary food she requires. During birth, she would be helped by an aged mother. In certain situations, a woman can deliver alone. These are people that normally go to maternity for antenatal. Those that stay at home usually have problems." -- Community Leader, Zaranda

"I don't like having my babies in the hospital, because they don't seem to care, and secondly, if you don't have money after delivery, they will not allow you to come back home." -- Woman who was pregnant for at least the second time, Gudum

Fear of exposing their nakedness is another reason why some women give birth at home. Men claimed it is against their religion to expose their nakedness. Some women reported need to preserve their self-respect.

"The reason why we don't allow our women to deliver at the hospital is that, you know we are muslims and Islam forbids everyone to expose his body. At the hospital, a woman is exposed and she can be seen by all women of all kinds, but even men who come to the hospital for one thing or the other." -- Man whose wife delivered at home, Jahun/Nassarawa

"I will prefer to deliver at home in my room because of the dignity and self-respect. I will not be exposed." -- Woman who delivered within the last 2 months, and had complicated delivery, Buzaye

Some of the factors that limit antenatal clinic attendance also contribute to making hospital care unavailable to the Hausa and hence preference for delivering at home. These include high cost of hospital care, lack of drugs at the hospitals, abusive attitude of hospital personnel and far distance to the hospital coupled with transportation problems.

"If you go to the hospital, you will be given a list of many things the husband will buy. The initial cost will be up to N100.00 (\$5), then others will follow. However, among these things that the husband will buy, it is not all that will be used for the patient, so this discourages people from going to the hospital." -- Community Leader, Zaranda

"Taxis do not like to take a woman who is in labor to the hospital. If they agree, you will pay a large amount, and since you are desperate you have to do so." -- Woman who was pregnant for at least the second time, Kofar Dumi

"What use will it be (going to deliver at the hospital) since you will be left alone without attendance. They just let you lay there screaming shouting and whatever." -- Woman pregnant and delivered for the first time, Shekal

"Sometimes there is favoritism in the hospital because as long as you don't get anyone who will assist you among the staff, you will be neglected completely." -- Women delivered last two months, Gudum

It is clear from research that many would prefer using hospitals for delivery only when there is a problem. For instance, many claimed to attend antenatal clinic so that they can deliver at home without any problem. In many cases, the decision about where to deliver is not made until labor time in the bid to avoid hospital

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delivery. Men claimed it is usually a thing of joy when your wife delivers at home, instead of the hospital.

"If one will prefer at home without any problem, I will prefer to deliver in my home." -- Woman who delivered for the first time, Jahun/Nassarawa

"It depends, if it comes quickly then I'll deliver at home, but if it is delayed, I'll go to the hospital." -- Woman who delivered within the last 2 months in the hospital, Kangere

"For some, the husband will ask her to go (for antenatal care) for fear that if there is any complication, the problems will be too much for him." -- Woman who delivered in the last two months, and had complicated delivery, Buzave

"We do go for antenatal, but giving birth, I am lucky to be giving birth at home." -- Woman pregnant for at least the second time, Kofar Dumi

"Though I have never delivered at the hospital, any time labor starts I'll prefer to deliver at the hospital because I am alone at home." -- Woman pregnant for at least the second time, Kofar Dumi

"But as for our parents, they don't care about the hospital, they say God will take care of you." -- Woman who delivered at home, Zango

"I want to deliver at home because when my labor starts, I don't take a long time before I deliver." -- Woman who was pregnant for at least the second time, Gudum

Research indicates that apart from those that are forced by circumstances to deliver in the hospital, there is a group of Hausa, mostly in urban areas, who prefer and plan for their babies to be delivered in the hospital. This is as a result of disappointment with traditional care for pregnant women caused by greater awareness of the limitations of traditional healers to handle complications of pregnancy. They claimed that not only is the quality of care (in terms of effective drugs, modern equipment, knowledgeable personnel) greater in the hospitals, hospitals are also better at handling many of the problems and life threatening complications of child bearing. In addition, it is thought that problems in obtaining care are not enough reasons to deliver at home instead of the hospital. They suggested that every woman should deliver in the hospital.

"There are some Hausa women that don't like to go (to the hospital). The Hausa women did not understand, but now they are beginning to understand, they try to go now more than before." -- Woman in third trimester, considered high risk pregnancy, Jahun/Nassarawa

"The problem of traditional healers is they tell more lies than truth. They only deceive. While in the hospital, they do thorough check and tell you what is wrong with you. So since people are more enlightened, they don't go to 'boka' (traditional healer)." -- Woman who was pregnant for the first time, Sheka

"Whatever they do at home is just on trial and error basis, but the hospital will not take anything that will not be of use to you and give you. That of the home, even if you take it, it will not be of use to you." -- Woman who was pregnant for at least the second time, delivered 2 months ago, considered high risk pregnancy

Knowledge and treatment of complications during delivery

Research indicates that there was poor knowledge about the causes of complications in the communities studied. Apart from a few that mentioned age (too young was common, too old less so); 'births too close together,' and too many births were also mentioned, stature (linked with 'too young', anaemia, hypertension, previous difficult delivery, many women claimed ignorance of reasons for difficult delivery or attributed it to some traditional beliefs, including the will of God.

"Early marriage, lack of sex or intercourse during pregnancy, fear and poor nutrition are likely to pose difficulties during delivery for a woman." -- Man wife pregnant for at least the second time, Wunti/Dada

"Shorter women with small pelvis suffer during child birth." -- Men wife pregnant at least the second time, Wunti Dada

"If you don't have sufficient water in the body. During childbirth you make use of a lot of water, and it finishes, it causes some problems." -- Woman who was pregnant for the second time, delivered within two months, considered high risk pregnancy, Zango

"If God plans for you to have difficulties, you will just have to do it during delivery." -- Woman who was pregnant for the second time, delivered within two months, considered high risk pregnancy, Zango

It was found that a woman in difficulty during delivery usually attracts attention and assistance from those around her including her husband, close relatives, and other community members. Women reported that home remedies are usually applied first before seeking additional care.

When additional care is sought, it could be traditional or from the hospital depending on the predisposition of the husband towards the two means available, perceived seriousness of the ailment and beliefs about the cause. In most cases, care at the hospital is sought last.

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The husband is responsible for looking and paying for transportation, though can be assisted by community members if unable.

Blood loss

Excessive blood was identified by our respondents as one of the commonest complications during delivery which they claimed could be identified by paleness, dizziness and fainting.

Excessive blood loss is usually taken seriously when it occurs as it could lead to death and thus referred to the hospital. Only few attempt local treatment, which some claimed involve the use of herbs.

It was found that Hausa don't have any objection to taking blood transfusion, but many are afraid of giving their blood to needy women.

When a woman needs blood during delivery, the immediate family are the first choice not only because the quality of the blood is assured, but also because they are more involved. It was found that in reality, many people do not give their blood because of the fear of ending up needing blood themselves. Patients then end up buying. Respondents claimed to be aware of cases where blood donors end up being hospitalized.

"And they will take your blood more than what you expect such that you and her will have to now become patients." -- Man whose wife delivered at hospital, Yelwa

"Taking blood from somebody to give another person is becoming difficult because it turns into another problem. If you donate blood and you cannot get enough food to eat and regain the lost blood, you will have the (same) problem. So since blood is sold, buying is the solution." -- Woman pregnant for at least the second time, Kofar/Dumi

Breech presentation

Research indicates that though Hausa in the communities surveyed had a poor knowledge of the cause of breech presentation, they see it as a serious complication needing hospital care. For instance, some women discussants claimed that breech presentation is due to too much work during pregnancy and evil spirit. One woman claimed that it is a cause of Vesico Vagina Fistula (VVF).

"Some say it is because of too much work. Other say meeting with bad spirit at night makes women to deliver their children legs first." -- Woman who was pregnant for at least the second time, Gudum

Caesarian Section (CS)

It was found that knowledge of the need for caesarian section was revealed among the Hausa and CS is usually seen as necessary to save the life of mother or child, sometimes both.

Group members claimed that big babies caused by excessive eating make labor prolonged since the birth canal is too small for the baby. Also, when women are married out at a tender age, the birth canal is not fully developed to withstand the rigors of child birth.

Vesico-Vagina Fistula (VVF)

It was found that VVF is known to many of our respondents and is considered very serious. According to respondents, VVF does not have any special name among the Hausa, but it is called 'yoyon fisari' (leaking of urine) in view of the most visible sign of this condition.

According to group members, VVF is caused by a burst bladder either as a result prolonged labor, or from traditional treatment of prolonged labor (gishiri cuts). Young girls that are given out early in marriage and women whose babies are presented legs first are believed prone to VVF.

"If happened during labor. Maybe, it is the baby that ruptures the bladder or the prolonged labor, nobody actually knows. And you are afraid that such should not happen to you." -- Woman in third trimester, considered high risk pregnancy, Kobi/Wunti

"I know of two women (who have VVF). The problem was that the old women (TBAs) cut them open during delivery." -- Woman who delivered at home in the last 2 months, Zango

According to our respondents, many women with VVF are isolated and divorced by their husbands. The only solution is said to lie at the hospitals, both for the prevention and the cure.

"You become isolated and nobody will like you again. People will even be saying that you are smelling. If it were in the hospital, they will do something at least to see that you are helped. There is no way you can deliver in the hospital and develop such complications." -- Woman who delivered within two months ago, considered high risk pregnancy, Zango

AFTER DELIVERY

After delivery, the newly delivered mother is expected to observe a traditionally important routine hot bath period.

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Hot bath

Among the Hausa, it was found that the hot bath period is considered a very important ritual for newly delivered women to observe.

According to the respondents, during the first 40 days after delivery, the newly delivered woman is expected to rest, eat nutritious food to regain her health and take hot baths every day to heal her birth canal and get rid of 'bad blood'. Women reported that during this time, relatives usually help them to do household chores. Failure to observe the hot bath period is believed to meet with dire consequences -- swelling up, smelly vaginal discharge, etc. However, many of the women who deliver in the hospital do not observe the hot bath period. This, respondents claimed, was in line with hospital injunction.

"If she did not bath for 40 days, her body will swell up." -- Women pregnant at least the second time, considered high risk, Jahun

TBA Care

It was found that TBAs are not usually called to assist Hausa women at the inception of labor. Most are called after delivery to bathe the baby and clean up the mother. According to the respondents, TBAs perform two additional functions; cord care and removal of retained placenta.

After the excess part has been cut and buried, the cord is massaged with warm cloth until it falls off.

Women reported that retained placenta are treated traditionally in several ways: sneezing is induced by sprinkling pepper in fire to be inhaled by the women; vomiting is induced by putting stick into the mouth of the women; shaking of the women vigorously; and massaging of the abdomen.

Treatment of Complications

Aside from retained placenta, pain in the area of the womb, chills and fever were commonly cited as post partum ailments by the respondents. A few women also mentioned having experienced or being aware of women with cases of unusually heavy or smelly vaginal discharge and very sore breasts.

It was thought that, pain in the area of the womb is caused by bad blood. Women reported that the traditional treatment is ginger mixed with assorted spices (called 'yaji') for drinking.

It was found that unusually heavy and smelly vaginal discharge is believed to be due to failure to take hot bath for 40 days after delivery. Women claimed that it can be cured traditionally using herbs.

We found that very sore breast is usually treated locally by rubbing the breast with the product of burnt rubber (type using for drawing water from the wells) mixed with oil or vaseline.

Child Care

Women claimed that they could tell a sick child by mere looking at him, and women mentioned a number of indications that a child was sick.

Women reported that eye infection is suspected if the baby fails to open his eyes or if the eyes are reddish or the baby cries all the time.

It was thought by some women that eye infection in the baby is due to the failure of the mother to obey taboo regarding eating pepper during pregnancy. Group members claimed that eye problems are treated traditionally using 'tozali' (traditional eye pencil).

"They apply traditional eye pencil. They say it clears the baby's eyes and if there is any sand inside the eyes, it will come out." -- Woman who was pregnant for at least the second time, delivered within two months, considered high risk pregnancy, Zango

"It (eye infection in baby) is nothing but eating pepper during pregnancy." -- Woman who was pregnant for at least the second time, Kofar Dumi

Warmth is provided for the baby by rubbing oil or local butter, then wrapping the baby with thick clothes. Cord infection is suspected when the cord brings out water and does not heal in about three days. It was thought that fits are caused by evil spirits and thus usual cure is traditional. Breathing difficulties is suspected when breathing is labored and is also treated traditionally.

"When the child has breathing problems, certain traditional medications are given which will clean the tract and make breathing easier" -- Women pregnant and delivered for the first time, Shekal

"They believe it (fits) is caused evil spirits, so they bring some spices from certain plants or grasses, put inside fire and make the baby inhale the smoke." -- Woman who was pregnant for at least the second time, delivered within two months, considered high risk pregnancy, Zango

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Breast feeding

It was found the breast feeding is not usually initiated immediately after delivery; breast feeding usually starts after 2 days. Women explained this as due to their belief about colostrum. During this period the baby is fed with warm water, or in some cases goat or cow milk, while the breast will be washed with traditional concoction and colostrum squeezed out.

It was found that colostrum called 'nono parako' is thought to be dirty, harmful or at best, not useful, though many claimed to be aware that healthcare workers think differently. Among the Hausa, the attitude to colostrum has been passed down by the elders in the community and one that is expected to be strictly adhered to.

"They advised that I should wait for the colostrum to drain off because it is not good. They said it cause abdominal distension to the baby." -- Women delivered at least the second time, Kofar Dumi

"The breast has to be washed using some traditional concoction so that the nipple will be cleaned so that milk will flow freely." -- Woman pregnant at least second time, Kofar Fada

"It has been said that it is not good. All the dirt that got accumulated in your breast has to be done away with. In addition to that, if you give the baby that milk, it will make him not to pass faeces." -- Woman who delivered in the hospital two months ago, Yelwa

Those that claimed to feed their babies with colostrum are those that have been convinced by health care workers that colostrum is indeed good for their babies.

Family Planning

Research indicates that no deliberate attempt to limit number of children exist among our Hausa respondents. Both men and women reported that they will like to have as many children God will allow them.

It was found that, the Hausa feel very strongly about limiting the number of children since this is believed to be against what God wants. In apparent counter to one of the arguments for the need to limit number of children, women and men in most of the groups claimed that children come from God, and even when they are many, he (God) will provide for their needs. It was also thought that each child comes with his particular blessing.

"There is one fact about it, if the number of children God has given did not finish you will just have to deliver them even when you are old." -- Women pregnant for the first time - Jahun

"Because babies are of God's and he will give all as much as you need. And one should receive all God gives." -- Woman who delivered at home in the last 2 months. Buzaye

However, even when some women would like to limit the number of their children because of the need to properly take care of them, their efforts are frustrated by their husbands.

On the other hand, the Hausa are favorably disposed towards proper spacing of their children. Many of the respondents claimed they would like a space of 2-3 years between births. This is to allow them to properly wean one child before carrying another. Additionally, it is long enough for the mother to be ready to carry another child.

"I would like to wean this child and have a break of about one year. Getting pregnant while carrying another is a big problem because you will not rest and the child will not rest, and the pregnancy when it comes with its problems, it will be too much for you." -- Woman who delivered at home. Zango

"As soon as she purifies herself according to Islamic injunction, I will come to her at night and I don't even bother whether or not she will get pregnant because God will take care of that." Man whose wife delivered at the hospital. Yelwa

"For us, the husband has a lot to say. If you look at the fact that it is an injunction that you don't disobey your husband. If you disobey him, you will burn in hell, when you meet God. if you make your husband angry, you also make God angry. It is for this reason that some get pregnant while still carrying another baby." -- Woman who delivered at home. Zango

DECISION MAKING

Research indicates that the husband plays a very prominent role in the health care seeking behavior of their wives.

Majority of the women claimed that husband makes many if not all the decisions.

But research indicates that decision making is also influenced by circumstances; the wife herself, relations, especially the parents; elders and leaders in the community; traditional and formal healthcare providers.

The husband's prominent position explained the respondents, is because the husband is the traditional head of the family and with him lies the responsibility of providing money for care.

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COMMUNICATIONS

Research indicates that radio is a popular medium of information as mentioned by both urban and rural communities studied. The popularity of radio derives from its accessibility in terms of cost and longer broadcasting hours, and more transmission in the local language.

It was found that TV is less common in rural areas because of cost and lack of electricity, while low literacy among the respondents make newspapers restrictive.

The types of programs women claimed to prefer on radio and TV such as include cookery, children's drama, while news, political and health programs feature mainly for men.

Research indicates that there is a paucity of songs, adages and proverbs regarding maternal healthcare among the Hausa. Most of the songs, and adages rendered during the group sessions were either taught during antenatal attendance or were about the value and taking care of children.

"Prevention is better than cure, take your children for vaccination." -- Women delivered in the hospital, Kanyere

"Children are nice gifts, I will give him every thing" -- Woman who delivered in the hospital, Katsinawa

"Woman should take care of themselves by going to take care of their pregnancy." -- Woman pregnant for at least the second time, Gubi

Research indicates that many men feel ambivalent about song singing during antenatal sessions. For them, it tends to give the impression that women go to the clinics to enjoy themselves instead of going to obtain care.

**DETAILED FINDINGS FROM HEALTH CARE SERVICE PROVIDERS:
FULANI AND HAUSA**

During the course of the research, we conducted IDIs with a number of healthcare service providers, including TBAs, village doctors, nurses/midwives (who take delivery of women), and medical doctors.

TRADITIONAL BIRTH ATTENDANTS (TBAs)

It was found that TBAs, usually old women who have stopped childbearing, exist in Fulani communities, but majority claimed that they are involved with care for the mother and the baby after delivery rather than before. This confirms the same finding from the FGDs with women. On the rare occasions that they are called to assist, it was that the woman has problems to deliver.

When they are called to assist during pregnancy, they are not called in their capacity as TBAs, but rather as one of the more experienced mothers in the community. Thus, it is our opinion that their recognition and treatment of complications prior to delivery is not different from that of the community that they are part of.

Among the Hausa, some TBAs do see and treat women for various conditions prior to delivery. These conditions include 'sweetness' and 'zir zir' (also called 'zur zur'). This is usually in the form of herbs and potash for drinking around the 7th month. Cutting, (possibly 'gishiri cuts') another routine care to prevent hard labor used to be the mode of treatment, but TBAs reported that this practice is dying.

In addition, they are called for assistance, when labor is starting. According to them, first time deliveries are almost always a must, for such women are thought to be in need of such care because of their inexperience.

It was found that TBAs in both communities (Hausa and Fulani) have a very good knowledge of after-delivery complications and problems in their locality and would not hesitate to advise women to go to the hospital when complications persist after applying their own treatment.

TBAs reported that they are involved in cord care for the baby, treatment of complications like retained placenta, pain in the area of the womb, bleeding, etc. The mode of treatment employed for these cases was presented earlier.

Persistent bleeding, baby lying in transverse position, women with previous caesarian section, prolonged labor, fits, women with VVF repair are cases that TBAs normally claimed to promptly refer to the hospital, except in communities where the women are not permitted to deliver in hospitals. A TBA interviewed in Jar-kasa village will not advise any woman with complications to be taken to

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the hospital because it is the custom for the women to deliver at home. TBAs claimed that husbands almost always comply when a TBA advises hospital treatment, especially when the woman's life is in danger.

In our opinion, TBAs, especially when they have not been trained by formal healthcare providers, are part of and operate within the limitations of the myths and superstitions about pregnancy and maternal healthcare in their localities as they usually inherit their trade from their mothers, who trained them. This then underlie the importance of training of TBAs if they are to contribute meaningfully to maternal healthcare delivery system. One trained TBA in Sade village, seems to have benefitted from training as she was already putting some of the things that she learnt into practice, though meeting with what seems to be a head-on collision with tradition. Now, she does not allow women to spend too much time in labor before advising that the woman be transferred to the hospital, unlike before. But she has not been very successful in convincing pregnant women to eat chicken, which is considered taboo.

But, the potential to reduce ignorance have not been adequately explored. For where TBAs have been trained, there had not been adequate follow-ups to find out how they are coping with their new found knowledge or to replenish materials given them for use. One TBA in Kangere lamented that after 4 years, she was yet to get the promised follow-up visit.

Another problem area is what to do when hospital practice conflicts with home delivery practice. At the hospital, normal delivery position is woman lying on the bed, while at home it is kneeling or squatting. When one trained TBAs decided to put what she learnt about hospital delivery into practice, she discovered that it was very difficult for her and hurtful for the mother. It is easy to imagine that she would revert to her old ways, if follow-up visits do not further teach her how to make delivery through this way easy for everybody.

It is the opinion of POP that training should build up on what they already know how to do best -- assisting women that have complications during delivery or prompt referral to formal healthcare providers for cases that prove recalcitrant or those they (TBAs) are not capable of tackling.

It was found that TBAs, even those that have been trained by formal healthcare providers don't have any link/professional relationship with them. Each knows that the other exist, but apart from that there is nothing else. But TBAs claimed to recognize the competence of formal healthcare providers in dealing with problems which have defeated them. It is our opinion that this could serve as the

foundation for more formal link of the two care providers.

VILLAGE HEALERS

It was discovered that traditional healers are also prone to the myths, superstitions and traditional beliefs about pregnancy and maternal healthcare prevalent in their community and are a strong force in keeping these alive.

Traditional healers claimed to start providing care for pregnant women right from when they are pregnant through labor and delivery and even after delivery. According to them care during ante-natal period include counselling about what to eat and what not to eat, work, rest, sex, etc. In the Hausa area particularly, mention was made of a common routine care for 'zaki' (or 'sweet') and 'zur zur' which are believed to cause prolonged labor and other difficulties during labor.

Traditional healers use herbs and Quranic verses in providing care, and while many use both, there are those that specialize in the use of either.

Traditional healers reported being able to deal with any complication that is presented to them, for it is believed that every complication has a certain set of herbs or Quranic verses that could cure it. Not all of them are so confident of their skills, though. Some traditional healers reported that they would not treat cases of breech presentation and where the woman is suspected to have high blood pressure as such cases are considered very risky. In addition, cases of unwanted pregnancy are turned away for religious reasons.

Usually when cases has been treated unsuccessfully they are then referred to formal healthcare facilities, most times too late.

In some situations, cases that have been initially referred to the hospital and treated unsuccessfully are claimed referred back to traditional healers.

Traditional healers reported that they cooperate with other maternal healthcare providers such as TBAs, local pharmacists, and prayer houses. Prayer houses are claimed to be very powerful and more respected out of all these. This is because they utilize Quranic verses, which are well respected by everybody.

Traditional healers don't have the same kind of cooperative relationship that they have with local healers with formal healthcare providers. According to them, this has neither prevented them from having a very good knowledge of health care facilities in their areas of operation nor from being influenced, maybe just a bit, from what little advise they get from doctors when they have cause to accompany their patients to the hospitals.

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They, however saw hospitals as expensive and unaffordable to many in their communities, the major reason why husbands might refuse to follow advice about referral to the hospital when their wives have problems.

To solve this kind of problem, a traditional healer in Katsinawa village would like to have a Traditional Maternity Center, which will provide full traditional maternity services for women from pregnancy to delivery at affordable prices.

Many traditional healers believe that formal healthcare and traditional care can exist side by side, and complementing each other. For instance, traditional healers believe that there are some conditions that hospitals can handle which they can't and some which they can handle but the hospitals can't. The most often mentioned are cases involving surgery and evil spirits respectively.

It was found that cases of women dying during or as a result of child birth, whether or not in their care are usually taken as the will of Allah. It was thought by traditional healers that nobody can die before the time that is stipulated for her by Allah.

NURSES/MIDWIVES

Nurses/midwives reported that their first contact with pregnant women is usually around the third or fourth month, when they come to ante-natal clinics and where they provide a wide variety of care such as nutritional and hygiene counselling, weight monitoring, anaemia screening, urine test, taking of the blood pressure and general examination, though many times they are limited in what they can do by lack of the necessary equipment.

According to them, ante-natal days are usually the busiest time even though it is thought that antenatal clinic attendance is poor among the people.

As far as treatment of complications are concerned, nurses/midwives claimed that most of the maternity clinics in villages largely serve as referral centers to the bigger hospitals in the towns as they often lack the proper equipment to tackle the smallest of complications. Thus, they take deliveries if it was trouble free. But when complications arise, they usually give only first aid, then prepare a referral file and send the patients to a bigger hospital, mostly to the nearest urban center. Usually, there are no ambulances to convey the patients to the hospital, they claimed.

The most common complication that nurses/midwives claimed to come into contact with was retained placenta, and is normally handled by a doctor. Hemorrhage is also fairly common, and again is normally handled by doctors. Many nurses/midwives reported feeling frustrated about the under-utilization of their capabilities regarding the treatment of simple cases of complication such as: setting up intra venous infusion and treating hemorrhage.

If persuading women to come for antenatal care is hard enough, nurses/midwives claimed to have a harder time persuading them to come for postnatal checkup. The feeling is, if both mother and baby are well, why go to the hospital. The situation does not change much even when one of them is sick. Nurses/midwives claimed that many women run away from postnatal clinic because of counselling on family planning (interpreted by the women as how many children to have), which they and their husbands are not interested in knowing about. Experience has taught the nurses/midwives to talk instead about child spacing, as this is a less sensitive issue.

Research indicates that many nurses/midwives are overworked and get very little additional training after leaving school.

As previously noted, there is no link with traditional maternal healthcare providers like TBAs, and even when some have come for training under the formal healthcare, there is no further contact to see how such people are coping with the application of knowledge gained. Many nurses/midwives believe that this link would be useful and think that the local government can provide it.

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Nurses/midwives interviewed are attached to the local government maternity centres and are either nurses or midwives, and at times both.

OBSTETRICIANS/GYNECOLOGISTS/MEDICAL OFFICERS

Our findings suggest that, the medical officers in Bauchi State do not have a good idea of the traditions and customs of the people whose health needs they are serving. Many claimed ignorance of the beliefs about the causes nor the traditional treatment that are put in place for the complications that women have during pregnancy and childbirth.

The issue of the type of life saving skills that nurses/midwives are allowed to acquire and practice is still a very contentious one. It is found that doctors are against nurses/midwives being trained and allowed to perform life saving skills like I.V. infusions, giving antibiotics, performing manual removal of placenta, vacuum extraction, etc, though against the background of shortage of medical personnel in Bauchi State, some would give their consent on the issue.

Research indicates that the shortage of staff in Bauchi State hospitals is a very serious problem, and has adversely affected the effectiveness of the healthcare delivery system. As at the time of the study, there was no single obstetrician/gynecologist in the employment of Bauchi State Government, while most general hospitals were reputed to have less than three medical officers.

Doctors' briefing of midwives on referred cases from the maternity centers on a regular basis has a very strong influence on the effective management of maternity patients. Research indicates that briefing of this nature is largely hampered because of the busy workload of medical officers.

In our opinion, if government hospitals are to play their proper role in the healthcare delivery system of especially pregnant women in the state, adequate and functional equipment and more medical personnel will need to be provided.

It is clear from research that hospitals have to be better equipped to deal with complications and obstetric emergencies, while campaigns should be stepped up to educate the people about the need for antenatal clinics. Traditional/Religious leaders are highly respected and could assist in this respect, but we believe that a mutual understanding is called for since many of the medical doctors are not indigenous to the area in which they operate. If the medical officers want the people to understand them without first understanding the people, only limited success will be attained.

THE SITUATION IN OYO/OSUN STATES

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DETAILED FINDINGS FROM WOMEN, THEIR HUSBANDS AND COMMUNITY LEADERS

INFORMATION

Research indicates that women, men and their community leaders are exposed to a lot of information relating to health and pregnancy. These include: immunization, breast feeding, ORT, family planning, environmental hygiene, need to attend antenatal clinics by pregnant women, proper nutrition during pregnancy, hazards of self medication, personal hygiene among others. The sources mentioned are radio and TV. Others include household members such as elderly men and women; public address systems from mobile vehicles, house visitation by health workers and posters.

Household Sources

It was found that elderly parents of both sexes constitute a major source of information to first time mothers, especially those in the rural areas, when they are usually informed about the traditional 'dos' and 'don'ts' during pregnancy. Women reported that their credibility stems from their experiences in such matters. In fact, the experienced mother is sometimes more credible than hospital sources.

"One may adhere to experienced mothers. At least they took care of us through their experience." -- Pregnant woman delivered first time - Ibadan

Radio and TV

Research indicates that radio is thought to be a very important source of information on health and pregnancy in terms of reach and types of information covered, especially to the urban dwellers. Women, especially in rural areas claimed that switching on the radio to listen to is a rarity as it would be considered forward for them to do so.

Group members claimed to obtain information on family life and health care, hygiene, family planning, child care and nutrition from the radio.

It is claimed that TV is not common in most rural areas, but tends to be more preferred in urban areas because of its audiovisual qualities. It is found that women mostly watch TV because of drama and plays rather than for health programs.

Research indicates that the credibility of radio is impaired by its impersonal nature. When messages from radio or tv conflict with strongly held traditional beliefs or practices, it requires a very respected personal source to influence behavior. According to

respondents, sometimes promises made on the radio are not fulfilled.

Hospital sources

Women reported that they have contact with hospital personnel through visits to the hospital or home calls by nurses/midwives in rural areas, or through antenatal clinic attendance when they receive information that center mainly around the need for pregnant women to observe personal hygiene.

Where hygiene is concerned, respondents largely expressed the opinion that hospital personnel usually expose them to the benefits of effective health care. Such benefits were claimed to center around the ultimate well being of mother and foetus until safe delivery is ensured. As a result, personal hygiene in the area of hair, outer and underwear as well as general environmental care were claimed to require specific attention during pregnancy.

Apart from hygiene, respondents generally claimed that a most important information received by them from the ante natal clinics at hospitals, is usually to do with the need to take high protein foods and vegetables. Most of these foods are within what respondents refer to as the "e" group (a convenient mnemonic to help women remember the types of rich foods to eat during pregnancy); that is, foods that bear names which start with the letter "e" such as 'efo' (vegetables), 'edo' (liver), 'eran' (meat), 'ewa' (beans) and 'eyin' (egg).

Women enthused about the usefulness of the information obtained from hospital and health workers. Women reported that nurses/midwives are very credible because they are learned and experienced in caring for pregnant women. They are called 'iya ewe' (mothers of infants) in view of their expertise in delivery.

"I like the information I receive from nurses because I understand what they are saying very well. Also, these nurses are educated and they are very experienced." -- Woman pregnant for at least the second time, delivered within last two months and considered high risk pregnancy, Ibadan.

Mission House

It was found that some women also receive health pregnancy related information from mission houses. The types of information obtained are usually comparable to those got from hospital. The credibility of this source, apart from the obvious religious reasons, also derives from the claimed expertise and motherliness of mission house TBAs.

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PRENATAL CHANGES AND ANTENATAL CARE

Research indicates that Yoruba see the period of pregnancy as a delicate time for the woman when she needs special care and attention, as she is also going through changes.

Ailments

Women claimed to experience a host of ailments/conditions such as nausea, vomiting, tiredness, lack of appetite, eating too much, fainting, swelling of feet, sleeping a lot, headache, stomach pains, etc during pregnancy. It was found that many saw these ailments as normal to pregnancy and as such not really something to worry about.

"Though I was not sick during pregnancy but I used to faint." -- Pregnant woman, delivered first time, Ibadan.

Research indicates that men are indeed aware and conscious of the need to provide special care for their wives at this time, usually assisting with minor household chores and contribute in more dedicated manner to housekeeping and the welfare of their wives and children. Women expressed the opinion that the period of pregnancy is usually considered by most husbands as delicate periods in a woman's life and inadequate care at this time was considered incomprehensible. As a result most husbands were described as being in states of anxiety when their wives are pregnant and would usually ensure the supply of fruits and necessary food items for their wives. In addition, some women claimed to receive encouragement from their husbands to attend antenatal clinics.

"The matters of women require patience when they are pregnant because their behavior changes, they get easily annoyed, some become lazy and some fall sick." -- Man whose wife is pregnant at least second time - Ibadan

"The difference is that he did not beat me again as he used to do before I was pregnant." -- Woman delivered first time, Ibadan.

Eating Habits and Food Taboos

It was also found that the eating habits of women are usually disrupted by pregnancy. According to our respondents, around the first three months, eating is usually subdued because of lack of appetite, but around mid-pregnancy to the last trimester, the tendency was to eat too much, thereby putting on weight. Just, a few claimed to go through pregnancy without any appreciable change in their eating pattern.

Eating more than normal during pregnancy is encouraged because it was thought that a pregnant woman eats for two.

"Before I become pregnant I could not eat much but .. in the fourth month of pregnancy I ate at least four times a day." -- Woman who delivered first time, Ibadan.

"She should be eating a lot, and not just anything but a balanced diet because it is from what the woman eats that the child will eat." - Man whose wife is pregnant for first time, Ode-Omu.

"My wife eats more when she is pregnant, you know its two people that now eat." -- Man whose wife delivered last two months in hospital, Ode Omu.

It was found that work load (especially market women) and money impair women's ability to eat the right kind of food during pregnancy. One woman reported that when she was in the market, she normally cannot find time to eat what she really would like to eat.

Research shows that food taboos exist among the Yoruba for pregnant women. Both men and women reported that pregnant women are forbidden to eat snail, snake (a local delicacy), 'ajawu' (a bush bird and local delicacy), antelope (another local delicacy), bush rat (local delicacy), 'awusa' (walnut), 'ebolo' (a kind of leafy vegetable), ripe plantain and banana.

According to the respondents, beliefs concerning some of these food items are:

- Snails are believed to cause excessive and uncontrollable salivation in children ('senukoto').
- Walnut and 'ebolo' are believed to precipitate hiccups at the time of delivery, causing prolonged labor.
- 'Ajawu' and snake are believed to delay walking in children.
- Antelope is perceived to cause restlessness in children.
- Bush rat is believed to be one of the responsible factors for infant mortality ('abiku').

We note that most of these food items constitute some of the more important sources of good nutrition among the rural populace, where the taboos are most deep-rooted.

It was found that credibility attached to food taboos among the Yoruba derive from the need to respect the words of the elders.

Research reveals that cases of repercussions of breaking food taboos are mostly based on hearsay and outright acceptance without questioning. Only in a few cases did women mentioned actual experience.

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"As for 'ajawu', I believe that it is true because when I was pregnant I ate it in the village. When my child would not walk on time, my 'iyako' (mother-in-law) then asked what I ate in the pregnancy that may have been responsible, I then told her I ate 'ajawu'. She knew immediately and said I should take 'omorogun' (wooden spoon) put it on his chest and the same day, he walked." -- Woman pregnant for at least second time, Ibadan.

"You see that of walnut, when I started labor, I had eaten walnut during pregnancy - I didn't know then. Each time I wanted to push, the child would move back up again. I would then run into hiccups. It took a while before my child came. That is why I believe that of walnut."-- Woman pregnant for at least second time, Ibadan.

"It is the 'ebolo' I know. It has never happened to me but it happened to a co-tenant. She had been in labor since midnight but the child won't come and she kept having hiccups. Then they took her to the hospital, that was how she had the baby." -- Woman pregnant for at least second time, Ibadan.

"Why I believe is that, it is the elders, our husband's mother that usually tell us these things are taboo and once they say so, we believe." -- Woman pregnant for at least second time, Ibadan.

"In my own case during pregnancy, I was usually advised not to eat plantain, not in the hospital but by people around, like in our family compound. They say it causes the baby's head to split in the middle ('oka'). Walnut is bad, ebolo is bad for pregnant women, I didn't eat them because they say so." -- Woman delivered in hospital, Ode Omu

"What (taboos) we inherited from our fore father, should not be discarded by us." -- Man whose wife delivered at home, Ikoyi.

Sex

It was found that many women are opposed to sex during pregnancy. Such women reported that in polygamous households, the pregnant wife is supposed to give way to other wives who are not pregnant when it comes to sex. Most of our older respondents expressed that engaging in sexual relations with their husbands during pregnancy is not only indecent, but borders on unnecessary disturbance for mother and foetus. It is claimed that, in fact, sex at this time may even lead to abortion.

However, not all women are opposed sex during pregnancy. Women reported that sex during pregnancy leads to more intimacy between husband and wife, apart from making delivery easier. In addition, it was felt by younger respondents that refusal to engage in sexual relations with their husbands was likely to make their husbands have extra marital affairs or even make their husbands neglect them.

"Why would one bring unnecessary suffering on herself? Once we know the pregnancy is already there, it is not good to disturb the work of God." -- Woman pregnant for at least the second time, Ibadan.

"I don't know about that one! I really feel the baby should come first before doing any such thing." -- Woman pregnant for at least second time, Ibadan.

"They usually tell us in the hospital that it makes delivery easy. I don't see anything wrong with it since one is not promiscuous. It's with ones husband. -- Woman pregnant for the first time, Edun Abon.

"It was during my first pregnancy that they used to advice us at the hospital that the fact that we were pregnant did not mean that we should stay off sex. They said it usually helps to make child birth easy. According to them, the man's sperm will make it easy." -- Woman delivered in hospital, Ode Omu.

I can't deny that since pregnancy we have never come together. The reason I allow it is because if one does not allow her husband to do it, he will be looking for it elsewhere. It may not happen all the time but when it is convenient, one should." -- Woman pregnant for at least for the second time, Ibadan.

Research indicates that men generally see sex during pregnancy as normal and healthy, though some find it repulsive or limit it to a certain stage of the pregnancy for the health of the woman.

"In my own case, I have sex with my wife throughout the duration of pregnancy, up till the moment she wanted to deliver, even the sperm came out with the child." -- Man wife delivered in hospital, Ibadan

"I can't do it with a woman when she is pregnant I find it repulsive." -- Man whose wife delivered in hospital, Ode-omu

"It is not advisable that a man should have sex with his wife, except when the pregnancy is about four months. The woman may be feeling pains in the lower abdomen, which may result to stomach ache." -- Man whose wife was pregnant for at least the second time, Ibadan.

Work Habits

Research indicates that pregnancy or no pregnancy, many women carry on their normal work, contrary to injunctions receive to reduce work load during pregnancy. Women reported that except in serious cases of illness during pregnancy, they usually continued with their normal work whether at home, in the farm or market until labor sets in, though they sometimes avoided those that have to do with excessive standing or bending. Sometimes, hired hands and relatives assist with work.

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ANTE-NATAL CARE AND CARE PROVIDERS

It was found that, most pregnant women get some kind of routine care during pregnancy, from traditional and formal sources.

Traditional Care

Many women claimed to go to traditional healers for medicine to assist in having easy delivery. Such medicine include concoctions ('aseje') for drinking/eating or herb tea ('agbo') for drinking and bathing, 'awebi' (a local soap preparation that aids easy delivery), 'asoro' (usually tied to the roof and believed to be a give protection against threatened abortion). In some cases, especially in rural areas, some of the men claimed to make these local preparations for their wives or daughters-in-law.

High cost of obtaining care at the hospital, habit and familiarity are said to be the main attractions for traditional care.

"If one does not want to go to hospital especially if one is scared of injection, you will be given herbs and even soap by these people it will flush all the ailment away." -- Woman delivered for the first time, Ibadan.

"I believe in traditional health care methods because it has been before we even came to be, even in those days when there was no hospital or injection."-- Woman pregnant at least for the second time, Ibadan.

TBAs

It was found that in many churches both in the rural and urban areas, TBAs provide antenatal care to women. Women claimed that TBAs provide them holy water for drinking or bathing for protection and easy delivery, apart from weight monitoring. Women reported that they consult TBAs mostly for religious reasons for the quality of care received from them.

Care received in mission homes was claimed to bear similarity to the one received in hospital with marginal difference only. One basic difference is in the area of medication as usually given in hospitals instead of holy water in the mission houses.

It was thought that holy water (which is derived by praying into water) is effective in curing diverse ailments that may afflict pregnant women. Women reported that antenatal sessions in mission houses also include songs and minor exercises.

"The difference between mission and hospital is that at the mission home one would not be treated with injection but with prayer. If it is the hospital one would be given injection and other drugs. Where care of the foetus is concerned, they are more or less similar." -- Woman delivered at home, Edun Abon

"The treatment given in hospital is similar to that of the church, but there is a slight difference. The fact that they have doctors and nurses (in hospital) is a main difference. The prayers given us is one major source of salvation for us. They do not give medications, they usually give us water. They also test us in the church, we also sing, dance and clap our hands (just like the hospital). -- Woman delivered at home, Edun Abon

Antenatal clinics

Research suggests that antenatal clinic attendance is poor in Oyo/Oshun State. It was found that it is relatively better among the urban areas than those in rural areas.

Women who attend antenatal clinics claimed to undergo various care like weight monitoring, urine and blood test, testing for foetal movement, counselling on nutrition, hygiene, etc. It was found that the smaller clinics have fewer facilities. Women reported having to go to a bigger clinic for some tests because one they normally use did not have the right facility.

It was found that for many women, antenatal clinic attendance is laden with several obstacles. Women who attend antenatal clinics reported that they are usually given a list of the things to be bought for delivery in the hospital, for it is assumed women who attend antenatal clinic will deliver in the hospital. These things include cotton wool, detergent, disinfectant, olive oil, disposable gloves, among others. Research shows that the cost of purchasing these items is beyond what most women and their husbands can afford and since hospitals are very strict about the completeness of such items, women reported that this scares them from even attending the antenatal clinics.

It was found that each time a woman goes to the antenatal clinic, money is needed to purchase drugs and sometimes injection. For women who attend antenatal clinics about once a week as we found common, cost of care represents an unaffordable expenditure to many women and their husbands. Women reported that this forces them to adopt a cost saving measure of not going to register until the 7th month.

Research indicates that distance to the hospital, especially in the rural areas; unavailability of drugs; long waiting time and abusive attitude of the hospital staff, especially nurses/midwives constitute obstacles to antenatal clinic attendance.

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Research shows clearly that many of those who attend antenatal clinics do not really mind all these problems, for the fear of complications is very strong, more so when traditional care is not trusted. We found that in many cases, the husbands play a very prominent role in persuading their wives to go to antenatal clinics.

Research also indicates that apart from women that obtain care from mission houses, many women who attend antenatal clinics also try one form of traditional treatment or the other. It was thought both have a role to play in ensuring good health.

"As for me, I think we should utilize both the medications received from traditional herbalist and the one's from the hospital. For example, it was even in the hospital that they advised one of my younger sisters to try the traditional health care method so she could have a child. When she did this, God answered her and both the mother and child are alive."
-- Woman pregnant for at least the second time, Ibadan

"Both the hospital and traditional methods of health care are the two most important ones. There has been a lot of times when the hospital has failed to solve some problems and the traditional methods did it. The home aspect is very good."
-- Woman pregnant for at least the second time, Ibadan

Knowledge and Treatment of Complications

Focus groups reveal that for every complication occurring during pregnancy, there is a traditional cure for it. It was found that care is not necessarily given by health care providers like traditional healers and traditional pharmacists, in some cases, husbands, elderly men and women do provide this type of care.

Research reveals that traditional care was usually the first care sought when complications arise as this is thought to be the most convenient and cheapest care available.

The general belief in the areas studied is that complications are the work of evil doers and thus traditional treatment is the more appropriate treatment. Research indicates that antenatal clinic attendance does not seem to be a strong factor militating against this kind of care when complications arise.

It was found that traditional care did not always work. Women reported cases where traditional treatment was applied for emergency cases, and the patients died before hospital care can be sought after traditional treatment has failed.

"If women have problem (complication) like this, we try our best to treat it and if it is not possible, we then take them to the hospital, where the doctors will treat them." -- Community Leader, Ikoyi

"Obstacles or complications that a women may have when she is pregnant at times is that the child may not be turning around. We then take such a woman to whoever is helping to treat her ... the doctors could be of help, our fathers could do it and some religious sect can do it with lots of prayer." -- Man whose wife delivered at home last two month, Ikoyi

We found that women who could not go to the traditional healers for treatment go to the TBAs in their churches where complications are not necessarily seen as work of evil, but are all the same treated with prayers and holy water.

It was found that swelling of feet, hands and face called 'oyun emi' is linked with a number of beliefs. Research shows that this condition is associated with a number of causes: multiple pregnancy; blood shortage; prior disease before pregnancy and too much intake of salt. Generally, it is not taken as a serious ailment during pregnancy and few seek any care at all for it.

Women who claimed to experience headache during pregnancy did not describe it as severe but may seek care for it when it is persistent. Analgesics are normally used first.

Our respondents claimed that bleeding from the birth canal occurs in some women but is not very common. When it occurs, it is believed that the pregnancy is simply interrupted, and the woman will take more than nine months to deliver. A few women remarked that this condition sometimes lead to miscarriage.

"I have heard it is broken ('o bu'). At times it causes miscarriage and if she does not miscarry, the pregnancy will last more than nine months, but such women should go to the hospital immediately." -- Woman who delivered for the first time, Ibadan.

LABOR AND DELIVERY

Commonly referred to among the Yoruba as 'ojo ikunle' (day of kneeling), in obvious reference to the traditional position adopted during the process of childbirth, labor is perceived as the most dangerous period of pregnancy, that usually requires utmost care and preparation by expectant mothers, their husbands and relatives and the healthcare personnel.

Preparation for Labor and Delivery

Research indicates that materials that are normally needed in the hospital for treatment and care constitute a major area of preparation for expectant mothers. While those that plan to deliver in the hospital get their hospital requirements together

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(previously mentioned), those planning to deliver in mission houses with the help of TBAs claimed to take olive oil, clothing, cleaning materials, etc. It was found however that in mission houses such requirements are waived if the woman cannot afford to get them.

On the traditional front, group participants claimed that preparation starts around the seventh month when a powdery substance 'agunmu adera' is used for a woman to prevent cold, fever or stomach ache. Again, the 'asoro' (a substance tied to the roof to prevent the pregnancy 'from coming down' (being aborted)) is removed so that the woman can deliver.

"If it is time for her to deliver, we must cut loose the "asoro" or else the women won't be able to deliver." -- Man whose wife delivered at home, Ikoyi.

"Preparation is in many folds. Apart from what the child will use (such as) flask, cloths, milk, ... preparation must also be made for what the mother will use after the delivery. Plus other things that one may be requested to bring from the hospital." -- Man whose wife delivered in the hospital, Ibadan.

Labor Signs and Duration

Most respondents who were pregnant for the first time claimed that they would know that labor has set when they felt unusual pains in the lower abdomen and any other signs of discomfort that appear to be very different from what they normally felt in earlier months.

Research indicates that the reality was different. It was found that when women were delivering for the first time, they generally could not identify when labor commences. Some women claimed they thought it was stomach pain, while some reported going to the hospital way ahead of time to await delivery, due to anxiety about delivery.

It was found that for many, labor usually begins with cramps which will be followed in some, by the breaking of water ('omira') or by 'ijan', a mucus-like substance that is often mixed with blood. This experience is also referred to as 'ibekun' (literally, the breaking of the stomach). We were informed that they call it 'show' in English Language antenatal parlance.

When labor starts, some women reported that they usually engage in physical activities like walking, washing of clothes, sweeping, etc. They have been told that this can help them to relax and reduce fear and anxiety. Women claimed that the husband is usually the first to be called for assistance or in the alternative, any elderly person around.

"In the case of first pregnancy, it is usually a case of inexperience. It was a day to my delivery, I just went to sit in the hospital. They told me that I should go home. I refused initially but had to go eventually. It wasn't until the next day that I had the baby. But during my second experience, it was not until I had seen the sign that I told those around me that I was ready. I gave birth to the child as soon as I got to the hospital." -- Women Pregnant for the second time, Ibadan.

"For labor, perhaps one would experience stomach discomfort, it will be harder than it normally is and one would have to go and seek help and care for delivery." -- First time Pregnancy, Edun Abon

"When I was pregnant with my first child, I started feeling labor cramps, I thought I was suffering from 'tapa'/'jedijedi' (hemorrhoid). I then started taking its medication in an indiscriminate manner. I then went to my friend's house and we went out on a visit to another friend. That was where I started feeling the urge to use the toilet. As I was about to ease myself, I felt the baby turn inside of me, I felt as if it was turned upside down and I quickly got up. I went out and started locking my legs together. We left (for hospital) immediately." -- Woman pregnant for at least the second time, Ibadan.

How long should labor last? Research indicates that there was no agreement. Our respondents believe that it will vary for different women, but will like it to be as short as possible and should normally precede delivery by just a few hours.

Places of Delivery

Research reveals that the fear of complications during delivery is responsible for the preference for hospital delivery among the Yoruba in Oyo/Oshun states. According to them, the overriding factor is safe delivery. It is generally perceived that hospitals are better equipped - both materially and personnel-wise to treat complications that may arise from delivery. Some women reported that no woman should deliver outside the hospital, since any problem that occurs can be addressed in the hospital. First time mothers are a special category of those that are believed should deliver in the hospital.

Research findings indicate that generally, the decision to deliver in the hospital is more deliberate than accidental.

"Delivery at home and with traditional healers is not encouraging, and what we hear about them is disquieting." -- Woman pregnant for at least the second time, just delivered, considered high risk pregnancy, Ibadan

"The reason why the hospital is better off than the home is that one may have the baby and start to bleed excessively. Elders will not be able to do much. If it is in the hospital, they will give her some blood." -- Woman delivered at home, Ibadan.

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"The hospital is a better place because when one is in hospital (at delivery time), the nurse on duty would keep asking how one is faring and as they ask, they will administer the appropriate tests to know where the child is positioned." -- Woman pregnant for the first time, Edun Abon.

"I just cannot afford to have my child at home but I know that hospital is the best place for one to have her child. What they have in the hospital is not in the home." -- Woman delivered within the last two months, Ode Omu.

"As for home delivery, if a woman delivers at home, it is possible that something may go wrong with the child because some children require special care as soon as they are born. Where this is the case, it is possible for such a child to die. The mother too, may require injection but where she delivers at home perhaps she will be given some form of traditional medicine that may even cause her death. That is why it is not good for a woman to deliver at home." -- Woman pregnant for at least second time, Ibadan.

"The person who has many children can afford to toy with the idea of giving birth at home. Ha! which first time mother would want to have her baby at home?" -- Woman pregnant for the first time, Edun Abon.

However, research shows that many obstacles stand in the way of hospital delivery for many women.

In all the groups, respondents reported that hospital delivery is costly and unaffordable to many people. For instance, apart from hospital bills, the cost of items that women are asked to bring before delivery is considerable and hospitals usually turn back women who do not have the complete 'kit'.

"Some people prefer to deliver at home (because) we don't have an hospital that is well equipped ... they will be thinking of financial side of it ... when they go to hospital and they (nurses) see that one will soon deliver, they will give them a very long list of what they (pregnant women) need to buy before they move in. That one again used to scare them away." -- Community Leader, Ikoyi

"What is there is that if we have hospital very near, we will be going there. But since there is none, we can't be travelling far away... Even when we take them to the hospital the money charged us is high and there is no money. That is why we normally deliver at home. In any case the TBA's are also trying." -- Man whose wife delivered at home, Ikoyi

It was also found that other reasons such as distance to health facilities, especially among those in rural areas; and abusive and rude attitude of hospital staff, especially nurses/midwives militate against hospital delivery.

Rural respondents reported having to travel fairly long distances to get to the hospital in contrast to mission and traditional herbal homes which are usually within short distances to their homes. This evidently requires that patients spend more money to get to the hospital.

Even among those in urban locations, the distance covered to get to the hospital, when added to the problem of transportation was claimed to tend to reduce preference for hospitals.

"One day, I went for check-up at the doctor's and met a pregnant woman who had been in labor from her house but who did not get transport to take her to the hospital on time. The baby she was to deliver was breech and by the time she eventually got transport and delivered her baby, it was dead." -- Woman who delivered in hospital in last 2 months, Ibadan.

"My own experience was like this; we had to trek to get to the hospital but before we got to the hospital, I had to deliver the child by the bridge on the way."-- Woman delivered at home in the last two months, Ode-Omu.

"Concerning distance, the hospital may not be most appropriate because of this. It is necessary to add a touch of home medication to it. Once a pregnant woman has taken the necessary traditional immunization, she will not have much problem." -- Woman delivered at home in the last two months, Ode-Omu.

Perception of hospital care vis-a-vis traditional care, habit and religion were also found to play a role in preference for home over the hospital for delivery.

Some women claimed to deliver at home instead of the hospital because they did not see much difference between treatment obtained in the hospital and the traditional treatment. Squatting or kneeling to deliver is the traditional method to deliver among the Yoruba. Some older women claimed that hospital mode of delivery which entails a woman lying on her back and spreading her legs was unfamiliar and uncomfortable for them. Some women claimed to deliver at home because of their membership of a church. All members, except first timers are expected to deliver in the church. An added benefit is the caring attitude of the TBAs in the church.

"I went to call mummy (church TBA) in the mission.. I prefer them to Catholic hospital, they care for us, even when we sleep every two hours they will come and look over us." -- Pregnant woman delivered first time, Edun-Abon.

Knowledge and Treatment of Complications

Research indicates that men and women alike displayed good awareness and knowledge of why a woman may have very difficult delivery. Respondents mentioned that anaemia, lack of good

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nutrition, young age at delivery, too many children, high blood pressure, are some of these factors. In addition, first time mothers are also said to find delivery difficult. Fear is thought to be the reason for this. Women reported that advanced age is not a likely cause for difficult delivery, rather the number of children that a woman has already is.

"You see, one's age can hinder delivery... what usually happen these days is that there are some girls that are not of child bearing age and older women who have passed child bearing age, when they get pregnant, their safe delivery is in the hand of God." -- Man whose wife was pregnant for the first time pregnancy, Odeomu

"Women that never had child birth experience, it is often difficult for them... because some of them are afraid." -- Man whose wife delivered at home, Ikoyi

It was found that knowledge of the problems that may occur during delivery are fairly good among many of our men and women respondents. In addition, there are traditional beliefs regarding many of them.

On the whole, complications during delivery, as largely expressed by respondents, are fearful situations that cause great anxiety for the individual and her relations. Research shows clearly that when there is an obstetric problem, it is not seen as the problem of the couple alone. Respondents claimed that immediate family members, relatives and neighbors and church members usually play important roles. These include financial assistance and providing transport when needed. For women that delivered at home, it was found that treatment of complications usually start at home and progress to the hospital when traditional or home treatment fails.

"In fact, they (TBAs) try. They used to try for the women. People used to have very good delivery. But at times the problem that could be beyond the mission here, they will transfer such a case to Ibadan (hospital)." -- Community Leader, Ikoyi

Research indicates that in all the communities studied, there was no standing program for helping needy couples. It is believed that this is not necessary as people are always willing to help each other when in need.

The issue of causes of maternal mortality was greatly avoided by respondents with the expression 'olorun ma mu wa' (may God not support our enemies) since such occurrence is not considered to happen on its own but through one's enemies. As a result, the issue of how this could be avoided was largely met with responses that indicated that it is only God that can prevent such happenings.

Women mentioned that cases of prolonged labor especially through breech presentation, retained placenta and hemorrhage are common in their communities.

Blood Loss and Donation

Many of our respondents claimed that they will recognize excessive blood loss by dizziness, fainting and tiredness, though some claim that only the doctor or the more experienced mothers will know.

"For how would one know there is too much blood? But if it is in the hospital, once the nurse see her, they will know if the blood is too much or not and they will know what to do to stop the excessive flow." -- Women pregnant for the first times, Edun Abon.

"We are not really going to know when the blood is too much, but older and experienced women can know." -- Women pregnant for the first times, Edun Abon.

Where a woman bleeds excessively after birth in hospitals, women claimed that she is usually given some intravenous drugs which would have been known to reduce such flow.

Research shows that mission homes usually apply prayers while traditional home deliveries use incantations and herbs to cases of excessive bleeding, though final treatment usually comes from the hospital when bleeding does not respond to treatment.

"Like those of us that delivered at the mission home, if such bleeding persisted after they would have prayed and used the blessed water on the person, they would ask that the person be transferred to the hospital." -- Women delivered at home within the last two months, Edun Abon.

Yoruba have no objection to taking blood. Most of the respondents claimed that they are not averse to blood taking, provided it is certified as good. The general belief was that by the time blood was being sought, it would have become a matter of life and death and many will be willing to help.

Respondents claimed that their husbands and relatives are those normally asked to donate blood, failing, leads to blood purchase in the blood bank.

In reality, research indicates that there are more people that are unwilling to donate blood than those willing to. Women consider blood donation as not for them since they need it for menstruation and child birth. Some men reported that they can only donate to their wives.

"They don't normally ask women to donate blood, it is only the men that do this." -- Women pregnant for at least for the second time, Ibadan.

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Breech Presentation

Many claimed to be aware of complications whereby women have their babies legs first or the baby lying transversely. Women with breech presentation are believed to have used the tail of a wood instead of the head to make fire during the pregnancy. This was mentioned by only a very few of our women respondent, otherwise most claimed ignorance of the cause.

Children born leg first are called 'ige' and are believed to be wicked to their mothers, because of the suffering their mothers are believed to go through in delivering them. Respondents claimed that cases of breech presentation are normally transferred to the hospitals.

Caesarian Section

It was found that there was good knowledge about the need for caesarian section among our respondents. According to the respondents, it becomes necessary when the woman's birth canal is too small for the child to go through.

Among a few Yoruba, it is thought that a woman delivers all her children the same way she had her first issue. Thus, a woman whose first child was delivered breech is pitied and prayed for.

"When a woman is in labor for too long, and when she does not have any energy to deliver herself, she has to be helped so that she does not die, and the child too." -- Woman who was pregnant for at least the second time, considered high risk, Ibadan

Vesico Vaginal Fistula (VVF)

There is a very little knowledge about this complication among the Yoruba.

AFTER DELIVERY

A lot of care is available to the women and their children after delivery, provided mostly by relatives and traditional healers.

Hot Bath and Massage

It was found that many new mothers go through a period of hot bath or massage with hot napkin after delivery. Most of our respondents claimed that this will get rid of blood that has coagulated inside the woman during delivery, apart from healing the wounds sustained during delivery. Respondents claimed that this period could be as short as 7 days and as long as 40 days.

It is our opinion that this ritual though similar to what the Hausa and Fulani go through is not viewed with the same seriousness that the Hausa and Fulani attach to theirs.

"If she is given hot bath, it is possible that all the blood which have coagulated in her blood will be flushed out -- Community leader, Ode-Omu

Instead of hot bath, some respondents claimed to sit on hot potty (chamber pot containing hot water). The process, like the hot napkin one, also assists in emitting blood clots and other after - birth substances from the uterus. It was found however that some women, especially those from Osogbo are traditionally forbidden to use hot water.

"It is taboo, we must not use hot water. Some other people too, if they are worshippers of Osun Osogbo are not supposed to use hot water. If they do, they will get tired and their stomach will be bigger and they will have pains on their bodies even if such a person is taken to the hospital it will not cure" -- Woman who delivered at home Ode-Omu.

Traditional Care

It was found that some other traditional care are available from traditional healers to put the woman back on her feet after the trauma of childbirth. These are in form of herbs and concoction mostly. Women claimed that they rarely go back to the hospital for postnatal check up.

Child care

It was found that newly delivered babies are usually looked after by female members of the household, regardless of the place of delivery. Research also indicates that unless the child is seriously ill, most don't go to the hospital for treatment. The reason was explained to us that there is a whole lot of home/traditional remedies for all the ailments that may befall a small child. For example, after the bathing at the hospital, further bathing is considered necessary at home.

The cord is usually cleaned with cotton wool and spirit as claimed by majority of our respondents who appeared to have responded positively to hospital instructions concerning cord care of the infant. The traditional pattern of heating the baby's cord with part of a broken mud pot was revealed by research, as being gradually taken over by the adoption of the cotton wool and spirit method. Cord care is continued until the outer part of the cord drops.

It was found that a convulsing child is usually treated with cold water. Women reported that such a child is put under the running tap for the purpose of effecting coolness and general muscle

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relaxation. Also, traditional medicine in the form of herbal mixture is commonly administered while hospital care is also greatly relied upon, but as a secondary measure in most cases.

Respondents did not overtly express much anxiety over the issue of possible breathing difficulties in their babies. Any incident along that line, though claimed to be uncommon, was largely said to be a necessary case of hospital referral or in some cases, of hot pepper treatment, with drops of hot stew being given to the child orally. This is believed to have a relieve breathing difficulties.

Where babies are small, the hospital is mostly believed to provide the most adequate treatment although breast milk is also believed to have a boosting effect on size deficiency in babies. Hospital care is however considered the ultimate in taking care of smallness in babies.

Respondents claimed in the majority that minor eye problems in babies have been known to be traditionally responsive to breast milk, which is usually squeezed directly from the mother unto the baby's ailing eyes. Alum and water are sometimes used too.

This curative method for eye problem was claimed by most respondents to have been made known to them through discussions with relations, friends and members of the community. It was in fact considered as common knowledge. Where breast milk does not appear to be effective however, some respondents claimed usage of sugar and boiled water solution. Hospital care is usually sought only when these other home based therapy may have been exhausted.

"It happens to children a lot, (convulsion). The very first treatment usually applied is to put the convulsing child under a running tap or its equivalent before any medication is used at all. Some may administer the traditional herbal mixture ('agbo') while others may seek hospital help where injections will be administered to the child." -- Woman delivered at home, Ibadan

"It is necessary to pour water on the baby's head first because convulsion is caused by high temperature." -- Woman pregnant at least for the second time, Ode Omu

"I have never seen the situation where a small baby is effectively treated the traditional way. It is only in the hospital that health care is given for the treatment of small babies." -- Woman delivered in hospital - Ibadan

"Once one sees this sign of size deficiency in a baby, one would begin to feed the baby consistently, but it is only breast milk that one would give often. If one treats the size problems with breast milk and does not see much improvement, one would then take the baby to the nurses who would

diagnose the cause." - Woman who was pregnant for at least for the second time, Edun Abon

"When the baby is small, there is no need to take him to the hospital. He should be taken to the herbalist where all types of herbs are available to make him grow bigger in no time." -- Woman pregnant in the third trimester, considered high risk pregnancy, Ibadan

"As for eye problem in babies, we can use breast milk to cure it. If it does not then improve, we may use sugar in water and apply this with cotton wool on to the baby's eye. Both breast milk and sugar solution method are very important." -- Woman who delivered at home, Ode Omu.

"The breast milk therapy is not only the words of the elders but when a person who has used it once tells someone else about it, the knowledge of the method will begin to spread." -- Woman who delivered at home, Ode Omu.

Breast feeding

Breast feeding was largely considered by our respondents to be natural and of utmost necessity for a mother who desires the love and compassion of her child in the future. A child that is not breast fed was explained to us as being likely to be hard-heartedness where the mother's case was concerned.

It was found that most women don't start breast feeding their children until after 2-3 days to allow time for colostrum to be expelled. This was explained to us as due to the belief passed down from experienced mothers on colostrum which was called 'idoti oyan' (dirt of the breast) which if not expressed will cause yellow fever in babies. Many women claimed not to know the reason for this practice, though when describing colostrum, the yellow color was invariably mentioned leading us to believe that the difference in color is responsible for this perception.

"I thought that it was dirt that first came out" -- Woman pregnant in the third trimester, considered high risk pregnancy, Ibadan

"The first flow of breast milk is usually yellow. It cannot be given to the baby because it causes yellow fever." -- Woman who was pregnant for at least the second time, Ibadan

"As it comes out in that yellow color, the person looking after us will wash it off until it becomes clear before we give it to the child. It is because it is not good, except it gets clear." -- Woman pregnant for at least second time, Ibadan.

"You see once a person gives birth to the baby, she will wash the nipple well. They did not tell us to give the child the first yellow one." -- Woman who delivered in hospital, Edun abon.

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"It is because it is very thick and not white. That's why I dislike it. I see it as dirt in the breast ('idotu inu oyan')." -- Woman who delivered in hospital, Edun Abon.

One woman provided another insight as to why colostrum could be considered dirty.

"I squeezed it (colostrum) out because, I don't want it to worry my child. For its been long that the last child sucked at it." -- Woman currently pregnant, in third trimester, considered high risk pregnancy, Ido Oshun

Women that feed colostrum to their babies are usually those that have been counselled about the usefulness of colostrum at the hospital.

"At first, I did not know that it (colostrum) is good. It was in the hospital that they told us that first milk is the best." - Woman pregnant in the third trimester, considered high risk pregnancy, Ibadan

Research indicates that in some cases, the washing of the nipples that is often carried out in response to nurses/midwives' advice is likely to be confused with the need to express the colostrum.

"After washing the nipples, until it is clean, the thick one (colostrum) will then keep flowing out. In the hospital, they insist that we have to wash the nipples for as long as one could, until all the dirt is removed and the white one will start coming out. After this, one could then give the baby. Actually the reason we don't give the baby that thick yellow one, is because we feel that there has to be a good reason before they (nurses) ask us to wash off all the dirt." -- Woman delivered at least the second time, Ode Omu.

Family Planning

As concerns when respondents would like to have their next babies, most respondents expressed the view that it is always reasonable and face-saving to give adequate spacing to children. Community itself is believed to frown over short time spacing and women who find themselves in such situations are usually subjected to ridicule by neighbors and acquaintances.

Most of our respondents thus expressed the opinion that child spacing should be encouraged with emphasis on the ideal period of three years. This time gap was further suggested as being most realistic in terms of giving time for the first child to mature, since this will determine the ease with which a pregnant mother will be able to cope with her condition. Some respondents went as far as saying that inadequate spacing, will result in mental retardation for the last child. As a result of this belief, the

period of three years was suggested to be wide enough for giving birth to a child without the embarrassing burden of carrying babies both inside and outside.

On the whole, many of our respondents expressed the desire to put an end to child bearing after four children at the most. Research findings indicate that this opinion was borne more out of economic considerations rather than for the health of the mother.

A few of our respondents, specifically those in the Ode-Omu area, were however differently disposed to the idea of limiting the number of their children. This view was particularly expressed by a group of respondents who have just delivered in the hospital within the last two months. The blatant use of contraceptive (referred to as 'roba') condom was also greatly condemned among this group. Songs rendered by them are portraying the value attached to child bearing in Yoruba land, warned against putting a stop to child bearing while one could still have them. The use of family planning methods also came up as unnecessary in such songs:

YORUBA:

E ma so pe o se mo
E ma so pe o se mo
Omo dara, omo dara lehin obirin
E ma so pe o se mo

ENGLISH:

Do not say you have put a stop,
Do not say you have put a stop,
A child looks good, a child looks good
When backed by a woman, so
Do not say you have put a stop (to child bearing)

YORUBA:

E ma ti roba bo abe
E ma ti roba bo abe
Omo dara, omo dara lehin obirin
E ma ti roba bo abe

ENGLISH:

Do not insert condoms into your private part
Do not insert condoms into your private part
A child looks good, a child looks good
When backed by a woman, so
Do not insert condoms into your private part

YORUBA:

B'ogun omo ku meji lorun
Awa la o bi o, awa la o bi o
B'ogun omo ku meji lorun
Awa la o bi o

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ENGLISH:

If there are only two left of the twenty children above
We are the ones to have the two.

If there are only two left of the twenty children above
We are the ones to have the two.

YORUBA:

L'aiye mi, ibadi mi terere ma fi gbomo si o

L'aiye mi, ma teni golu ma fi temo si o

L'aiye mi, ma pana, ma bo yeri ma pe k'oko wa se!

ENGLISH:

In my lifetime, my hips are wide enough to carry children

In my life time, I'll lay my baby on mat of gold

In my lifetime, I'll put off light,

Remove my slip and invite my husband for sex!

This reaction is an indication of low acceptance of family planning schemes in the area.

Complications

Problems commonly experienced by women after delivery are largely centered around what is normally called 'womowomo' or 'awomoka' (child seeker), engorged/sore breasts and post-birth fever.

'Womowomo' is usually characterized by what respondents described as extreme pain in the area of the womb. This experience is believed to be common to most women after delivery. It is in fact believed that women necessarily have to experience this ailment after delivery as it is an attestation to the fact that a child has left the womb. The pain is believed to be caused by the 'playmate' of the baby while inside the womb. Some respondents see it as the stool ('apoti') that the baby was sitting on before its delivery. The ailment is believed to come sharpest when the baby is put to breast. Every indication of the description given to 'awomoka' or 'womowomo' points to the occurrence of the contraction of the womb. The persistence of 'awomoka' or 'womowomo' is usually referred to as 'agaro'. The following describe respondents perception of 'womowomo'.

"One of such ailments is stomach ache, they call it 'womowomo' or 'agaro'"
-- Woman who delivered at home in the last two months, Edun Abon

"It is called 'awomoka' because it is the chair used by the foetus when it was in the womb. My own came out the following morning after delivery. I had to ask what it was and those that were already experienced said it was the chair used by my baby and that it had been the cause of the pain I was experiencing." -- Woman who was pregnant at least for the second time, Ibadan

"The person suffering from 'womowomo' (child seeker or 'agaro' would keep having lower abdominal pains. They are both the same. They may even refer to it as 'roaming blood' ('eje ti nyi') and once they press the tummy with hot napkin, that is the end of it." -- Women pregnant at least for the second time, Ibadan

Engorged breasts were pointed out by respondents as being caused by breast exposure soon after delivery. The effect of the cool air on the breast was said to breed some insects ('kokoro oyan') around the nipples. This ailment is usually considered to be very painful and could be cured both in the hospital and by traditional herbalists. Respondents however explained that hospital treatment though equally effective, cannot detect and expose the 'insects' believed to be in the breasts. Such detection is believed to be the exclusive preserve of the traditional herbalists who would give the breasts a ritual bath with native soap and some herbal solution. The ritual bath is believed to kill the insects, which were described as larvae-like and could be seen dropping into the bowl that the breasts are washed into:

"If a person exposes her breast (after delivery), it is possible for air to penetrate the breasts and so cause breast engorgement -- Woman who was pregnant for at least for the second time, Ode Omu

"If the breasts gives the newly delivered mother a lot of pain, she will be taken to the herbalist, who will wash the breasts with traditional herbal soap. They will also use some herbal solution to scrub round the nipples, some larvae-like insects will then begin to drop into the bowl. In the hospital they cannot see it but they will treat the ailment." -- Woman who was pregnant for at least for the second time, Ode Omu

"When I was pregnant, I experienced some problems with my breasts, they then 'washed' it for me. They washed it with natural soap, the insects were tiny like beads and they were dropping. Later though, they had to operate it when it started paining me all over again. -- Woman who delivered at home in the last two months.

Retained Placenta

Placenta retention is usually attended to in hospitals, through massage applied to the woman's womb area or through manual removal. In mission homes, prayer and massage of same is usually applied but in cases where prolonged delay sets in, the woman is usually transferred to the hospital.

In traditional birth settings, women reported that retained placenta is treated in various ways. A cloth may be tied round the woman's waist, or she may be asked to blow hard into bottles or calabash, or asked to insert wooden spoon into her mouth - these will cause the woman to push involuntarily and the placenta would be released in most cases. Where further delay is experienced, traditional healers may be called and usually places his or her

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hands on the woman's back and stomach and say some incantations, using the woman's parents' names. This has been known by those who experienced it, to be effective. Where these methods do not prove successful, such cases are usually transferred to the hospital.

Fever was mentioned by some of our respondents as one of the ailments caused from blood loss from delivery and that they usually treated it with home medication like Panadol and generally keeping the woman in warm condition.

Many of our female respondents claimed that they view blood loss after birth seriously, and promptly go to the hospital for treatment.

DECISION MAKING

Research revealed that decision making concerning what respondents should do in pregnancy is shared, albeit unequally among husbands, parents-in-law, parents and the pregnant women themselves. In many cases however, it is the decision of husband that holds most, followed by the husbands's parents and the woman's parents.

*"I as a person, I decide on where she should go because I look at it that if there is any problem, she is not the one that have the problem per se, I am the one that has the problem, that's why I make the decision about where she should go." -- Man whose wife was pregnant for the first time.
Ode Omu*

It was found that child bearing on its own, is an issue which although involving the coming together of husband and wife, is subject to great influence by parents, in-laws and other relations. Parental influence was claimed to be mainly in terms of advice as to the spacing of children while in-laws are recounted as exerting an almost authoritative influence on the idea in question.

Some parents-in-law were claimed by respondents to encourage large number of children from their sons and daughters-in-law. Some were claimed to even go as far as giving their daughters-in-law the ultimatum of either providing that they are highly fecund or staying out of their son's homes. Cases were reported in which respondents have had to give birth to more children on such conditions.

COMMUNICATION

Amongst our respondents in the rural areas, the main sources claimed for obtaining general information are the radio and word of mouth. For our urban audience on the other hand, the daily newspapers, radio, television and word of mouth are their main sources of general information. Television and radio programs that

deal with feminine matters like 'Aiye Obinrin' (Woman's World) 'Tokotaya' (Husband and Wife) and cookery programs were mainly claimed as being preferred by the female respondents. Others claimed interest in drama programs like 'Koto Orun'. Most popular programs for the men are public enlightenment/ombudsman programs such as 'Agborandun' and plays ('ere ori itage'). It is evident that messages related during the presentation of such programs are likely to catch the attention of the target audience.

Research reveals that the Yoruba in Oyo/Oshun states, generally possess within their child rearing repertoire, a rich vocabulary, proverbs and songs that relate the value of the child and mother within the community. Not much was however obtained concerning the particular issue of maternal healthcare. From songs rendered during the groups, it was clear that children are seen as sources of pride to mothers, while barrenness is greatly condemned and considered as a shameful predicament for a woman to find herself in. Thus, most proverbs and songs expressed the investment potential accorded to children since they are believed to stand the chance of taking care of their parents in the future. The inheritance aspect of children is also greatly reflected in most songs that deal with maternal matters.

It was found that our respondents were more articulate in song rendition than they were in relating proverbs and other adages that reflect ideas which are inherent in maternal conceptions. This is because of the inseparable nature of songs and lullabies in child nursing. Songs reflecting maternal healthcare are tied to the desire of women to go through pregnancy and delivery safely.

PROVERBS

YORUBA:

Omo eni laso eni

ENGLISH:

A person's child is her dress.

YORUBA:

Bami na omo mi, ko de inu olomo

ENGLISH:

The person who calls others to discipline her child usually ends up not being pleased with the idea.

YORUBA:

Iya ni wura, baba ni jigi

ENGLISH:

Motherhood is likened to gold while fatherhood is likened to glass. (Gold being more lasting valuable than glass which breaks too easily).

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YORUBA:

Omo l'afe aiye

ENGLISH:

Children are the essence of life.

YORUBA:

Omu Iya dun, b'eniyan lowo ti ko bimo, asan ni

ENGLISH:

A mother's breast is delicious. Affluence without children is more emptiness.

SONGS

YORUBA:

Ma je nbi sanku o Oluwa
Lojo ikunle, k'omi ma poju, keje ma poju
Ki won ma s'alai to o

ENGLISH:

May I not die during delivery
May there not be too much water or too much blood
On the day of delivery

YORUBA:

Omo lo ye mi
Igo funfun lo ye omi adura
Omo lo ye mi o

ENGLISH:

I'm worthy of having a child
Just as it is only the white bottle that should be used for
collecting prayer water.

YORUBA:

Ma ya gbe omo mi jo
Kasa ma wo palo gbe omo mi
Ma ya gbe omo mi jo

ENGLISH:

I will straight away dance with my child,
Lest the hawk enters my sitting room to pick my child.

YORUBA:

Ope meta l'emi o se
Moru layo, mo so layo, Mo tun ri gbejo
Ope meta l'emi o se

ENGLISH:

My thanksgiving are threefold
I went safely through pregnancy
I delivered safely
I even have a child to show for it
My thanks are threefold.

YORUBA:

Jesu ma je n fobe bimo
Omo ti nbo were ni koje
Jesu maje n fobe bimo

ENGLISH:

May Jesus not allow me to be operated upon at delivery
This child that is coming, may it be delivered with ease
May Jesus not allow me to be operated upon at delivery

YORUBA:

Ma je ngba oyun ku o Oluwa,
Ma je ngba oyun ku o Eleda, lo jo ikunle

ENGLISH:

May I not die through pregnancy on the day I'm supposed to deliver.

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DETAILED FINDINGS FROM HEALTH CARE SERVICE PROVIDERS

A number of interviews were conducted among traditional and formal healthcare providers like traditional healers, village doctors, nurses/midwives, and obstetricians/gynecologists.

TRADITIONAL HEALERS

It was found that Yoruba traditional healers in Oyo/Oshun States provide routine care to women before delivery. Such care, as expressed by the traditional healers are mostly herbs to drink alone, with pap, or to bathe with. They claimed that routine care are designed to make delivery easier for the woman. In fact, from discussion with the healers, there is a high level of importance attached to easy delivery among the Yoruba. This is a confirmation of the finding from interviews with women.

Research findings indicate that traditional healers have a cure for all the problems and complaints that women could probably present during pregnancy. Traditional healers reported that they encounter and treat conditions like stomach aches, bleeding from the birth canal, dizziness, convulsion, hypertension, fever, and baby lying in transverse position. In fact, it is believed that there are specific herbs for any illness under the sun.

It was also found that some complications need more than herbs. Yoruba believe that when a baby is about more than 4-5 months old, it has ears and you can 'talk' to it. This is the belief that guides traditional treatment of breech presentation using incantations.

Traditional healers claimed that they normally refer cases of complications to the hospital only after they have tried and failed. After all, they argued, traditional drugs have been in existence before the advent of the white men. They however reported that there is basically no conflict between the two brands of treatment and can go side by side.

It was found that Yoruba traditional healers perform midwifery functions. Thus, they are called when women start labor and the first thing they do is to tell her to walk around. This is to make her relax. Where they are women, they also serve as women leaders in their community.

It was found that traditional healers are also called to treat complications during labor and indeed at all stages during pregnancy, delivery and even after delivery.

They claimed that they normally do not want to help deliver first time mothers because they are not courageous and may wound the

child because of fear and clumsiness. This is why such first timers are encouraged to deliver in the hospital. They also refuse to help deliver women that are perceived to be cowardly ('ojo'), but all other kinds of women, including those with previous caesarian section are usually attended to.

Research shows that after delivery, traditional healers are involved in care for mother and child. According to them such care include cord care, massaging of the stomach and body with hot water to enable the excess blood to come out, treatment of cases of retained placenta by 'talking' to it, convulsion, hemorrhage, small babies, breathing difficulties, etc.

Traditional healers claimed to be against abortion, and will not procure abortion for professional reasons since they cure and not destroy.

It was found that traditional healers do not have any association with TBAs because many TBAs as earlier noted are church-based, but they associate with each other. Again, they claimed not to have any relationship with the formal healthcare providers. In a way they are like loners in the healthcare delivery system.

Many claimed that they belong to the health committee in their villages, whose meetings are usually ad hoc rather than regular and confirmed that there are no revolving funds for emergency or stand-in programs to help pregnant women in their communities. They reported that there is no need for such as people are always willing to help each other.

TRADITIONAL/COMMUNITY BIRTH ATTENDANTS

Most of the TBAs in the Yoruba community tends to be linked with churches and thus their only stock in trade is prayer, apart from midwifery skills. Even one TBA that was not affiliated with a church that we talked to said she does not use any herbs in treating women.

TBAs claimed they are consulted as early as two months after conception for routine care, which is mainly in terms of counselling about hygiene, nutrition, and other type of care. In addition, holy water is used copiously by church members and tends to give the women added security.

It was found that when complications arise during ante-natal period, or even during and after delivery, TBAs claimed to refer women to the hospital promptly. They rarely start treating the woman except to give her 'first aid' (hot beverage drink with milk is normally given women that have lost too much blood to provide energy before she reaches the hospital). Thus, when complications like, swelling of feet, hands and face, fits, excessive blood loss, etc occur they are promptly referred to the hospital.

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Many of the TBAs reported that they have cups given to them from the hospital to measure when blood loss is excessive and as such hospital care becomes necessary; and referral cards for their patient who are on referral. These referral cards contain the TBAs' diagnosis. It was found that when TBAs say hospital care is necessary, relatives usually comply.

It was found that TBAs do not take all deliveries brought to them. Women having their first babies, those with more than five children, women with previous caesarian section and those with previous VVF repair are usually referred to the hospital.

Research shows that TBAs do not give drugs during delivery, but wash the woman's vagina with antiseptic to clean the birth canal. Some cares that are given are delivering women though not very common include; massaging the woman's breasts as a way to reduce stomach pain. The stimulation they claimed takes the woman's mind off the pain. Sometimes, light clothing is used to tap the woman's stomach as a way of inducing the placenta to come out after delivery.

After birth, the major area of care concerns the cord. The cord is normally treated with methylated spirit. Also, warmth is provided the mother and the baby and the woman is expected to use sanitary pad to prevent infection.

It was found that a few of the TBAs are trained. One of such of the TBAs claimed that formal healthcare personnel, mainly nurses/midwives, maintain constant touch with them, counselling them and teaching them new skills. We found that the untrained TBAs on the other hand do not have the same kind of relationship with the formal healthcare personnel, though they claimed they are received warmly whenever they have cause to go to the hospital.

NURSES/MIDWIVES

Research finds that nurses/midwives' first contact with women is mostly around the last trimester of pregnancy, when they come to register for antenatal clinics. They claimed that this late registration is deliberate and is due to the fact that attendance at antenatal clinics is very expensive and women want to delay registering as much as possible.

The nurses/midwives reported that though many of the women in this areas are still steeped in superstitious beliefs about pregnancy and child birth, this has not prevented them for realizing that women who go to hospitals have safer deliveries. They believe that cost is a major limiting factor in antenatal clinic attendance.

They further reported that during antenatal clinics, women are counselled about a lot of things including personal hygiene, care of breast, signs to expect during labor, diet, work habits, etc.

It was also found that nurses/midwives treat many un-booked cases, a fall-out of unsuccessful treatments from traditional healers, especially in rural areas.

Nurses/midwives claimed to encounter some common complications during antenatal period such as shortage of blood and fever. During labor, common complications include obstructed labor and fits. Bleeding and retained placenta are also said to be fairly common after delivery. For the new babies common complications are said to include jaundice, cough and catarrh and inability to breathe well.

It was found that in any of the complicated situations, the nurses/midwives either refer the cases immediately to the doctor in attendance or give an emergency treatment before referring to the nearest referral station which could be a government hospital or a private hospital e.g Catholic hospital, Oluyoro in Ibadan, with better facilities to handle such complications.

Research shows that nurses/midwives face many obstacles in tackling and managing complications that come to them. Maternity centers in the rural areas are said to be often ill-equipped to handle many cases of complications that come to them. For instance, Ode Omu comprehensive health center lack pipe borne water, weighing scale, bowl to bathe the baby, etc. Even some maternities in the city which are owned by local government lack equipment such as hand gloves and mask. It was also found that most nurses/midwives and midwives hardly have refresher courses after leaving school or any planned effort to update their knowledge. It was also reported that very little or no follow up is done about a high risk patient who stops attending ante natal clinics. Nurses/midwives claimed not to have the time to do this, and in any case, it is supposed to be the duty of a community health worker.

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Nurses and midwives interviewed are attached to local government maternity. Some are qualified nurses/midwife while some are nurses.

OBSTETRICIANS/GYNECOLOGISTS/MEDICAL OFFICERS

According to doctors in Oyo/Oshun States antenatal care is a very important one to pregnant women as many of the complications of pregnancy could be identified early enough to take remedial action. But unfortunately, not as many as they would want take this care seriously. Doctors claimed that the major reason for this is ignorance since pregnancy is considered to be a natural thing and is thus taken for granted. Distance to the hospital, cost of obtaining care and abusive tendencies of hospital staff are also believed responsible.

It is clear that doctors see more complications that they would really like to see. They reported that most of the complications that they treat are preventable by good antenatal clinic attendance.

Doctors claimed that their work in treating complications is not made easy because a lot of traditional beliefs exist about complications. The causes which hinge on the work of 'evil doers' make traditional healers the first port of call for mostly the rural-based, and thus most sufferers if not already dead from traditional care are brought to the hospital too late. For instance, a medical doctor in Ibadan mentioned some ways of respectively treating obstructed labor and prolonged labor as; a stick is put in the mouth of the woman which she chews while incantations are being said; 'effirin' leaf is put inside the genital tract of the woman.

What roles do nurses/midwives play in handling complications? Very little, we found out. Most doctors believe that complications should be referred to them as the nurses/midwives are not trained to handle complications. Many would concede however that episiotomy, manual removal of placenta and starting IV infusions are simple enough for nurses/midwives to be trained to handle. Other areas which are still seen by many as their exclusive preserve by nature of their training and experience are vacuum extraction, and prescribing antibiotics.

Doctors absolved themselves from lack of feedback on cases referred to them by nurses/midwives, saying it is the responsibility of nurses/midwives and more to their advantage to do so. It was argued that this feedback improves their knowledge about how to handle complications, aside from bringing them closer to the patient and so increases trust between patient and nurses/midwives.

Doctors said they sometimes feel frustrated in discharging their duties because of negative attitude towards government hospitals, proper equipment for working, especially dealing with life threatening obstetric emergencies, and poor conditions of service.

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SUMMARY OF KEY FINDINGS

1. Ailments such as regular nausea, vomiting and lack of appetite make many women nutritionally deficient during pregnancy. In cases where a woman is not hampered by these conditions, poverty prevents her from obtaining the right kind of food to cope with the demands that pregnancy places on her.
2. Another obstacle in the way of women in obtaining adequate nutrition during pregnancy is food taboos. Many of the food items that women are prevented from eating during pregnancy because of traditional beliefs are those that can be beneficial to them. Such food items include among the Fulani and Hausa, chickens, sugar/sugar cane, oils, vegetables, eggs, and among the Yoruba, 'ebolo' (a leafy vegetable rich in vitamins), some fruits (walnut), snail, snake (good sources of protein in rural areas).
3. Anaemia, a result of poor nutrition tend to contribute to making many women tired and weak during pregnancy. Despite this, some are still required to fulfill their work obligations whether in the house or farm or market without assistance.
4. Antenatal clinic attendance is poor among women in all the study areas, but the major reasons differ from one state to another.
 - Lack of knowledge about need prevents many women and their husbands from seeking care for especially in Bauchi State.
 - Among many of the Yoruba in Oyo/Oshun state, the problem is more of cost of obtaining routine care.
5. Other factors, apart from those mentioned above that stand in the way of antenatal clinic attendance and indeed hospital care include:
 - distance
 - transportation problems
 - attitude of hospital workers
6. Women that are too young, or too old and those with many previous births are exposed to risks of difficult delivery because of lack of knowledge and some cultural practices and beliefs. The young age at marriage and negative attitude towards family planning among the Fulani and Hausa immediately come to mind.

7. The Hausa and Fulani prefer to deliver at home rather than in the hospital for the following reasons:

- cost of care
- transportation problems
- distance
- traditional beliefs
- attitude of hospital workers
- perception that hospital delivery is only for those with problems
- cost and scarcity of drugs

8. The Yoruba in Oyo/Oshun States however prefer to deliver in the hospital because of:

- fear of complications
- quality of care in the hospital.

But many end up delivering at home because of:

- cost of care
- distance to health facility
- transportation problems
- attitude of hospital workers
- demands of hospital.

9. Many do not have extensive knowledge about causes of complications during pregnancy and childbirth.

- Among the Hausa and Fulani, especially, death of women resulting from such complications is seen as the will of Allah.

- Among the Yoruba, some traditional beliefs about causes of complications sometimes preclude their treatment through formal healthcare providers.

10. When complications arise, many women tend to seek emergency care during pregnancy from sources outside the formal healthcare system, e.g. traditional healers, some TBAs and elderly women.

Lack of knowledge of the need for life-saving care that can only be provided by a formal health care system, leads to late referral and unnecessary deaths and deformity, especially in Bauchi State.

11. Many communities have no standing program to help women during obstetrical emergencies. The general perception is that people are always willing to help each other when called to do so.

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12. Many people are not positively disposed towards donating their blood, even during obstetrical emergencies because they fear that their blood will be depleted. Women see themselves as most unsuitable donor for reasons of blood loss during menses and childbirth.
13. The first 40 days after delivery, known as the hot bath and massage period is traditionally a very important one among the Fulani and Hausa during which the new mother is expected to rest, eat and regain her strength and take hot baths every day.
14. Many women do not feed their children with colostrum (the first rich milk that a new mother produces). Among all the communities studied colostrum is largely perceived as harmful to the baby, a tradition that many have not questioned. The negative feeling about colostrum has to do with the color mainly.
15. Most people are strongly opposed to limiting the number of their children, but claim favorably disposed towards adequate child spacing.
16. Men wield a lot of power when it comes to decision making about the healthcare of their wives and women in their communities during pregnancy, mainly because of their economic power.

Many times, this power is not absolute. Parents, community leaders, religious leaders, healthcare providers, both formal and traditional and even women themselves, influence decisions concerning the healthcare of women during pregnancy and childbirth.

17. Care provided by TBAs for women differ among the three communities studied.
 - Among the Fulani, TBAs don't perform midwifery functions. They are usually called to take care of the child after delivery. They are rarely consulted during antenatal period.
 - In Hausa communities, many TBAs are called to assist women during delivery, especially for first time. Again, they are rarely consulted during antenatal period.
 - Yoruba TBAs are called to perform midwifery functions; and when they work in mission houses, they are consulted from antenatal to post-natal.

18. TBAs in the three different communities are fairly similar in the way complications are managed. Attempt is usually made in treating complications before referral, although this attempt is not prolonged among those that have been trained.
19. Most traditional healers render routine and emergency care at any stage of pregnancy and labor to women in all the three communities, but differ somewhat in the two states in the type of care rendered to women in their areas of operation. While many of those in Oyo state perform midwifery functions, there is no indication that those in Bauchi state do the same. Again, traditional healers tend to believe that every complication has a particular herb or quaranic verse and incantation that can cure it.
20. Many of the maternity clinics in rural areas serve as just referral centers as they lack the necessary personnel and equipment to tackle even the smallest complications.
21. The issue of what life saving skills nurses and midwives are allowed to acquire and practice is still a very contentious one.
22. Many nurses/midwives feel their skills are grossly under-utilized, when it comes to treating some simple cases of complications.
23. The level of interaction between formal and traditional healthcare providers is poor.

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KEY MESSAGES AND APPROACHES TO MESSAGE DEVELOPMENT

The key messages that IEC should focus on should involve the following:

- The need for adequate nutrition during pregnancy. The campaign should be moved from just letting people be aware to providing convincing reasons why pregnant women should have adequate nutrition during pregnancy. Women should also be enlightened on the benefits of certain foods that have been largely relegated to the realm of taboos. Knowledge of food taboos originate from within the community and kept alive by community leaders and traditional healthcare practitioners. To this end, efforts at re-educating about food taboos should be directed primarily at community leaders and the custodians of customs.
- The need for pregnant women to attend antenatal clinics as all women are at risk during pregnancy. The message should explain why this is so. Attack the belief that only people with problems go to the hospital. Also, since many women tend to obtain one kind of routine care or another during pregnancy, campaigns should specify what kind of care women need and who is best qualified to provide it.
- The need to inform people of women in high risk categories. Message should list those at risk, and why they are at risk.
- The need to seek hospital care for life threatening situations, as only hospitals with modern healthcare facilities can help women in difficulty. This message to be effective should not dismiss the skills and expertise of local healers, but should emphasize that, with time, there are better ways of doing everything including healthcare.
- The need for donate blood for needy women during emergencies. Message should attack the belief that blood donation leads to blood depletion in the donor nor does it transfer any disease. Also, emphasize the need to save life in campaigns.
- The need to feed colostrum to the baby. Attack the fear that colostrum is bad because of the color. A possible way to go about it is to mention that colostrum is different from the normal milk because it is better and richer than normal milk.
- The need for adequate spacing of children. This is a message that looks unnecessary at first blush considering traditional practices that support adequate child spacing. But the approach that we recommend is one that encourages action

rather than lip service. Modern methods of family planning must be mentioned as being necessary to encourage men and women to achieve what they believe in rather than to limit the number of their children.

- As religion arouses very strong emotions among most people, messages should not go against strongly held religious beliefs and should be screened for such.

- The love that these communities have for children should be taken into consideration in approaches to message development. In situations where talking about the benefit to the child, has identical effects with talking about the benefits to the mother, the former approach should be adopted.

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STATE SPECIFIC RECOMMENDATIONS

Bauchi State

- The thrust of the strategy to reduce maternal mortality and morbidity in Bauchi state should be to make it safer for women to deliver at home. This is in view of the expressed preferred place of delivery for most Hausa and Fulani, and the scarcity of hospitals.
- The central message could be that: It is not the intention of Allah that any woman should die during childbirth, for the ability to reproduce is Allah-given. This is in view of the fatalistic attitude towards maternal deaths.
- The primary targets should be: men; community leaders, ward councilors, religious leaders and husbands. Women should be a secondary target, especially for campaigns to encourage good antenatal clinic attendance.
- Messages should be developed and directed to rural Fulani as to how to go about obtaining care from the hospital, to forestall a situation which prevents people from seeking hospital care because they don't want to feel embarrassed or exploited.
- News programs and political debates appeal to men and messages could be associated with these.
- In view of the impression many people have about hospitals as a place to go when in difficulties, a campaign should be developed to address this misconception.
- For women, drama, musical and cookery programs are the major interests and messages should take these into consideration.
- Media preference should be radio.
- There is no gainsaying that messages should be in local dialect.
- Disseminating messages through films and documentaries shown in the village square at night should be explored. This is in view of the Hausa's and Fulani's love for theater and films.

Oyo/Oshun States

- The thrust of the strategy to reduce maternal mortality and morbidity in Oyo/Oshun states is to make it easier and more convenient for women to deliver in the hospital, while also making it safer for women who want to deliver at home to do so.
- The central message for this state could be that: If going for hospital care is expensive, not going can be even more expensive.
- Messages should also capitalise on the fear that Yoruba have about complications during delivery. Recounting success stories of how antenatal care attendance was able to prevent potentially difficult deliveries should be considered.
- Men and women should have equal exposure to messages, in view of the important roles played by either in maternal healthcare seeking behavior in these states.
- Women, cookery and drama programs are a very useful way to attract the women folk and messages should be associated with these.
- Again messages should be rendered in local dialects.
- Media preference should be radio and TV.
- As proverbs, adages and songs tend to feature prominently in communication among the Yoruba, messages should include these as a way of attracting attention.

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OTHER RECOMMENDATIONS

1. Governments in both states will need to devote more money to the provision of healthcare services to pregnant women by providing more functional maternity clinics and more personnel to run them.
2. The siting of comprehensive health centers at the outskirts of the towns, especially in Oyo/Osun States should be rectified.
3. Hospital staff should endeavor to treat people who come to them for help more humanely. The rural Fulani in Bauchi state is a special case in point.
4. In view of the impasse between nurses/midwives and doctors concerning what nurses/midwives should or should not do, the desire to help women in need during childbirth should be the main consideration in resolving the issue.
5. The incidence of quack doctors in Oyo/Oshun states is a problem with very serious implications and should be given priority attention.