Standard Research Journal of Medicine and Medical Sciences Vol 2(1): 044-056, July 2014
http://www.standresjournals.org/journals/SRJMMS

Research Article

Pregnancy Care and Maternal Mortality in Ilesa, Osun State, Nigeria

***[1]Owoseni Joseph Sina, [2]Jegede Lucy Iyabo and [2]Ibikunle Ayodele M**

[1]College of Medicine and Health Sciences (Medical Sociology), Afe Babalola University, Ado-Ekiti, Nigeria
[2]Department of Sociology, Ekiti state University, Ado – Ekiti, Nigeria

*Corresponding Author E-Mail: owoshynah@yahoo.com, Tel; +2348066504953, +2348039140118, +2348037280943

Accepted 20 July 2014

Abstract

Maternal mortality is high in Nigeria as one woman dies every 30 minutes. A nation devoid of sickly population is a potentially prosperous one. Maternal health is a basic indicator of national health and well-being. These deaths and morbidity can be reduced if pregnant women seek and receive adequate care. This study examined maternal health care in Ilesa, Osun State. Health Belief Model (HBM) provided the basis for conceptual frame work for this study. Both qualitative and quantitative methods were employed to generate primary data. Survey method was employed for quantitative data. Simple random sampling was utilized to select 11 out of 21 wards in Ilesa and fifty women were interviewed in each selected ward. Five hundred and fifty copies of questionnaire were administered to pregnant women in form of personal interviews and 91.3% of them were found useful. The findings indicated that women attend antenatal clinic (ANC) but preferred to deliver in mission houses. The combination of socio and demographic factors have positive correlation with decision making in pregnancy (R = 0.548. Qualitative data revealed that pregnant women were found to attend hospitals for ANC and immunization but deliver in faith homes. Soap, sponges, anointing oil, bathing in flowing rivers and mountain tops are spiritual rituals that are common in faith homes. Consequently, holistic approach to health should be employed in care of pregnant women. Husbands, Faith Birth Attendants (FBAs), hospitals and pregnant women should be targeted. FBAs should be trained to reduce maternal mortality and spread of HIV.

Keywords: Pregnant Women, Care Givers, Husbands, Maternal Mortality, Morbidity

INTRODUCTION

More than half a million women die every year due to pregnancy complications. Ninety nine percent of these occur in Africa and South Asia alone (Freedman and Maine, 1993). This figure does not include rural women who, for various reasons, do not go to hospitals. Maternal and infants' health are basic indicators of development but unfortunately both are high in Nigeria (Akinlembola and Oguntimehin, 2006; Nigeria Demographic and Health Survey, 2004). Nigeria's scenarios are among one of the worst among developing countries.

A pregnant woman desires good life and health for herself and her baby and so she will seek means to make herself and her baby healthy. It is obvious that good care during pregnancy is positively related to child's health. Maternal health is an action an individual takes to remain healthy and when she falls sick, it is the action she takes to regain her health (Mechanic, 2012). Maternal health of a pregnant woman will include all the actions the pregnant woman, significant others, and health care providers take to make or mar her pregnancy from conception to six weeks after delivery. These actions may include request for confirmation of pregnancy, ante natal treatment, immunization at the right time and

complying with routine drugs, exercise, rest, and diet prescriptions. These actions include her decision to seek western health Care Providers or Faith Birth Attendants (FBA).

Statement of the Problem

Reproductive health problems account for more than one third of the burden of diseases in women (Mbizvo, 1996). Ebhuomhan (2008) and Dada (2008) reported that in Nigeria an estimated 54,000 maternal mortality (MM) occur per annum. That translates to a woman dying every 30 minutes in Nigeria, and for every death, there are about twenty others who suffer from diseases, disabilities, or physical damages that impede their health for life (Dada, 2008). How can a nation in pursuit of national development afford such perennial wastage? It means that yearly there are 54,000 cases of widowers, motherless babies, bereaved parents and relations. Every year Nigeria records 1.5 million women in agony of maternal morbidity (Dada, 2008; Population Reference Bureau, 2005; World Health Development Report, 1995; Ransome – Kuti, 2010 and Kanu, 2010).

Maternal mortality in Nigeria ranges from 640 - 800 per 100,000 live births (Awosiyan, 2013; Akinlembola and Oguntimehin 2006; WHO, 2004). An African woman's lifetime risk of dying from pregnancy complications is about 1:16 while the risk in industrialized world ranges from 1:4000 to 1:10,000 (Population Reference Bureau, 2005; Roth and Mbizo, 2001; Kessel and Awari, 1987). Among Nigerian women of reproductive age, 1:18 dies due to pregnancy related complications; while in Bosnia and Herzegovina 1:29,000 dies (WFFC MDGS table 2007; Population Reference Bureau, 2005; World Bank, 1998; WHO, 1997). Millennium Development Goal (MDG) number 5 is to improve maternal health and reduce maternal mortality by 75% by the year 2015. In line with this goal Nigeria in the National Reproductive Health Policy sets the goal of reducing MM by half within ten years (FMOH, 2001). More than ten years into the national goal and four years to MDGs' 2015, there is need to evaluate why these efforts have not increased adherence to hospital regimes and lowered MM ratio in Ilesa.

Ilesa was privileged as early as 1913 to host a western medical centre established by the Methodist mission. Since then, more hospitals, maternity centres and clinics have been established. No one has to travel more than one kilometre or spend more than fifty Naira (#50.00) to get to the nearest hospital or maternity centre. In fact, the maternity centres are within trekking distance to all the citizens. Are pregnant women patronizing them? What are the factors that determine whether or not a pregnant woman will seek health assistance from any of these places? Are there advantages in proximity of pregnant women to utilizing the Health Care Services available?

The following research questions were generated for this study.

Research Questions

1). How do socio and demographic factors influence decision on care during pregnancy?
2). How does religious belief systems influence pregnant women's health seeking behaviour?
3). What are the perceptions of pregnant women on aetiology of pregnancy related complications?
4). Among women that patronize hospitals, do pregnant women adhere to basic instructions and prescription?
5). What are the roles men play in caring for the health of pregnant women?
6). What informs the choice of health care provider during pregnancy?

Objectives of the Study

The general objective of this study is to examine maternal health care among pregnant women in Ilesa.

The specific objectives are to

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

Justification for the Study

Maternal mortality is an important indication of standards of health in different countries. Reproduction is the key to survival of species and motherhood is a dream of every woman. It could be made safe or complicated depending on living standard of the reproducer. However, if in the process of reproducing, the reproducer dies, reproduction becomes

a source of great distress. Nigeria has only 2% of the world's population but produces more than 10% of world's maternal deaths ranking second only to India which has about 7 times the population of Nigeria. This highlights a very serious health emergency in Nigeria (Akintaro, 2013).

Majority of the studies have been predominantly on antenatal care attendance, accessibility and availability; but there are other factors such as perception of aetiology of disease, religion, husband's role and general maternal care that do have great influence on pregnancy care.

A reduction in MM and morbidity would greatly reduce cases of widowers, motherless babies, bereaved parents, relations as well as orphans and vulnerable children. This will also reduce agonies of the 1.5 million Nigerian women in agony of maternal morbidity (Dada, 2008; Population Reference Bureau, 2005; World Health Development Report, 1995; Ransome – Kuti, 2010 and Kanu, 2010). Further as MM and morbidity happen when these women are economically productive, a reduction in MM and morbidity would enable the women contribute to the economic growth of their families in particular and their country in general. Those in morbid conditions will be able to enjoy healthful life.

Scope of the Study

The study investigated maternal health in Ilesa East and West Local Government Areas of Osun State. The target population was currently pregnant women to give room for easy and accurate recall of events.

METHODOLOGY

Research Design

This is a descriptive study. Data were collected from pregnant women at household level, Faith homes and hospitals. Both quantitative and qualitative techniques were triangulated to generate primary data. Questionnaire was used to generate quantitative data while In-depth Interviews and participant observations were utilized to generate qualitative data. Five hundred and two copies of questionnaire were administered to pregnant women in form of personal interviews. The questions were related to adherence of pregnant women to hospital regimes, husbands' roles and care seeking. Also, pilot study was conducted in two of the wards that were not selected for the study.

The Study Area

The study is in Ilesa Osun State. Its population was 328, 327 (Adefila, 2004). About 60 percent of the population are farmers. The people are industrious, adventurous, enlightened, and prayerful (Fatubarin, 2008). They are traders and known for the local hire purchase and credit system in Nigeria. Ilesa women are traders and engage in various finance generating activities that make them fairly financially independent. Ilesa women are very religious and most churches have more women than men. Many women are 'Oludasile' (church founders). The Methodist Church introduced orthodox medical system to Ilesa in 1913 known as Wesley Guild Hospital, now Obafemi Awolowo Teaching Hospital (OAUTH). It provides primary, secondary as well as tertiary health care services for Ilesa and adjoining areas. No patient in labour is refused admission.The people are predominantly Christians and there are many birth houses attached to churches. Pregnant women who attend these churches patronize their birth houses and invite their pregnant friends to do same. Some of these Churches were established on belief in divine healing and efficacy of prayers without medication. This belief system is transferred to their birth houses. However, some pregnant women combine faith homes with hospital care.

The Study Population

This study is focused on pregnancy care and management in hospitals and faith homes. All currently pregnant women, their husbands and their care providers formed the study population.

Sampling Techniques

Simple random sampling with was used to select eleven of the twenty one wards in Ilesa. Five hundred and fifty copies of questionnaire were administered to fifty pregnant women from each ward using snowball sampling technique but only 502 were analyzable. Twenty four in-depth interviews (IDIs) were conducted among Faith homes and hospitals. Twelve were conducted among each of them. Ten willing husbands were also interviewed to provide information on men's roles

in pregnancy care. Twenty visits were made to care providers to participate in prayer meetings and ANCs. The researcher could not identify practicing traditional birth attendants as all those identified as using herbs claimed they are mission care providers and operated under some established churches, though in most cases they are the founders of such churches.

Method of Data Analysis

Frequency distributions, means, percentages and multivariate analysis were used to analyze quantitative data, which were processed using the Statistical Package for Social Sciences (SPSS). Content analysis and ethnographic summary were employed to analyze data from IDIs. Direct quotations were translated verbatim, transcribed and put in italics.

FINDINGS

Socio-Economic and Demographic Factors that Influence Decision on Maternal Care

Tables 1 and 2 present summary of socio- economic and demographic factors which influence decision on care during pregnancy. The results reveal that the combination of socio- economic and demographic factors have positive correlation with decision making during pregnancy (R=0.548). This combination explains 11.3% of the total variance observed on decision making (R=0.300; $R_{adj.}$0.113) which is not statistically significant F (11, 41) = 0.601, P> 0.05. However, when viewed jointly, socio economic and demographic factors can predict decision on care during pregnancy.

Table 1. Model Summary

Model	R	R^2	R_{adj}	Std Error
1	0.548	0.300	0.113	1.8925

Economic influence on Pregnant Women's Health Seeking Behavior

Table 2. ANOVA on Economic influence on Pregnant Women's Health Seeking Behavior

Model	Sum of Square	df	$\bar{X}^2$	F	Sig
Regression	63.077	11	5.734	1.601	0.135
Residual	148.848	41	3.582		
Total	209.925	52			

A regression test was carried out to find out the influence of some demographic characteristics on pregnant women\s health seeking behavior. The result reveals that, of the different categories of variables, spouse/partners' occupation (0.043) had significant influence on women's health. As stated above, though the people are literate, many do not earn enough money that commensurate to their certificates. They could neither give money to buy delivery materials nor food. According to a faith Care giver:

Some husbands behave irresponsibly because of poverty as they cannot afford the money for delivery materials. They cover up with boldness and rudeness. Some husbands run away on the day of their wives' deliveries because of poverty. We pray for such husbands because we know that some of them want to be responsible but are very poor. (IDI Female Faith Care Provider, Ilesa West, October, 2013).

Table 3. A Regression on Economic influence of Husbands/Partners on Health Seeking Behaviour

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1(a)	Spouse Education	-.306	.184	2.783	1	.095	.736
	Spouse Occupation	-.442	.218	4.105	1	*.043	.643
	Education	-.035	.165	.044	1	.833	.966
	Income	-.131	.134	.956	1	.328	.878
	Religion	-.536	.467	1.321	1	.250	.585
	Type of marriage	-.116	.350	.109	1	.741	.891
	Constant	1.658	1.037	2.554	1	.110	5.246

Influence of pregnant women education and income on Health Seeking Behavior

Influence of pregnant women's education and income were explored and table 3 reveals that there is none of the women's social demographic characteristics that influenced their health seeking behavior but that of their spouses do. This underscores the important roles husbands play in the health seeking behavior of their wives. Expectedly, women's education should influence the care they sort and received but their dependability on their husbands/partners as the heads of their families reveals the contrary. Therefore, husbands/partners' influences should be taking into consideration if the society would not jeopardize the lives of these women.

Table 4. A Regression on Pregnant Women's Economic influence on Health Seeking Behavior

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1(a)	Education	-.156	.122	1.641	1	.200	.855
	Income	-.139	.121	1.314	1	.252	.870
	Religion	-.399	.396	1.014	1	.314	.671
	Type of marriage	-.126	.330	.147	1	.701	.881
	Constant	.119	.734	.026	1	.871	1.126

Influence of Religious Belief system in pregnant women's health seeking behavior

The general belief in the study area is that pregnancy and child bearing are the work of God and it is a secret that only God knows and understands, therefore no one can query Him. He gives children to whomsoever He wishes (Olorunnisomo and Ebunoluwa, 2001). The respondents believe that God does not do evil and so breech babies and pregnancy complications are the work of the evil ones. If the orthodox medicine sees pregnancies as natural phenomenon, the pregnant women see it as spiritual. They patronize churches for care and deliveries of their babies. Many care givers in hospitals during the interviews confirmed that many pregnant women only come to them for ANC and immunization but delivered in mission houses. Kisekka et al. (1992) and Ekanem et al. (2007) studies were in line with this findings. This is an indication that the people's religious belief system has great impact on maternal health seeking

Many of the compounds of religious houses are located at the bank of a river that runs through the town and there are wells within the religious houses. Pregnant women who come for prayers and care take water from either the running water or the wells into bottles for bathing and drinking. Some are allowed to bring their own water from home. Prayers are said on the water and women are to drink this water until the next visit. If the water finishes, they could come back to take fresh ones. In all religious houses, prayers are said for save delivery for pregnant women at every gathering. Anointing oil, water and reading of psalms are spiritual symbols that are common in religious houses. Anointing oil was also for pregnancies that were not developing as they ought. Such women were to drink two spoons of the oil every week until they deliver. Some of the delivery houses claimed that they help barren women looking for children. In one of the religious houses visited the 'Iya Adura' (FBA) said,

when infertile women come to me for help, I pray for them with soap, sponges and water and give them three months to get pregnant; such women are to return for thank giving after their babies arrive **(IDI, Female, Faith Home, Ilesa West, Oct 2013).**

All FBAs interviewed instructed pregnant women not to walk between 1-3p.m or late at night. They believe that children with familiar spirit can drive out good children in their wombs and replace them.

We tell the women not to go out in hot afternoon or at midnight between 1-3am and pm to avoid evil children who may take over their wombs (**IDI, Female, FBA Sept 2013).**

Pregnant women pay weekly visits to religious houses for prayers a typical meeting starts with a long time of dancing, singing and praise worship to god; then they make rigorous prayers against maternal mortality and still births. they pray for easy and safe delivery as well as against evil imaginations of wicked people and breech babies and whatever would occasion caesarian operations. One of the FBA that was interviewed reported that

I give Olive or Robot or Goyal oil into which I had prayed and read Psalms 3, 11, 24 to drink and rob on their bodies. I use it to make sign of the Cross on their forehead and tummy to ward off evil from them and their babies (IDI, Female, FBA Sept 2013).

Durkheim claimed that the society set apart some items as sacred while the rest are profane. In these religious centers oil, water, soap and sponges that have being prayed on are regarded as sacred and the pregnant women believe this would drive evil far from them. During the visits pregnant women are seen joyfully robbing this oil all over them.

In addition, each pregnant woman submits a big sag bag with her delivery materials to the mission. The FBAs reported that that they fast, pray and read psalms of victory on them and during the weekly prayer meetings all pregnant women pray on the bags. Leaving the items with the FBAs for her individual and corporate prayers was believed to ward off evil. When contractions start the woman walks out of the house without carrying load to avoid suspecting "evil eyes" from following her. However, this practice might force pregnant women to deliver with the FBAs as most women cannot duplicate the materials.

Generally, there is no religious barrier in pregnancy care. Attendance to Faith Homes was open to all pregnant women, church members and none members as well as Muslims and African Traditional religionists. However, as the qualitative study reveals, in some congregations, pregnant members who do not deliver in their Faith homes would not have their babies christened

Tables 5 and 6 show that the influence of religious belief systems on pregnant women's health seeking behavior is low but have positive correlation; R = 0.267. All the religious groups whether Christianity, Islamic or traditional religions only explain for 17% of the total variance observed on health seeking behavior; $R^2 = 0.071$; $R_{adj} = 0.0176$ which is not statistically significant: F (3, 52) =1.326, P>0.05

Table 5. Model Summary

Model	R	R^2	R_{adj}	Std. Error of the Estimates
1	.267	.071	.017	1.1492

Table 6. ANOVA on Influence of Religious Beliefs on Pregnant Women Health Seeking Behavior

Model	Sum of Squares	df	$\bar{X}^2$	F	Sig.
Regression	5.525	3	1.751	1.326	.276
Residual	68.676	52	1.321		
Total	73.929	55			

Some faith care givers take pregnant women to designated mountain tops for prayers regularly; every month or twice a month where they pray, read Psalms and hold vigils. In two of the Faith Houses visited, the FBAs said when they look at pregnant women; they can discern the position of the babies in the wombs. If the babies were in breech positions, they prayed to make the babies take desired positions. Those who were likely to have problems were referred to hospital but rigorous prayers are said for them.

The Pastor in one faith home emphasizes the importance of visions and prophecies as one of the reasons why pregnant women patronized faith homes. He said people have problems and they are looking for solution. They also want to know what the future holds for them. These services are not available in orthodox medicine. The researcher observed in some of the faith homes that the pregnant women kneel in front of their Prophets to hear

Thus says the Lord. There are 3 -4 battles in front of you. God will destroy all of them

Then the Prophet/Prophetess would pray for them. A Prophet/FBA said:

You nurses and doctors in hospital are blind. You only open your eyes and could see nothing. You collect chalk and give people to swallow you cannot see the problems in their lives. As for me when a pregnant woman comes, and I look at her, 'some maleka' (angels) would tell me the problems in her life and the 'maleka' would tell me what solutions to proffer to these problems. (IDI, Male Faith Care Giver, Ilesa East, 2013).

Solutions range from bathing in flowing river or water from the well within the church, going to mountain tops to pray; using anointing oil to rub the body and fasting. Pastor provided the soap and the sponge as well as the anointing oil. He takes those who were to go for prayers to their selected mountain top for whatever number of days the '*maleka'* stipulated.

There was also the '*Igbe'le adura or Abe Aabo*'(seclusion for prayer) that is to come under God's special protection. The pregnant woman comes to reside in the religious house for a whole day or more as indicated by the '*maleka*'. When the Iya/Baba adura perceives in a vision that evil was looming on a pregnant woman, he/she ordered such woman to come to church for special prayers. Prayers are said for her at regular intervals: 9a.m, 12 noon, 1p.m, 3p.m, 6p.m, 9p.m, 12 midnight and 3a.m or on hourly bases. It is repeated if the *'Igbe'le'* lasted for more than one day. Psalms 128, 91, 62, 35, 29:5, 28, 24, 1-7 are usually read. A FBA said:

Adura longba agbara kii gba – meaning *things prayers would accomplish physical exertion/energy/agility would not be able to.*

Women are predominant in prayer houses because they claimed to love prayers. When problem ensues women tend to be more anxious in looking for solution.

Faith houses are more sympathetic to the course of the pregnant women. A nurse reported an incidence of a pregnant woman who tested positive to HIV. When she was in labor, she went to the hospital, the midwife on duty who knew her status told her to come back hours later when she would have finished her duty. The pregnant woman had no alternative but to resort to a faith home where she delivered shortly after she arrived. The FBA did not use gloves. It was the pregnant woman who knew her status that insisted that the FBA used gloves. This incidence is a pointer to the need to train FBAs to use gloves to reduce continuous spread of HIV. They use bare hands to take deliveries and circumcise children.

Pregnant women registered in hospitals but eventually delivered in mission houses because of fear of Caesarean Section (CS). The women knew that if they labor for two days in hospital and could not deliver, CS would be performed but in Mission Houses they were free to labor for four days or more before they would be referred.

Three of the FBAs interviewed assured pregnant women that if hospitals want to do CS and they come to them, they would deliver within one hour. Women, who hear this, may refuse CS. This might cause delay that might be life threatening and result in the women being taken to hospital in moribund conditions. However, hospital reports may not have the final answer at all times; a pregnant woman reported a supernatural intervention in her case. She went for scan and the baby was breeched, the FBA sent her to a hospital but she refused to go and started crying. She reported that she looked through the window towards the sky and said:

O God you know my financial position, the money I owe in this hospital I have not paid it, one nurse stood in for me. Would n't you have compassion on me and deliver me safely without operation? (IDI, Female, Pregnant woman Sept 2013).

She said as she tearfully prayed, she sat and in 30 minutes the baby had turned so that in less than one hour she delivered safely. The influence of religion is evident even in hospitals' ANC where pregnant women pray, sing praises and worship to God before nurses attend to them.

However, all is not well in religious houses. A nurse recalled that a woman came during labor and was told to stay and send for her delivery materials. She told the nurses she had to take a special bathe in her church before delivery. She went and delivered the first and second of triplets there. But the third was transverse and bleeding started. They invited an inexperienced nurse who forced it to vertical version. When bleeding continued she was brought to the same hospital very pale and two of the triplets had died.

A pregnant woman reported that she had had three dead babies delivered in her religious house and that the babies were always delivered in the eighth months and bathed in cold water. She wanted to deliver the fourth in the maternity centre to see the outcome. She had the baby at ninth month and it survived. The religious group refused to christen the baby. There was another pregnant woman in another religious house; the FBA punctured the membrane before the baby's head descended. The woman lost fluid and became septic. She was referred to maternity centre where community health worker battled over her life and the baby. After delivery, she went to the FBA who gave her certain concoction to drink and she died. The nurse reported that community rose up against the FBA and she ran away.

A nurse reported an incidence of a woman in labor who came to the maternity and was making progress when her Pastor came to pray for her after which the labor ceased. While the health worker slept, she claimed she had a dream and saw a psalm she read into water and gave the pregnant woman to drink. After this labor continued and she eventually delivered safely. The religious house refused to christen the child. According to this health worker, the second day, a man came physically to meet her and said:

What makes you so courageous, how dare you deliver this woman? We had planned that she should die with this pregnancy. She is very proud. Anytime she comes to tailors' meeting she talks proudly (Female, IDI, Private Maternity Centre, Oct. 2013).

A few religious houses cooperate with hospitals and allow nurses to attend their prayer meetings to give instruction on cleanliness, personal and environmental hygiene, immunization, blood tests and scan. Where these tests were done, and there were no sign of complications, the FBA took the deliveries but when the result envisaged complications, the FBA allowed the nurses to direct the women to appropriate hospital*;*

but when the women insist that they would deliver here; I asked the heavenly spirit: *If the spirit tells me to deliver her I will do I; if not I send her away (*Female Ilesa West, Oct. 2013)*.*

There was also the influence of mothers-in-law in the choice of care giver. At one of the maternity centers, the nurses reported a rare case of a woman whose husband usually sent to his mother in village when she took in. The mother-in-law nursed the pregnancies to delivery. She took the pregnant woman (her-daughter-in-law) to a religious home where from the first month of pregnancy they made some concoction ('aseje') which she took monthly until the pregnancy was

seven months when the baby's fluid would be punctured forcefully by the Founder. After delivery, another concoction would be prepared for the baby and the mother. The pregnant woman in question had two children in that religious house. The first baby survived, while she lost the second. When she became pregnant the third time, she refused to be sent to the mother-in-law because she wanted to know what would happen if the pregnancy reached nine months and she did not take concoction. She attended ANC irregularly but the baby was born at term. When queried further so as to know the religious house, she declined because she was sore afraid of her mother-in-law.

Perceptions of pregnant women on aetiology of pregnancy related complications

The fourth study objective was to find pregnant women's perception of etiology of pregnancy related problems. This was achieved by looking at the following items.
i) Perception of pregnancy complications.
ii) Perceived causes of pregnancy complications
iii) Perceived places to treat pregnancy complications
iv) Perceived treatment of anemia
Table 7 and 8 reveals that 26.3% attributed pregnancy complications to infections; 26.5% attributed it to the physical nature of the woman; 12.4% attributed pregnancy complications to witches and wizards; 13.4% attributed it to adultery on the part of the woman. The study revealed inadequate knowledge of causes of pregnancy complications. Pregnant women that are not aware of causes of complications cannot work at preventing them; prevention they say is better and cheaper than cure. This observation is not due to chance but statistically significant X^2=655.54, df = 1, N= 502, P<.05.

Table 7. Perceived causes of pregnancy complications

	Frequency	Percentage
Perception of etiology of pregnancy Complications		
Infection		
Yes	91	26.3
No	411	73.7
Total	**502**	**100.0**
Physical Structure of woman		
Yes	133	26.5
No	369	73.**5**
Total	**502**	**100.0**
Witches $ wizards		
Yes	62	12..4
No	440	86.6
Total	**502**	**100.0**
Adultery by the woman		
Yes	67	13.4
No	434	90.6
Total	**502**	**100.0**
Others		
Yes	31	6.2
No	471	93.8
Total	**502**	**100.0**

Source: Survey, 2013

Table 8. Chi Square Table on Perceived Causes of Pregnant Complications

Items	Infection	Nature of Woman	Witches	Adultery	Others	df	Chi Square	Sig.
Causes of com.	91 (263%)	133 (265)	62 (12.4%)	67 (13.4%)	31 (6.2%)	5	655.54	.000

Respondents were asked to identify places where they perceived pregnancy complications should be treated. Table 9 reveals that 208 (41.4%) reported that church /FBA are places for treatment of pregnancy complications, 11 (2.2%) reported that mosque is places for treatment of pregnancy complications; 32 (6.4%) reported that maternities are places for treatment of pregnancy complications 247 (49.2%) reported that hospitals are places for treatment of complications and 4 (0.8%) recognized others unspecified places for treatment of pregnancy complications. This observation is not due to chance but statistically significant X^2 = 505.737, df = 1 N= 502, P< 0.05.

Table 9. Perceived Places for Treatment of Pregnancy Complications

Items	Church/ FBAs	Mosque	Maternity	Hospital	Others	Df	Chi Square	Sig.
Treatment of complication.	208(41.4%)	11(2.2%)	32 (6.4%)	247(49.2%)	4 (0.8)	5	505.737	.000

Respondents were asked to identify their support for blood transfusion if there was need. Table 10 reveals perceived treatment of anemia; 354 (70.5%) reported that they would agree to blood transfusion while 148 (29.5%) would not agree to blood transfusion if there was anemia. This observation is not due to chance but statistically significant $X^{2 =}$ 84.5334, df =1, N= 502, P< 0.05.

Table 10. Perceived Treatment of Anemia

Item	Yes	%	No	%	df	Chi Square	Sig.
Need for Blood transfusion	354	70.5	148	29.5	1	84.534	.000

Table 11 reveals women's adherence to food prescription. Among the respondents, 475 (94.6%) claimed that they ate balanced diet during their current pregnancy while 27 (5.4%) did not. This observation is not due to chance but statistically significant $X^{2 =}$ 399.809, df =1, N= 502, P< 0.05.

Table 11. Food Prescribed in Pregnancy

Item	Balanced	475	94.6%	df	Chi Square	Sig.
Types of Food to eat in Pregnancy	Unbalanced	27	5.4%	1	399.809	.000

Pregnant women were asked to identify signs/symptoms they perceived as pregnancy complications; only seventy percent of the respondents acknowledged that labour of more than 12 hours was a symptom. This explains why they would labour for 3 or 4 days in Mission Houses without trying to seek help. A gynecologist said those who were transferred to the hospital and were advised to go in for CS would not give inform consent saying:
I believe God I would deliver safely. I will not die. (IDI Male, OAUTH, March 2010).

Table 12 reveals pregnant women's knowledge of signs and symptoms of pregnancy complications. Among the respondents, 71.3% recognized that excessive bleeding before or after delivery could be dangerous while only 67.5% were aware that high fever was a sign of complications. Fifty seven percent were aware that swollen legs and bodies are signs of complications. In the study area, when a pregnant woman has swollen body and face, it is believed to be a sign of multiple pregnancies. Another 74.7% of the respondents knew that breeched babies were dangerous and 63.9% knew that convulsion was a sign of pregnancy complications. The study revealed lack of adequate knowledge of signs and symptoms of pregnancy complications. When pregnant women and their husbands are ignorant about these complications, they may not seek help on time. There is a need to sensitize the community and Faith Homes on these signs and symptoms to reduce maternal mortalities.

Table 13. Perceived Places to Treat Pregnancy Complications

Perception of how and where to treat pregnancy Complications	F	%
Perception on where to treat pregnancy Complications		
Church	208	41.4
Mosque	11	2.2
Maternity	32	76.4
Hospital	247	49.2
Others	4	0.8
Total	**417**	**100.0**
Blood Transfusion		
Yes	354	70.5
No	142	28,3
Not sure	36	7.4
Total	**501**	**100.0**

Source: Survey 2013

Factors that inform choice of care givers and Places Women Patronize for Pregnancy Care

In every facets of life, choices are made and the choices we make determine our destiny. Some choices we made many years ago determine where we are now. The choice of care providers pregnant women make may make or mar their pregnancies. One of the factors that determine the choice of health care giver is the attitude of the Care Givers. FBAs are easily available and their cell phone numbers are given to all pregnant women. They are allowed to call them any time of the day. Worthy of note was the cordial relations the researcher observed among the religious care givers and pregnant women. The women were allowed to sleep and sit anywhere they liked. The researcher observed that some women went to lie full length on the altars of the churches asking God for mercy during their deliveries. This was different from what was observed in hospitals where the women sat on long benches and trying to sleep might not be allowed because of space congestion or fear of the nurses.

An individual's preferences would reflect in the kinds of decisions she makes from time to time. These preferences in pregnant women were reflected in the places they patronized for care of their pregnancies and these would also influence where they delivered past, present and future pregnancies.

Table 14 revealed that 372 (65.1%) of respondents had their last babies in mission/FBAs homes, 64 (12.7%) had theirs in clinic/maternity centre, 89 (17.7%) had them in hospitals and 2 (0.4%) in other unspecified places. This observation is not due to chance but statistically significant X^2=468.864, df =1, N= 502, P<.05.

Table 14. Places Respondents had their Last Babies

Item	Mission/ FBAs	Mosque	Clinic/ Maternity	Hospital	Home	Other	Chi Square
	370 (65.1%)	1(0.2%)	64 (12.7%)	89 (17.7%)	17 (3.8%)	2(0.4)	*468.864

Table 15 reveals that 150 (29.9 %) of pregnant women hoped to deliver their current pregnancies in mission/church; 180 (35.9%) are not yet sure whether they would have their babies in mission or hospitals while 26 (5.2%) hoped to deliver with auxiliary midwives 12 (2.4%) would deliver at clinic/maternity 111 (22.1%) hope to deliver in hospitals while 21 (4.2%) were not decided on where they would deliver their current pregnancies. When labor starts on the day of delivery those that were not decided may not know where to go on time and consequently may result in delay to seek help. However, this observation is not due to chance but statistically X^2=803.378, df =1, N= 502, P< 0.05.

Table 15. Reasons for Choice of Care Providers

Item	Husband	Proximity	Prayer	Others' Recom.	Parents/ In-law	Care	Cordiality	Chi Square
	14 (2.8%)	22 (4.4%)	137 (27.3%)	141 (28.0%)	3 (0.6%)	98 (19.4%)	88 (17.5%)	*399.99

*Indicate that it is significant

DISCUSSION

When socio-economic and demographic variables were correlated; the correlation was weak and not statistically significant, but under descriptive analysis age and husbands' occupation were potent contributors to care during pregnant as they were both significant. The Chi Square were P<0.05 respectively. The study revealed that poverty and religiosity were of causes of women non attendance and deliveries in hospitals.

The ANOVA table revealed that the influence of religion on pregnant women health seeking behavior is low but there is positive correlation, though not statistically significant. Christians, Muslims and traditional worshippers attended ANC where they thought they would best be helped without taken cognizance of their religious affiliation.

Spiritual reasons were attached to maternities and deliveries. Belief in witches, wizards, familiar spirits and supernatural intervention in pregnancies and maternity are common and these were reasons why women recur to praying houses for maternal care. Spiritual symbols such as water, anointing oil, soap, sponge, bathing in flowing rivers and praying on mountain tops were prevalent among the respondents. Prayers and reading of psalms are spiritual symbols believed to ward off evil. The belief system of the people cannot be jettisoned if there should be a reduction in maternal mortality.

The result shows that pregnant women perceived that pregnancy complications result from infections, physical nature of the woman, witches, wizards and adultery. The physical nature of the woman was perceived to be most potent cause of pregnancy complications. The next cause of complication perceived as potent was infection. All are statistically significant. Prayers, oil, water, soap and bathing in flowing rivers are perceived as solution to complications.

The level of a pregnant women's adherence to hospitals regimes will determine the benefit that accrue to them from

such care. Pregnant women are supposed to attend ANC after missing two consecutive menstruations. This would enable them take at least three of the immunization schedules as well as some routine drugs adequately before delivery. A sizable number of the respondent attended half hazard. About two thirds of them took only two of the immunizations. It is also observed that only 1.6% the respondents completed their immunizations while 3.6 had not taken any. If pregnant women do not take immunization adequately as scheduled, they cannot prevent the diseases these immunizations are supposed to prevent. This also is true of drugs that were administered; they can be counter productive if not used as prescribed. Adequate exercises are important for healthy living therefore, pregnant women should do some to ensure vitality. Majority of the women walked, did housework, while only 7.4%did no exercise. Adequate food in balance proportion is essential for healthy living. To have healthy babies these women should consume all classes of food appropriately.

Important roles husbands/partners play in pregnancy care cannot be over emphasized. Husbands were found to be most influential in their wives' health seeking. Husbands were found to play significant provider and care giving roles in pregnancy. They accompany their wives to places of deliveries and stay by them. These emotional supports cannot be quantified as their influences upon their wives' emotion during deliveries were very important.

Since the respondents see maternity from spiritual angle, the people can be sensitized into combining hospital and religious care giving. They should be encouraged to pray in mission houses but be determined to deliver in hospitals.. Pregnant women and their husbands were found to be ignorant of signs and symptoms of pregnancy complications. Prayers with hospitals care are perceived as solutions to such complications.

CONCLUSION AND RECOMMENDATION

The study revealed that poverty is a major cause of non attendance and deliveries in hospital. Spiritual reasons were attached to maternities and deliveries. Belief in witches, wizards, familiar spirits and the supernatural intervention in pregnancies and maternity are common and these were reasons why women recur to praying houses for maternal care Spiritual symbols such as water, anointing oil, soap, sponge, bathing in flowing rivers and praying on mountain tops were prevalent among the respondents.. Prayers, reading of psalms and spiritual symbols are believed to ward off evil. The belief system of the people cannot be jettisoned if they are to patronize orthodox care givers and reduce maternal mortality. The people can be sensitized into combining the two. They should be encouraged to pray in mission houses but to determine to deliver in hospitals.

To solve the problems of poverty, ANC materials and deliveries must be made free for the poorest group. They and their husbands should be sensitized to do family planning so that they would not have too many children they could not cater for. Husbands, wives, public and Faith Homes should be sensitized to know signs and symptoms of pregnancy complications because throughout the several visits made to Faith Homes emphasis of health talks had been on hygiene, food consumption and family planning. Causes, signs and symptoms of complications should be included and emphasized.

Government and orthodox care givers should monitor and inspect Faith Houses with the aim of making them less risky and hygienic. A ban on mission houses will not bring any solution because the people are still poor and cannot afford the materials that are demanded even in government hospitals and maternity centres where deliveries are claimed to be free. Further, the people believe that the spiritual control the physical. There should be relative cooperation among the Care Givers. Hospitals should organize seminars to educate TBAs on referrals, hygiene, family planning, drug, food prescription, prevention of HIV as well as signs and symptoms of pregnancy complications. Formerly, workshops were organized by Ministry of Women Affairs and Ministry of Health which the TBA claimed had been long and many were not opportune to participate. During the interviews, the researcher discovered that the TBAs were willing and ready to be trained. They easily volunteered their cell phone numbers so that they could be called when and if any training was going to be. Some requested that there should be radio announcements when such training is organized. The TBA suggested that heads of wards and compounds be informed to inform them. The two Local Governments and Ministry of Health could organize this training at minimal cost.

Contribution to Knowledge

The study contributes to existing literature and body of knowledge on pregnancy care among women in Ilesa. It revealed that the respondents are spiritual and understand maternity and childbirth from spiritual angles. Therefore, spiritual rather than medical reasons are important to pregnant women and significant others for seeking help in pregnancies and deliveries. There is need to have a clear-cut health policy on how the spiritual healing houses and western medicine can be integrated to provide best health services for pregnant women. The study further revealed that husbands and

pregnant women are ignorant of causes, signs and symptoms of pregnancy complications and need to be sensitized on how to prevent them. This study provides useful information on the roles of faith, western medicines and husbands/ partners play in maternal health. The study contributes to existing literature and body of knowledge on pregnancy care among women in Ilesa. It revealed that the majority of the respondents understand maternity and childbirth from spiritual angles. Therefore, spiritual rather than medical reasons are important to pregnant women and significant others for seeking help in pregnancies and deliveries. There is need to have a clear-cut health policy on how the spiritual healing homes and orthodox medicine can be integrated to provide best health services for pregnant women. Therefore, this study provides useful information on the roles of faith, western medicines, and husbands/ partners in maternal health.

References

Adefila A(2004). *Osun State Directory Incorporating Who is Who*. D and G International Company Ltd.

Akinlembola T, Oguntimehin B(2006). How Safe is Motherhood in Africa? *Nigerian Tribune*. Sept. 19th: 19: 31

Akintaro A(2013). Nigeria: The Embarrassment of Maternal Mortality Akin Akintaro email "Retrieved February 25, 2013.

Audu-Airede LR(2000). The Safe Motherhood Initiative in Nigeria-mythical or Material *Sahel Med. J.* 3(1): 7-8

Awosiyan K(2013). *Infant/maternal mortality: Lagos Battles Hard to Meet WHO Standard. Nigerian Tribune* November. 17: 24.

Berger M(1994). The Meaning of Motherhood, Fatherhood and Fertility: for Women Who Do and Women Who Don't have Children. *Reproductive health matters.* 4: 6-10.

Dada J(2008). 54,000 Nigerian Women Die Annually during Childbirth. *The Punch*. June 2:7.

Duyilemi AN(2003). Breaking the Mould of Under- rrrepresentation of Women in Science, Technology, Mathematics Education and Profession in Nigeria in *Issues in Educatinal Measurement and Evaluation in Honour of Wole Falayajo.* Afemikhe O. A. and Adewale, J. G. Institute of Education University of Ibadan: 91-101

Ebhuomhan S(2008). 54,000 Nigerian Women Die Annually during Childbirth. *The Punch*. June 2: 7

Ekanem I, Ebigbola J, Igun A(2007). The Role of TBAs in the South Eastern State of Nigeria. *Institute of population and manpower*. series 3.

Ekwenpu CE(2010). Overview of child bearing in Some Northern Parts of Nigeria. Proceeding of Safe Motherhood Conference 22- 23 March. Kaduna

Erinosho L(2006). The Burden of Our Women. University of Ibadan 29th Postgraduate School Interdisciplinary Research Discourse 2005 Postgraduate School University of Ibadan.

Fatubarin A(2008). *The Story of the Ijesa People*. Keynotes Publishers Limited. Ilesa. 7: 126.

Fatusi AO, Ijadunola KT(2003). National Study of Essential Obstetric Care Facilities in Nigeria (UNFPA). Technical Report. Federal Ministry of Health Nigeria, Abuja.

Faureau V(1993). Maternal tetanus: *Int. J. Gynaecology and Obstetric. 40:2-12.*

Federal Ministry of Health(2001). The National Health Policy and Strategy to Achieve. Health for All Nigerians. Lagos.

Fishbein M(1996). Behavioural Science and Public Health Reports III supl. 1: 1 -5.

Freedman LP, Maine D(1993). Women's Mortality: A Legacy of Neglects. *The Health of Women: A Global Perspective.* M. Koblinsky , J. Timyan and J. Gay Eds. Oxford .Westview Press. 7: 147 – 170.

Graham WJ(1991). Maternal Mortality: Levels, Trends and Data Deficiencies. *Disease and Mortality in Sub-Saharan Africa*. R.G. Feachem and D.T. Jamison Eds. New York: Oxford. Pp. 101 – 106.

Harrison KA(1997). Maternal mortality in Nigeria: The Real Issues. *African Journal of Reproductive Health* March. 1:1. 7-13

Isiugo- Abanihe UC(2003). *Male Role and Responsibility in Fertility and Reproductive Health in Nigeria.* agos Centre for Population Activities and Education Development (CEPAED).

Kanu M(2010). For Safe Motherhood Paper Presented at Safe Motherhood Conference. *The Guardian*. September 11, 2010

Kessel G, Awari AK(1987). Maternal and Child Care in Developing Countries. *Proceeding: Third International Congress for Maternal and Neonatal Health.* Pakistan. Lahore

Kisekka MN, Ekwenpu ES, Olorukoba BM(1992). Determinant of Maternal Mortality in Zaria area. *Women's Health Issues in Nigeria*. Zaria. Tamaza publishing company.Chapter 6. 51 – 66.

Mbizvo MT(1996). Reproductive and Sexual Health. *Central Afr. J. Med. 42(3): 80-85.*

Mechanic D(2012). The Concept of Illness Behaviour. *J. Chronic Diseases.* 15: 189–194.

Nigeria Demographic Health Survey(2010). Nigeria Population Commission. Federal Republic of Nigeria. Maryland U.S.A ORC Macro Calverton.

Nigeria Demographic Survey. (2003). Nigeria Population Commission. Federal Republic of Nigeria. Maryland U.S.A ORC Macro Calverton. April.

Ojo OA, Ladipo OA, Adelowo M.A(1981). Maternity Care Monitoring in Ibadan, Nigeria, *Afr. J. Med. Sci.* 10:49-56.

Popoola J/NAN Features(2010). Want to have Twins Eat Yam! *Sunday Punch* April 11. Pp. 7.

Population Reference Bureau(2005). Women of Our World: *Wealth Gap in Health* Washington: Population Reference Bureau.

Roth DM, Mbizo MT(2001). Promoting Safe Motherhood in the Community: The Case for Strategies that Include Men. *Afr. J. Reproductive Health.* E E. Okonofua and R C. Snow Eds. 5(2) : 10 - 21.

Salama, P(2008). UNICEF REPORT highlights Risk of Maternal Mortality in Developing World. *The Nation* September 30. Pp.31.

Sindiga I, Chacha NC, Kanunah MP(1995). *Traditional Medicine in Africa*. Westland, Nairobi. East African Educational Publishers Ltd.

Tinker A, Ransom E(2002). Healthy Mothers and Healthy Newborns. *The Vital Link.* Population Reference Bureau. Washington D.C.

Wallace RA, Alison W(1986). Contemporary Sociological Theory: Continuing the Classical Tradition. Prentice- Hall, Inc. Eagle Cliffs, New Jersey. Pp.14-16.

Wardlaw T(2008). UNICEF Report Highlights Risk of Maternal Mortality in Developing World. *The Nation.* September 30. Pp. 31.

WFFC MDGS table (2007). MDG 5: Improve Maternal Health. and Neo Natal Programme, Effort Index Nigeria (mnpi) Maternal Health. pdf – Adobe Reader. 10: 24 07

WHO (2004). Region Office for Africa, *Maternal Mortality Threatens Africa's post Independence Socio-Economic Gains*: Geneva. World Health Organization World Health Organization

WHO and UNICEF(1996). Revised 2010 Estimates of Maternal Mortality; a New Approach by WHO and UNICEF. Geneva: WHO

WHO(1978). Alma – Ata Primary Health Care: A Joint Report. Geneva. New York.

World Bank(1998). World Development Indicators. Washington D. C. World Bank.

World Health Development Report(2005). *Workers in an Integrating World*, World Bank, Oxford University Press.
World Health Organisation(WHO). United National Children's Fund (UNICEF), and United Nations Population Fund (UNFPA) (2010). *Maternal Mortality in 1995: Estimates.* WHO, UNICEF and UNFPA Geneva: WHO.