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An intercept study of persons attending traditional birth homes in rural southeastern Nigeria

C. OTUTUBIKEY IZUGBARA and J. KINUABEYE UKWAYI

Analysing data from interviews with traditional birth assistants and their clients in rural Nigeria, this paper examines the characteristics and conditions of persons using the services of traditional birth homes. The clients of traditional birth homes mainly comprise women with little or no formal education and in low or no-income occupations. These persons present at traditional birth homes for child delivery, abortion, family planning, STIs, infertility and a host of other reproductive health-related conditions. Economic and cultural factors are primary considerations in the uptake of services. Findings highlight the critical role of poverty and culture in mediating access to good quality reproductive healthcare, the burden of unmet needs for good quality neonatal healthcare and reproductive health services among local women, and the critical health role of traditional birth homes in rural Nigeria. Local peoples’ access to good quality health services could be improved by integrating traditional birth homes into mainstream healthcare delivery, and making available formal health facilities responsive to the socio-economic and cultural needs of local peoples and communities.

Introduction

Throughout the 1980s, international health planners increasingly demanded greater focus on the health concerns of women. Nowhere is the need to pay greater attention to the health needs of women more urgent and challenging than in addressing maternal reproductive health issues and concerns (Population Reference Bureau 1994). By 1987, when the Safe Motherhood Initiative was launched, maternal reproductive health had become a useful indicator of the levels of socio-economic development attained, as well as a strategic measure of gender equality across regions. Maternal reproductive health status has important social and economic implications. Writers such as Parker et al. (1990), Ransom and Yinger (2002) and Shane and Chalkey (1998) posit that the vast majority of women who die from, or are disabled by, reproductive health-related disorders and complications are in the prime of their life.

Maternal morbidity and mortality deprive families of a woman’s crucial role in household management and care. Children in such households often...
suffer a decline in nutritional status and have lower school enrolment figures. Maternal disabilities arising from anaemia and malnutrition also influence child health. Babies of malnourished mothers have low birth weights, suffer more from disabilities and development delays, and have reduced chances of survival. Insufficient maternal care during pregnancy and delivery has been blamed for an estimated 8 million stillbirths and neonatal deaths globally (UNICEF 1997) When a maternal death occurs, the community loses a nurturer, provider, and productive member while the country loses its investments in the woman’s health, education and skills. Injury from maternal-related causes adds significantly to the total burden of ill-health and encumbers scarce health resources and facilities with further pressure. On the other hand, good reproductive health guarantees women’s survival and productivity and provides critical leverage for the progress of individuals, households, communities, and countries.

Although, maternal mortality is a global phenomenon, the critical issues associated with it are most profound in developing countries. Judging by recent figures, 515,000 women die annually from maternal causes (UNICEF 2001, WHO 2001) Ninety-nine per cent of these deaths occur in developing countries, making maternal mortality one of the sharpest indicators of the disparities that exist between developing and developed nations. Ransom and Yinger (2002) contend that these deaths are just part of a more tragic picture. They point out that for every woman who dies, approximately 30 more suffer injuries, infections, and disabilities during pregnancy or childbirth. The cumulative total of women currently affected has been put at 300 million (UNICEF 2001).

In Nigeria, the chance of a woman dying from reproductive health disorders and complications has been put at 1 in 10 (Population Reference Bureau 2002), placing the Nigerian woman at far greater risk than her counterpart in the developed world, where the risk is estimated to be 1 in 2000. Haemorrhage, infection, unsafe abortion, hypertensive disorders, and obstructed labour are the most common medical causes of maternal death in the global south. Most of these deaths could be prevented if women receive skilled care during pregnancy and childbirth. However, the majority of southern women deliver without skilled attendants.

Against this background, writers such as Feireman (1981), Ondimu (2000) and Thaddeus and Maine (1990) have argued that to substantially reduce the incidence of maternal reproductive health-related deaths and disorders, basic comprehensive and formal obstetric and gynaecological care must be readily available to all women. This assumption is however suspect. Researchers have found out that even when formal skilled care is available, women may not seek or receive it (Ashford and Mackinson 1999, Harrison 1996, Igun 1989). This is especially so in countries such as Nigeria where informal and formal healthcare services coexist and are viewed as veritable options for reproductive healthcare (Nagawa 1996, Goliber 1997, Igun 1989, Ityavyar 1984).

Traditional birth homes are a well-documented source of reproductive health care in many southern countries. The available body of writing on traditional birth homes, however, continues to view them primarily as places for child delivery. Yet as Lefeber and Voorhoeve (1997), and
Walraven and Weeks (1999) have shown, traditional birth homes do more than deliver babies. The other functions besides child delivery that traditional birth homes perform are, however, not well documented. From the perspective of sustainable public health planning and delivery, we urgently need comprehensive information on the various health concerns including child delivery for which people utilize traditional birth home facilities.

The aim of the present study was to provide comprehensive information on the essential services that traditional birth homes provide. The study aimed to investigate the clientele of traditional birth homes for their characteristics, health conditions, and reasons for the uptake of their particular form of service.

**Context**

With a population of 120 million people, Nigeria is easily the demographic giant in Africa. Half this number are women, and 65% of these women live in rural areas with little access to basic social amenities (Murphy and Baba 1981, Asuquo et al. 2000, Harrison 2001). In these areas, modern healthcare faculties are scarce and, where they exist, they are underfunded and lack basic essentials, from drugs to syringes. Skilled and professional healthcare is available to only a small number of persons in rural Nigeria.

It has also been estimated that only about 28% of rural Nigerian women have births attended by skilled personnel (Harrison 1996, UNICEF 2001, PRB 2002). The risk of maternity mortality in rural Nigeria stands at one in 12 births, and for every rural woman that dies during childbirth 40 more suffer injuries, disabilities and life-threatening infections (Goliber 1997, WHO 2001). Two-thirds of all births in rural Nigerian take place with the help of traditional birth assistants, accounting, perhaps, for the high risk of maternal mortality in these areas (Essien et al. 1997, Ransom and Yinger 2002).

Sexually transmitted infections (STIs) are prevalent in rural Nigeria, especially, among young people. One source estimates that at least two of every three rural Nigerian aged 13 to 24 suffer, or had suffered one or more STIs (Oladepo and Brieger 2000). Young rural girls are also two to six times more likely to contract STIs. Where the signs are recognized, treatment of STIs among rural peoples in Nigeria is often clandestine (PRB 2001, Ashford and Mackinson 1999).

Abortion is illegal and severely restricted in Nigeria. Abortion services are therefore rare and, where they exist, follow unsafe procedures and are performed clandestinely by untrained health providers (Howson et al. 1996). But as many as four Nigerian girls in every six under 20 years of age have had an abortion. One country-wide study shows that 60% of abortion-related deaths occur among those who obtain abortions illegally. And many of these people are girls under age twenty (Kinoti et al. 1995). A large number of rural women and girls also resort to abortion drugs or other informal means of inducing abortion often with fatalities and complications (Ransom and Yinger 2002).

In spite of world-wide increases in the uptake of family planning services, the percentage of rural Nigerian women of childbearing age using modern contraception remains below 30%. The situation is worse among
unmarried girls, putting them at high risk of unintended pregnancies and STIs. Several factors explain the low use of family planning services in rural Nigeria. Many rural women (and their husbands) fear the side effects of modern contraceptive methods such as pills and injectables, owing largely to illiteracy and ignorance. Women are also dissuaded by their husbands’ disapproval or by family pressure to have more children. Difficulties in obtaining contraceptives and a shortage of trained health personnel restrict access to services. Young people in rural areas, in particular, face economic, social, political, and cultural barriers to obtaining contraceptive services (Goliber 1997, Ratzan et al. 2000).

The uptake of formal health services is generally low in rural Nigeria. The healthcare needs of local people are thus serviced mainly by informal healthcare providers: traditional birth attendants, indigenous healers, itinerant medicine peddlers and chemist shopkeepers, etc.

Traditional birth homes offer an example of one informal setting in which many rural Nigerians seek cures for their conditions (Iweze 1983, Obikeze 1997, Ransom and Yinger 2002). Available data show that traditional birth homes are common in rural communities. Among the Igbo of southeastern Nigeria, they are known as ulonwa. The Yoruba of the southwest call them Ile Igbebi. The Ibibio refer to them as ufok uman, while the Urhobo in the midwest call them orherhe. Traditional Birth Homes have few links with formal health facilities (Iweze 1983). They are often run by women with little or no formal education or training. Most birth attendants are taught by their own mothers or by other women who practise the profession (Iweze 1983). Traditional birth homes are usually built within the homesteads of the birth attendants, but they are often located a little away from living accommodation to guarantee privacy.

Although comprehensive information on the services of local health providers is currently needed to chart and inform sustainable health interventions, available studies on traditional birth homes in Nigeria have focused on them simply as settings for child delivery, neglecting the other critical health services they provide.

The present study was therefore undertaken with the following specific objectives in mind:

- to explore the socio-demographic characteristics of the clientele of traditional birth homes in rural Nigeria;
- to gain understanding of the health concerns and conditions for which these persons were consulting or visiting traditional birth homes;
- to investigate the reasons for the uptake of the services of traditional birth assistants;
- to draw together lessons for current research and action on local health matters.

**Method**

**Study sites**

The study was carried out in four large rural Ngwa-Igbo speaking communities in Obingwa Local Government Area of Abia State, Nigeria.
Fieldwork took place between February and April 2001. From the 1991 census figures, there was an average of 14,500 persons in each of these communities. Although most of the people were Christian, there was a handful of animists in each community. The predominant occupation is subsistence farming involving the production of cassava, yam and cocoyam. The people are generally poor. Most live in houses shared with livestock such as poultry, goats, sheep etc. Services such as modern healthcare facilities, good roads, and well-equipped schools are also largely absent. Their main sources of drinking water are muddy streams and infested ponds.

Study methods

To locate and interview respondents, it was necessary to intercept them at the traditional birth homes. Key informants were employed to locate and identify one or more traditional birth assistants in each community. We then met individually with identified traditional birth practitioners (all of whom were women), interviewed them, and also sought their permission to interview persons presenting at their homes, which they granted. Altogether, thirteen traditional birth homes were identified in the four study sites. These acted as service location points at which users were intercepted for questioning. Service location intercept methodology relies on a purposive sample obtained by locating respondents at the place of distribution. Such respondents or participants would typically be difficult to locate in sufficiently high numbers through standard probability sample survey methods (Green et al. 2000).

Sample

A total of 149 separate service users were accessed during fieldwork in the 13 traditional birth homes surveyed. Two refused to co-operate with the study. All the intercepted users were females. Users were interviewed on one occasion using a semi-structured interview schedule which sought to collect information on their characteristics and the health conditions for which they were visiting traditional birth homes. The 13 traditional birth assistants were also interviewed. Information sought from them related to the health conditions which they treated and the characteristics and health conditions of persons who sought their cures etc.

Some special concerns

From a methodological standpoint, reproductive health-seeking behaviour can be a sensitive issue. Various reports have noted difficulties in eliciting participation in studies that focus on reproductive health, especially of rural women who are often inhibited by cultural and religious codes from
discussing reproductive health matters and conditions. We anticipated encountering objections from traditionally-minded respondents and birth practitioners and took great care to minimize the likelihood of misunderstanding, social tensions, and outright opposition. As part of these precautions, only female fieldworkers interviewed participants. All fieldworkers were versed in the local language of the study areas and were also provided with training to equip them to cope with the challenges of data collection. Participants were guaranteed anonymity and confidentiality of the reports. All discussions were tape-recorded. Respondents gave verbal consent to the recording of the interviews.

Results

Both traditional birth assistants and clients were all female. However, their socio-economic and demographic characteristics differed. The ages of clients ranged between 16 and 48, with the highest proportion of users

Table 1. Socio-demographic characteristics of intercepted users and traditional birth assistants

<table>
<thead>
<tr>
<th></th>
<th>Traditional birth assistants</th>
<th>Intercepted users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td>—</td>
<td>09</td>
</tr>
<tr>
<td>21–30</td>
<td>—</td>
<td>41</td>
</tr>
<tr>
<td>31–40</td>
<td>—</td>
<td>54</td>
</tr>
<tr>
<td>&gt;40</td>
<td>13</td>
<td>43</td>
</tr>
<tr>
<td><strong>Highest levels of education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>12</td>
<td>31</td>
</tr>
<tr>
<td>Primary</td>
<td>1</td>
<td>89</td>
</tr>
<tr>
<td>Secondary</td>
<td>—</td>
<td>24</td>
</tr>
<tr>
<td>Tertiary</td>
<td>—</td>
<td>03</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>4</td>
<td>56</td>
</tr>
<tr>
<td>Protestant</td>
<td>6</td>
<td>68</td>
</tr>
<tr>
<td>Traditional worshipper</td>
<td>2</td>
<td>23</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>—</td>
<td>18</td>
</tr>
<tr>
<td>Married</td>
<td>8</td>
<td>93</td>
</tr>
<tr>
<td>Widowed</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>Divorced</td>
<td>—</td>
<td>15</td>
</tr>
<tr>
<td><strong>Occupation</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>House keepers</td>
<td>13</td>
<td>114</td>
</tr>
<tr>
<td>Maids</td>
<td>—</td>
<td>07</td>
</tr>
<tr>
<td>Farmers</td>
<td>13</td>
<td>132</td>
</tr>
<tr>
<td>Petty traders</td>
<td>9</td>
<td>74</td>
</tr>
<tr>
<td>Students</td>
<td>—</td>
<td>18</td>
</tr>
<tr>
<td>Civil servants</td>
<td>—</td>
<td>21</td>
</tr>
</tbody>
</table>

*Multiple responses allowed.
falling within the 31 to 40 age-bracket. Few teenage users were intercepted. The presence of teenage users, none the less, suggests early knowledge of, and preference for traditional reproductive health care sources.

All the traditional birth assistants were aged above 41 year. Their average age stood at 61. They had also practised for an average of 18 years. Nine of the traditional birth assistants had learned the profession from their mothers, three from mothers-in-law, and one from a friend.

With regards to education, the bulk of service users had little or no formal education. Altogether, the average completed years of formal schooling among users was 8.6 years. Only one traditional birth assistant had received some form of formal education.

The religious profile of the service users showed they were mainly Protestants (68) and Catholics (56). Only 23 were animist. Traditional birth assistants were also mainly Catholic (four) and Protestant (six). Two of the traditional birth assistants were, however, animist. Most of the service users were either currently married (93), widowed (21) or divorced (15). Eighteen of users were single. Most of the traditional birth assistants were married (8). A further five were widows.

When questioned about their occupation, service users said they were housekeepers (14), farmers, (132) and petty traders (74). There were also civil servants (21), students (18) and house maids (seven) among them. The traditional birth assistants also saw themselves as farmers, housekeepers, and or petty traders.

All traditional birth assistants surveyed claimed they delivered babies and cured infertility among men and women. They also treated vaginal bleeding, miscarriage, STIs, menstrual disorders, pregnancy-related morbidity, breast and breast milk problems, neo-natal morbidity, and vaginal itching/discharge. They all provided family planning, ante-natal and post-natal services, and also treated neonatal conditions such as teething problems and childhood fevers. Eighty-five per cent claimed they provided and are consulted for abortion services by local people. Nine of the traditional birth assistants also treated painful sex among women. Traditional birth assistants observed that although majority of those who presented at their homes were women and girls, men and boys also uptake their services especially for STIs, impotence and weak erections. One of the traditional birth assistants remarked:

> While most of those who come to me are women and girls, boys and men also come to me for advice and treatment. I have personally treated several boys and men for *nsi nwanyi* (gonorrhoea) and *omewu amu* (penile weakness).

And another said:

> ... I also have male patients. They come for many reasons. Some have weak erections. Some can’t get their wives pregnant. Some have *oria* (disease) ... I treat all of them. It is my job. My mother taught me.

The conditions for which service users presented at traditional birth homes were numerous. The majority had come to seek cure for STIs, pregnancy-related morbidity, and barrenness/infertility. One of the women in this category remarked that:
I came here because I have problem getting pregnant. My difficulties in conceiving started after my second baby. But I am optimistic that I would not leave here the same. The woman has been helping other women with similar problems.

Child delivery and infant circumcision/opening of the earlobes of female infants and facial marking were also frequently mentioned purposes for visiting the traditional birth homes. Other health conditions included abortion, management of vaginal bleeding, inadequate breast-milk production infant morbidity, menstrual disorders, and miscarriage. We were told by one of the younger participants:

I am here because I am pregnant … my friend who directed me to Mama (the traditional birth assistant) said she can give me ogwu (medicine) that will terminate the pregnancy … Well she’s done it for other people.

The least mentioned conditions for which participants were visiting traditional birth homes were painful sex (0.7%), vaginal itching/discharge (1.4%), and traditional family planning (1.4%). One young respondent commented:

I have boyfriends and I don’t want to get pregnant. I am here to take medicine that will prevent me from getting pregnant … The medicine is in form of beads. It is worn around the waist. This woman (referring to the Traditional Birth Assistant has done it for some people and it is working.

The traditional birth assistants reported that the affordability of their services, their proven ability to manage health conditions, past successes in their profession, and their proximity to local people were the major attractions to their homes. They noted that their charges for most conditions were very low. The average fee charged for normal child delivery by traditional birth assistants stood at 1000 Nigerian naira (about US$ 10), whereas hospitals and clinics in nearby towns charge up to 4000 Nigerian naira (about US$ 40) for the same service. Traditional birth assistants also felt that their successes in dealing with health conditions in the past also endeared them to the local people. This way, trust had been built in their abilities and services.

Secrecy and privacy was the most frequently mentioned reason for the uptake of services provided by traditional birth homes. Traditional birth assistants were felt to guarantee a level of confidentiality unlikely to be

<table>
<thead>
<tr>
<th>Reasons</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need secrecy/privacy</td>
<td>64</td>
<td>43.5</td>
</tr>
<tr>
<td>Condition has an unnatural cause</td>
<td>09</td>
<td>6.1</td>
</tr>
<tr>
<td>Doctors will meddle with ones body in hospital</td>
<td>18</td>
<td>13.9</td>
</tr>
<tr>
<td>Low charges</td>
<td>32</td>
<td>21.7</td>
</tr>
<tr>
<td>Proven/past case of TBHs ability to manage similar conditions</td>
<td>11</td>
<td>7.5</td>
</tr>
<tr>
<td>Need for quick and courteous attention</td>
<td>08</td>
<td>5.4</td>
</tr>
<tr>
<td>Recovery and perceived cure</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Western medicine failed to cure condition</td>
<td>15</td>
<td>10.2</td>
</tr>
<tr>
<td>Desire to be treated by experienced person</td>
<td>08</td>
<td>5.4</td>
</tr>
<tr>
<td>Proximity</td>
<td>04</td>
<td>2.7</td>
</tr>
</tbody>
</table>
encountered in hospitals. One young girl presenting for STI noted, ‘In hospital, everybody—nurses, doctors, sweepers, and even patients—before a long time knows what you are seeking treatment for’. Another major reason for the use of traditional birth homes related to finance. Twenty-one per cent of service users reported that affordability of the services of traditional birth homes was a key consideration. Hospital-based treatments were often expensive and out of their reach.

A number of service users reported that they patronized traditional birth homes because Western cures had failed to improve their conditions. Yet other reasons for the uptake of the services of traditional birth homes included not wanting doctors/nurses in hospitals to meddle with one’s body, perceived unnatural cause of condition, proximity, and desire for quick and courteous attention.

Service users generally perceived little or no risk in utilizing the services of traditional birth homes. Most felt that traditional birth homes were no more risky than other settings where health services are provided. They saw traditional birth homes as existing to satisfy peoples’ health needs, observing that even in well-equipped hospitals people die daily.

**Discussion**

Overall, two typical users of the traditional birth homes emerged in the course of this study: first, the married woman in her late thirties or early forties, with little or no formal education. Most likely to be a housewife who also does petty trading and farming, she perceives few risks in seeking cures in informal settings. Her health-seeking behaviour is dictated almost certainly by the low charges, her need for secrecy, her belief in traditional birth assistants’ ability, and the perceived failure of Western therapy to successfully manage her conditions.

Thaddeus and Maine (1990) have suggested that the primary factors which inhibit local peoples’ access to quality health are poverty and lack of proper health education. Poverty can be a significant barrier to the decision to seek proper medical care especially where the cost of hospital uptake is substantial. Financial barriers often prevent local people from being able to arrange transportation. In rural areas in Nigeria, vehicles are scarce and in poor condition. The cost of arranging emergency transportation can therefore be daunting (Essien *et al.* 1997, McIntyre and Hotchkiss 1999). The opportunity cost, or loss of productive hours of the person accompanying the sick person to the hospital can also be a disincentive. Additionally, patients may be required to pay repeated visits to far away health facilities to keep appointments with health providers. Ignorance on the other hand, arises from lack of proper education and often deters the utilization of life-saving services (PRB 1994). Many people who lack adequate formal education become superstitious regarding where and how to seek cure for their conditions, especially reproductive health conditions (Ibanga 1992).

The second typical user which emerges from the research is the young, uninformed, but sexually active girl. Most probably a maid or primary or
secondary school student, her condition is likely to be STI-related, an
unwanted pregnancy, or she may desire traditional family planning. She
too is also likely to be economically insecure. She is likely to come to the
traditional birth home on the advice of peers, and she too needs secrecy.

Cornwall and Welbourn (2000) report that young people in many sub-
Saharan countries lack access to adequate sexual health information. Talking
openly about sex, desires, and reproduction in these places is taboo. This
creates a culture of secrecy around sexual and reproductive health matters.
One result of this is lack of awareness and the low use of contraceptives and
safer sex skills. Young people in rural areas also face cultural and economic
barriers to accessing quality healthcare facilities (Oladepo and Brieger 2000,
Green et al. 2000). One recent national study noted that young rural people
in Nigeria with STIs preferred to use informal health services because the
high cost of hospital treatments, as well as fears of being branded irresponsible
at clinics (CEDPA/UNFPA 1997).

Most young people in Nigeria also rely largely on their parents for their
upkeep. Obtaining enough money for proper healthcare often proves
difficult. Owing to socio-cultural factors, most rural parents are also often
reluctant to believe or accept that their children are having sex, let alone
discuss health matters with them (Esiet 1996). In another study, youth in
rural Nigeria reported that when they presented at clinics for treatment or
to obtain contraceptives they were discouraged by nurses who felt they
were too young to be presenting for reproductive healthcare services, or to
be asking for contraceptives for themselves (Williams et al. 1998). Local
cultural attitudes toward sexuality limit space for information, education,
and communication about reproductive health matters among rural peoples
in Nigeria, fostering vulnerability to infection and even fatalities.

Major attractions of traditional birth homes revolve around service
characteristics: affordability, accessibility, and reliability of services. There
is often little rationality in seeking healthcare in settings that are not
responsive to one’s economic needs and cultural sensitivities (PRB 1994).
There is little evidence that modern healthcare services in Nigeria are
planned to recognize and respect the cultural and economic needs and
sensitivities of local peoples (Esiet 1996, Ibanga 1994). A mismatch between
the values, needs and sensitivities of health seekers and health providers is
therefore often a barrier to their uptake (Mitchell 1999). Such a mismatch
can occur due to social distance between poor local health seekers and
health care professionals who are mainly middle class men and women.
Cumbersome and inflexible procedures, formidable amounts of paper work,
and the literacy requirements of hospitals also dissuade local people
(Ibanga 1994).

While a substantial number of service users presenting at traditional
birth homes did so for pregnancy, parturition and peuperium-related con-
ditions, a much greater number had come to seek cures or advice for
infertility, STIs, barrenness, to circumcise their infants and/or to obtain
abortion. The long list of conditions for which traditional birth homes
were consulted offers some scope for appreciating the weight, extent, and
burden of unmet reproductive and other health needs among rural people.
Both Westoff and Bankole (1995) and Robey et al. (1996) have argued that
rural people, especially women and girls, have unmet needs for good quality abortion, family planning, and contraceptive services as well as skilled obstetric and reproductive healthcare. Experts estimate that between 10–20 million Nigerian women, a majority of them in rural areas, have various forms of unmet needs for reproductive, obstetric, and/or gynaecological health care. The picture from this study is one of poor women and girls struggling to address these unmet needs using available but unsafe sources. Too often, their attempts translate into complications, fatalities and further infections (Robey et al. 1996).

The findings of the present study suggest that local women and girls are aware of the need for good reproductive health. They seem able to recognize illness signs and seek cures from providers viewed as capable of managing their conditions. Local peoples’ ability to recognize signs and symptoms of illness conditions is a useful resource to be harnessed for the effective integration of grassroot populations into current health-schemes and in efforts to foster positive health orientation. In taking these myriads of health conditions to traditional birth assistants, clients clearly point to the fact that the latter form a critical group that may be useful in local maternal and infant health surveillance and intervention. Traditional birth assistants therefore need to be more fully integrated into mainstream health interventions. This could be achieved by training them to be able to recognize danger signs among their clients and to readily direct them on time, to where skilled and responsive care could be received. This way, they could help to promote early and effective diagnosis, treatment, and monitoring of rural reproductive health problem.

With a health-conscious local population, a crew of traditional birth assistants that are trusted and patronized for a variety of health conditions, and health facilities that are increasingly being strengthened to meet the economic needs and cultural sensitivities of rural people the scene may well be set for a new regime of improved rural maternal and infant healthcare delivery. However, political will is needed to ensure the sustainable and proper blending together of these components, their delivery in culturally-acceptable doses, and the development of frameworks for delivery that meet constantly evolving needs.

Acknowledgement

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References


En analysant les données provenant d’entretiens avec des accouchées traditionnelles et avec leurs clientes, menés dans des zones rurales du Nigeria, cet article examine les caractéristiques et les problèmes de santé des personnes ayant recours aux maternités traditionnelles. Les clientes des maternités traditionnelles comprennent principalement des femmes ayant été peu scolarisées, voire pas du tout, et ayant des activités à revenus faibles ou inexistants. Ces personnes se présentent dans les maternités traditionnelles pour les accouchements, les avortements, le planning familial, les MST, la stérilité, et une multitude d’autres problèmes relevant de la santé de la reproduction. Les facteurs économiques et culturels jouent un rôle prépondérant dans la décision de recours à ces services. Les résultats soulignent le rôle très influent de la pauvreté et de la culture dans l’accès à une santé de la reproduction de bonne qualité, la charge que représentent les besoins non satisfaits en matière de santé néonatale de qualité et de santé de la reproduction, et le rôle sanitaire très important que jouent les maternités traditionnelles du Nigeria rural. L’accès des personnes vivant en milieu rural à des soins de qualité pourrait être amélioré par une intégration des maternités traditionnelles aux services de soins dominants et en augmentant les réponses des services de soins formels aux besoins socio-économiques et culturels de ces personnes et de leurs communautés.
Resumen

En este documento estudiamos cuáles son las características y el estado de las personas que utilizan los servicios de los centros tradicionales de maternidad mediante el análisis de datos recogidos en entrevistas realizadas a asistentes de partos tradicionales y sus clientes en una zona rural de Nigeria. Los usuarios de estos centros tradicionales suelen ser mujeres con poco o nulo nivel de estudios que reciben sueldos muy bajos o ninguno. Los servicios que ofrecen estos centros son partos, abortos, planificación familiar, enfermedades de transmisión sexual, infertilidad y muchos otros problemas relacionados con la salud reproductora. El uso de estos servicios está directamente relacionado con factores económicos y sociales. Los resultados ponen de relieve el papel tan importante que desempeñan la pobreza y la cultura cuando se trata de recibir una atención sanitaria adecuada en la salud reproductora, el peso de las necesidades insatisfechas para una atención sanitaria neonatal de calidad y servicios de salud en materia de procreación entre mujeres rurales, y el papel decisivo de la salud en los centros tradicionales de maternidad en zonas rurales de Nigeria. Se podría mejorar el acceso a un buen servicio sanitario si se integrasen los centros tradicionales de maternidad en la atención sanitaria general y si las instalaciones sanitarias convencionales estuvieran disponibles a nivel local en función de las necesidades culturales y socioeconómicas de la comunidad.