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African Journal of Reproductive Health, ISSN: 1118-4841
Women's Health and Action Research Centre

African Journal of Reproductive Health, Vol. 5, No. 1, August, 2001 pp. 75-82

Traditional Belief Systems and Maternal Mortality in a Semi-Urban Community in Southern Nigeria

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Code Number: rh01009

ABSTRACT

Many factors are implicated in the poor maternal health condition in sub-Saharan Africa. Among the more popular focus are weak political and financial commitment, deteriorating institutional infrastructure, rapid population growth rates, pervasive poverty, and gender inequalities. Because of these and other related problems, pregnant women often face dangers, especially in emergencies. In a study conducted in Ekpoma, a semi-urban community in Edo State of southern Nigeria, it became evident that traditional beliefs and practices contribute immensely to the poor health status of pregnant women. These beliefs and practices are outlined in this study and possible ways out of the identified problems suggested. There is the need for a thorough investigation of extra medical factors in the design of any medical intervention program. A broader definition of maternal health, in line with the proposals of the global Safe Motherhood Initiative, is advocated. (*Afr Reprod Health* 2001; 5 [1]:75 - 82)

KEY WORDS: Ekpoma, Nigeria, traditional beliefs, safe motherhood, haemorrhage, Benin City

Introduction

In their examination of sub-Saharan Africa, Shaw and Elmendorf¹ observed that an enabling environment for better health status in the area is not only impeded by events like civil conflicts, natural disasters and economic recession, but also by more fundamental problems like insufficient political and fiscal commitment to the health sector, poor institutional and infrastructural frameworks, rapid population growth and pervasive poverty occasioned by poor economic performance.

For women, the picture is despairing indeed. Africa has more than a fair share of maternal deaths. While only 11 per cent of women live in Africa, an estimated 30 per cent of maternal deaths take place in the continent 173 per cent more than would be expected from a population alone.² In Africa, the lifetime risk of a woman dying from pregnancy-related causes stands at one in 21. For Asia, it is one in 54; South America, one in 73. In North America, it is one in 6,366; while in North-ern Europe, it is one in 9,850.³ The distressing environment that does not enhance improved maternal health makes it difficult to prevent the well known immediate causes of maternal death, which include haemorrhage, toxæmia, infections, obstructed labour; and unsafe abortions.

This study was designed to examine the possibility of reducing the high maternal mortality caused especially by haemorrhage. Obstetric haemorrhage is responsible for an estimated 28 per cent of maternal deaths that occur in developing countries.⁴ Three categories of problems that may lead to maternal deaths have been recognised and are anticipated by researchers in that field. These are:

- problems arising from the community and individuals;
- situations and occurrences in the modern health institutions; and
- the links between the individual/community and the health institutions.

Even though the overall study covered the three areas, this paper highlights issues related to the first problem area - the individual and his community. It is aimed at discussing the role of local traditional beliefs in the poor health status of pregnant women in the locality, as elucidated in the process of the study.

The Study Area

Ekpoma is a semi-urban community of about 70,000 people, situated about 84Km north of Benin City, the Edo State capital, and inhabited by the *Esan*. It is served by four

government owned health centres, a general hospital and a (new) specialist hospital in a neighbouring village (Irrua), about 10Km to the north of the town. There are also eleven privately owned hospitals/clinics of about the same operational standard as the general hospital. The main (tertiary) referral centres are the teaching hospital in Benin City, a specialist hospital at Ubiaja, about 60Km north east of Ekpoma, and the new specialist hospital at Irrua.

A dual socio-political structure exists: a traditional ruler, the *Onogie* (with his palace chiefs) presides over the traditional government, while there is also the local government council. The traditional institution is very strong and it commands greater respect from the people, hence greater authority. Ekpoma is made up of thirteen semi autonomous clans, each with a clan head (*odionwere*) who derives his authority from the traditional ruler (the *onogie*).

Being semi-urban in status, a great majority of the people are subsistence farmers, with average per capita income that is less than the national approved minimum wage. However, being a university town, it is gradually being urbanised (within the limits of the present economic recession). The literacy rate is also increasing as the number of migrant university workers increases. Also, a few business outfits usually associated with a university community are springing up, namely, computer/secretarial centres, photocopying outfits, supermarkets, bookshops, private nursery and primary schools, etc. Social amenities like pipe borne water, electricity and access roads are inadequate where they exist, and non-existent in some areas. The poor network of roads hinders transportation, even when there are not enough private vehicles (the only form of public transportation) in the locality. Commercial activities and transportation to hospitals when the need arises are, therefore, very difficult. The town centre (Eguare clan) is more developed than the other clans, probably because it is along a major road leading to the northern part of the country (business activities in Nigeria seem to concentrate along the highways), and because the first phase of the university campus was set up there.

Majority of the people are Christians (Catholics), a few practice traditional religion, and there are also few Muslims. Some of the practicing Christians also embrace traditional (not necessarily pagan) practices.

Inheritance is strictly by primogeniture, where only the first son inherits his father's property in the absence of a written will. He is expected, however; to use the proceeds from such property for the upkeep of his younger siblings. Because polygamy is widely practiced, there is bound to be a lot of rivalry, if not open rancour, envy and jealousy among the wives and children. The male children are guarded jealously, as the welfare of the mothers at old age would depend largely on the economic powers of their children. Traditional practices, however, do exist to check such envy and jealousy. Oath taking before shrines is a common occurrence.

Methodology

This study was a multi-disciplinary operations research project with the following principal objectives:

1. To establish the factors responsible for the high maternal mortality in the study area.
2. To mount intervention measures to tackle the problems.
3. To monitor and evaluate these interventions with the ultimate aim of achieving our overall objective of reducing maternal mortality rate in the locality.

Four major data gathering techniques were adopted for the study: focus group discussions (FGDs), interviews, observation of events in both the hospital and the community, and examination of hospital records. The methodological aspects that relate to this paper are highlighted in this article.

A total of seventeen focus group sessions (one in each of the thirteen clans that make up Ekpoma, with women; two with men selected randomly across Ekpoma; and one each with traditional birth attendants and the general hospital staff [see appendix]) were conducted between November 1989 and October 1991. Elders and opinion leaders in each clan helped in recruiting participants. The men, of course, granted permission for their wives to participate. The women fell within the childbearing age group of 15 - 45 years.

Contrary to what classical FGD guidelines demand⁵, participants in each group were (because they came from the same village) familiar with one another. The sites for the discussions (usually classrooms) were also familiar to the participants. These modifications of classical focus group guidelines were necessary because the cultural context is such that individuals in Ekpoma are more willing to share their views and experiences with familiar members of the society. The same situation has been found to exist in another African country.⁶

Experienced facilitators who had been properly briefed about the purpose of the study were used in the FGDs, which were conducted in the local language. A female sociologist and a retired school-teacher acted as facilitators for both the female and male groups respectively.

In the focus groups, we took 'educated' to mean having attended any level of formal education. Expectedly, majority of the people fell within the primary and secondary school bracket. Although there are a few graduates that live in the town, most of them, especially those that work in the university, are not indigenes; therefore, they were not included in the study. We also took 'working outside home' to mean any form of job that

has been introduced into the town as a result of urbanisation, such as working in the university or the local government secretariat, selling in the supermarkets as opposed to the regular market, working in the motor parks, tailoring, barbing and so on.

The discussions were recorded on audio tapes and later transcribed and translated into English before being analysed. There were also note takers in each of the sessions whose notes were compared with the transcriptions and translations of the audio tapes. Interviews, on the other hand, were conducted with TBAs, members of the village development committees, elders and opinion leaders, and some women who were not part of the FGDs. These interviews provided respondents opportunity to air community and personal views, and their evaluation of the former. Since we had no access to the computer software, *Ethnograph* or *Anthropac*, we had to depend on manual analysis of the qualitative data.

The same themes discussed in the FGDs were also covered in the interviews. They were as widely as possible chosen in order to cover as much grounds as possible, and these included:

- *Local ideas of the signs of haemorrhage:* It was necessary to find out how much the community members knew about bleeding in pregnancy. This became necessary because existing knowledge of most people's attitudes in this regard point to the fact that most people think that a little bleeding during pregnancy is 'normal'. The few people who do not share that view have problems deciding what level of bleeding is dangerous. Existing knowledge also points to the fact that most traditionalists believe that bleeding in pregnancy is a sign of the pregnant woman having gone against the 'established' laws (traditional) governing the conduct of women in the society.
- *The possible periods a woman may bleed:* This theme was introduced because most members of the community believe that pregnant women can only bleed at certain stages of their pregnancy.
- *Perceived causes of bleeding:* It is common knowledge that most traditionalists believe that bleeding by pregnant women is caused by witchcraft (most often, accusing fingers are pointed at the husband's other wives, especially those who are not as favoured by the husband, or those who have not been 'lucky' to bear male children). Infidelity on the part of the woman and violation of cultural taboos are other factors usually associated with bleeding in pregnancy. It is very common to hear:

Your grandmother bore eleven children, your mother had you and twelve other children, none of them had any problems with either conception or childbirth. How come you have brought us all these problems?

This obviously suggests a general belief that most of a woman's obstetric problems result from her having gone against the traditions of the land.

- *Dangers and possible sequel of bleeding and ways of preventing haemorrhage:*
This theme was included because of the erroneous and dangerous belief that 'a little bleeding' is not dangerous (they even go further to induce bleeding after delivery to 'cleanse the womb'), and that abiding by existing norms of the society will prevent bleeding in pregnancy, or any dangerous sequel.
- *Available forms of treatment for haemorrhage:* We were obviously worried about the belief that bleeding in pregnancy, caused by disobedience to the 'laws of the land', can only be stopped by 'traditional' means; a belief shared by a great proportion of communities in this part of the world. In a study by Adetunji⁶ in a Yoruba community in Nigeria, he pointed out that in the choice of a caregiver in pregnancy, since the enemies at stake might use supernatural powers, the caregiver's qualification would include ability to protect the mother and the fetus from both natural and supernatural enemies. Therefore, preference tended to be given to a caregiver who was both a herbalist and a diviner. We also wanted to verify this view, which is popularly held throughout Nigeria.
- *Patterns of use and accessibility of various types of treatment for haemorrhage:*
We were worried by the belief that modern obstetric care centres have little or no role to play in dealing with (certain) bleeding in pregnancy. For the more remote areas in the community, the modern obstetric care centres were considered 'inaccessible' and wasteful apart from being in most circumstances, irrelevant to their problems. The difficulties encountered in the area of transportation is even a further deterrent, for which one of our intervention measures was the setting up of a transport loan fund to assist pregnant women with problems of transporting themselves to the hospital. The global economic recession that had resulted in a lot of infrastructural decay, especially in government-owned health facilities and low morale, occasioned by neglect, on the part of the staff, have all tended to portray these government-owned institutions in bad light. A woman was once heard making the following comment:

Is it not more honourable to die peacefully at home than to borrow money and travel to the 'government hospital' only for the doctors to watch you die?

Results

Some of the results from the PMM team in Benin City have been documented elsewhere.^{8,9,10} Some revelations from both the FGDs and the interviews that touch on traditional beliefs and practices are highlighted in this paper.

Even though most of the findings, especially the food taboos, are aimed at protecting the

babies, we strongly felt that these should not be ignored, as any harm to the babies would also affect the women psychologically, or even physically by their husbands and husbands' relations. Child or infant deaths, especially if they are males, are very serious issues in this part of the world; in fact, "the essence of marriage is to have children, the more male children, the better". This, indeed, is an adage in most cultural settings in Nigeria; hence the existence of numerous taboos in most parts aimed at protecting the babies. For example, Maclean^{11,12} reported in a study of Ibadan and Idere, not very far from the present study site, that pregnant women were warned not to eat large plantains with clefts so as not to have babies with rigid skulls. In a nearby university town of Ile-Ife, many traditional healers discourage pregnant women from eating snails, snakes or okro soup, as these would 'harm the ba-bies'.⁶

A study in India by Khanna¹³ revealed that son preference contributes to an increase in the use of amniocentesis and ultrasonography followed by sex-selective abortion to avoid the birth of a daughter, a thing that would be unthinkable in the Western world, and which would obviously lead to long debates and legal tussles if ever it happened. This Indian study clearly demonstrates the reason for marriages - to have male children. In Nigeria, the situation is not very different, and in most communities, amniocentesis is not immediately available. Therefore, a woman who desperately desires male children and who is not lucky enough, may go on having many babies in order to have the desired number of male children. This (multiparity) obviously has its problems in terms of maternal health; it is one of the factors considered in assessing how risky a pregnancy might be.

Food Taboos

A pregnant woman should not eat kola-nuts, so there would be no swelling around the baby's mouth, and the baby would also not have scaly skin.

A pregnant woman should not eat snails, so the baby would not salivate excessively, become dull, or have a slow development of speech.

A pregnant woman should not eat puff adder meat (a delicacy in the locality), so the baby would not be dull, sleep excessively and walk (take his/her first steps) very late.

A pregnant woman should not eat 'sweet foods' like milk, so the baby may not be weak, and steal later in life.

A pregnant woman should not eat eggs, so the baby may not grow up to be a thief.

Forbidden Practices

A pregnant woman should not eat, bending, so that neither she nor her baby would develop severe hiccups.

A pregnant woman should not steal, so her baby does not become a thief.

A pregnant woman should not be rude to her husband or other elders, so she does not bleed during the pregnancy.

A pregnant woman should not have sex in the bush (love-making in the farm is not a very common practice, except in adulterous circumstances), so she and the baby may not die, she, from bleeding and the baby spontaneously.

A pregnant woman should not use the same bath bucket as the husband, so she does not suffer severe haemorrhage that could result to stillbirth.

Everybody in the audience (focus groups) totally agreed with these traditional food taboos and forbidden practices even though in most cases, the older, or the more vocal members of each group reeled out the taboos while the others would chorus their agreement. They were so unanimous in their agreement that if we had not personally initiated and supervised the focus group sessions, we would have thought that it was a well-rehearsed plot. The older members even supported their cases with life examples. An octogenarian woman told a story of why, in their village, they are not always very happy when a young man takes an extremely beautiful woman as a wife. She told the story of a young man who married a very beautiful woman in their village some time in the past and each time the woman got pregnant, the fetus would abort. In fact, at the fourth pregnancy, the woman nearly died from bleeding. She managed to survive only after she had "confessed to having affairs with other young men in the village. Even up to the present day, each time a young man picks a very pretty girl for a wife, the elders would pray that she should not be like lady "A" (not real name).

Of course, since such stories are not documented but only passed down from generation to generation, verification is difficult.

Antidotes

Any pregnant woman who incidentally partakes of the forbidden foods, or engages in a forbidden act may escape dire consequences if she confesses and certain cleansing rites are carried out, usually by diviners. Interestingly, there are no specific antidotes for each specific contravention. Confession is a very important aspect of cleansing. For example, if a pregnant woman is bleeding, and the bleeding is 'established' by the traditional healers, to be due to an act of 'sacrilege' on the part of the woman, cleansing rites are not started until the woman has confessed. In fact, before now, the woman would not be taken to an

orthodox obstetric facility until it becomes apparent that there may be other problems apart from her acts of 'sacrilege'. By that time, it would have been too late for the doctors in hospitals to do much for her.

The 'guilty' woman, to maintain her own health, have a successful natality and hope to have a normal baby, should cook her food with tiger meat and/or bones. In addition, she is expected to roast and then crush some quantity of tiger bones, add some oils, and lick the paste at intervals up to three months after delivery. This special paste is also expected to prevent convulsions in the new-born baby

Another antidote for these 'guilty' women is the wearing of special amulets, which can also be pinned at strategic locations in the house. It was not possible to find out the ingredients used for these preparations, but the bark of a rare but special tree (ede) is involved.

It is pertinent to note that among the traditional healers and diviners, guarding their trade secrets jealously is the order of the day. There are no schools where these skills can be acquired; they are not even documented anywhere; the skills are only handed down from generation to generation and, therefore, run in families.

In these traditional matters, gullibility is not a function of education or the educational levels of individuals involved. In the northern part of Edo State of Nigeria (Etsako), a few kilometres from where this study was carried out, during the initiation of young girls into adulthood, in preparation for marriage, teenage girls, even those in their final grades in the secondary schools, are required by custom to bare their entire bodies for all to see (they are required by custom to remain virgins until they are espoused, and it is claimed that experienced elders can easily tell a young woman who is not a virgin on merely seeing her nude). They then all march down to the shrine by their local brook, where traditional rites are performed on them, all bathed in brooklime. Of course, everybody, including the young men (their potential husbands), line the streets and cheer as these teenage girls march to and from the brook. No 'self-respecting' parent in the villages would debar his/her teenage daughters from taking part in these rituals, and they are not all illiterates.

This does not, of course, suggest that 100% of the people would always tow the line of these traditional practices. A few would always object, even if not publicly. But the more aloof one is from the traditional practices, the less relevant he/she will be in the system, as village and clan heads are more likely to be appointed from among people who believe strongly in and practice these traditional rites.

Another reason why people would not come out openly to challenge the system is the fear of traditional sanctions. A lecturer in the university who comes from that town once argued vehemently against the traditional institution, when one of his uncles called him

aside and said to him in pidgin English: *"na on!y you one dey, wey know se some of de tings no good, no come bring wahala for us?"* Which, translated into proper English, means: *"are you the one in this town who knows that some of these things (traditional practices) are not good, please do not invite trouble into this family?"*

Discussion

The findings confirm the initial assertion in the study design that endorses the essence of a broader definition of maternal mortality as recommended in the Safe Motherhood Initiative. This is the view that socio-cultural and other extra-medical and extra-hospital factors are important in the determination of maternal health, morbidity and mortality

If the traditional beliefs and practices identified in this study were restricted to old and illiterate people, they would probably have been less significant. However, in all the focus group sessions, all categories - sex, age, marital status, educational attainment and occupational exposure - had certain ideas to be the same. This may be out of fear of the 'powerful' traditional sanctions, even though they may hold contrary views. It is known that the more educated members of the community, as long as they reside in that community, are likely to abide by all its traditional norms. In fact, in some parts of Nigeria (Ibo speaking areas specifically), where the *osu* caste (outcast) system is still recognised, most educated members of the community would often argue that it is a primitive and an ancient custom that should be abandoned completely, but none of them would set examples by allowing their children to marry from the *osu* homes. It clearly shows how strong a hold our traditional values have on the people, irrespective of their educational attainment or exposures. Adetunji⁶ also reported this pattern of behaviour, among the educated, in his study among a Yoruba community in Nigeria. We surely need more generations to come for full changes to begin to occur in practice. Some beliefs may not even be as arbitrary as a foreigner may hurriedly believe. Some restrictions may be borne out of the society's effort to enforce public morality. The injunctions against stealing disobedience to husband, or adultery cannot be faulted by anybody only that it should cut across board, not just pregnant women.

Ours (Africa) is still a man's world, and it would take some time for radical changes to begin to take place. These laws are enacted by men and enforced by them. The stringent conditions attached, as part of the cleansing rites, like the provision of tiger meat or bones (tigers are not common in the locality), should confirm the intention of the 'law-makers' - deterrence.

The scientific mind could even probably explain some prohibitions. Kolanuts have stimulating effects that may not be good for a pregnant woman. Some 'sweet foods' (not milk though) may not be totally healthy for some pregnant women. 'Disobedience to husbands' and elders should be frowned at by all, at least in the light of our cultural setting.

As for the food taboos, there are, luckily other equally good sources of protein, which may even be cheaper, that the pregnant woman may opt for.

The significance of these beliefs and practices, as far as this study is concerned, is that they tend to delay the decision by pregnant women to seek help in modern obstetric care institutions when complications occur, especially when it is believed that only diviners or spiritualists can solve their problems. Indeed, that is the crux of the matter, as most of these beliefs and practices, potentially, may not harm pregnant women.

The approach aimed at effecting changes in the community should be subtle. It is not the duty of a (social) scientist to condemn traditional beliefs and practices, no matter how anachronistic these may appear. Rather, the short-term approach should be to provide more health information and education to the people and health care providers, with the aim of producing attitudinal and, therefore, behavioural changes in practice before the long-term effects of widespread formal education take over. Even though some educated members of the community, at present, tend to think like the traditionalists, there is no doubt that with increased formal education, and the passing away of the older generation with their unbending traditional beliefs, the bad traditional practices will also come to pass. It is my strong belief that as formal education spreads, and mass illiteracy disappears, adherence to most of these traditional practices will reduce and eventually cease altogether. It is generally believed that formal education can make us less dependent on the more dangerous aspects of our culture, but unfortunately does not make us abandon the culture altogether and immediately.

In the intervention phase of this operations research, in addition to attempting to effect attitudinal and behavioural changes in the community, efforts are also being made to strengthen the health facilities and improve access to them, in the belief that it is not enough to try to change the attitudes and practices of the people without corresponding improvements in these facilities. The importance of formal education on these issues cannot be over-emphasised. It may not produce changes immediately, but experience from advanced countries shows that this may be the fastest way to attitudinal change. As an interim measure, we have also put in place a transport loan fund with minimal interest from which pregnant women with problems could obtain relief, to transport themselves to the health facilities.

Conclusion

The position, regarding the role of traditional practices in the modern day is quite dynamic. Where beliefs are not harmful, they should be ignored. Where they are, alternate lines of action should be subtly introduced, advocated and encouraged, while anachronistic practices should be tactically discouraged. This is the only way to achieve the desired goals.

Tradition and modernity are not mutually exclusive,¹⁴ but agents of change should act with caution and a lot of tact.

Acknowledgements

The authors are grateful to the Carnegie Corporation of New York for financial support, and the Prevention of Maternal Mortality Program of the Centre for Population and Family Health, School of Public Health, Columbia University New York, for technical assistance.

Appendix 1

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Appendix

Characteristics and Number of Participants in the FGDs

Women's Groups

Village	Characteristics of Participant*	Number
Iruekpen	Age 15–25, educated and working	10
Ujemen	Age 15–25, educated and not working	9
Idumebo	Age 15–25, not educated, working	9
Uke	Age 15–25, not educated & not working	10
Ihumudumu	Age 26–35, educated & working	7
Ujoelen	Age 26–35, educated & not working	7
Ukpenu	Age 26–35, not educated & not working	13
Illeh	Age 26–35, not educated & not working	13
Uhiele	Age 36+, educated & working	13
Emuhi	Age 36+, educated & not working	9
Egoro	Age 36+, not educated & not working	11
Eguare	Age 36+, not educated & not working	9
Emaudo	Grandmothers, not educated & not working	8

Men's Groups (not organised on village basis)

Group 1	Age 20–40, educated & not educated	10
Group 2	Age 50+, educated and not educated	12

TBAs

Age 35–70 (all women and thirteen in number)

Mean age 46.1 years, none had formal education.

Health Workers Group

No. = 13, all educated and working (two medical doctors, five nurse/midwives and six orderlies). This group provided an insight into the managerial problems in the hospitals. Their views are not relevant to this paper.

** Educated means participant completed at least primary education.*

Working means working outside the home for a regular income.