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Human dignity for youth and women

Reproductive health care practices in Nigeria

topics:

- *traditional culture and fertility-patterns in Nigeria*
- *traditional and modern forms of maternal health care*
- *challenges for pastoral care in Nigeria*

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Introduction

Continued high fertility is recorded in Sub-Saharan Africa. Groups cover this area whose culture places a high premium on the child. A common greeting in West Africa „How are the children?“ which is a reference to the child and acknowledgement that the function of procreation is fundamental to identity definition in adulthood.

Renne (1995) emphasised that the importance of preservation of family name, lineage, a share in ownership of family and kin compounds, farmlands perpetuate the desire of people to have many children. Polygamous marriages make such competitions fierce in many places. The need for male issues to preserve continuity of patrilineal descent groups heightens the problem of persistent high fertility (Olusanya, 1989). Family owned houses and land continue to represent family political vitality in rural places, village or indigenous areas. They also serve as a means of economic commitment to a community, and a safety net for family members resident in urban and other areas, when there is failure in the economic activities they are engaged in (Berry, 1985). In the recent Nigerian experience of economic hardship many families relocated to the villages or segregated into sending all or some of the children and their mothers to the family homes, while the father alone or with the mother endure the hustle for survival in the urban areas. High fertility therefore remains critical in securing land tenure rights and engaging in economic activity in such lands, prospective old age income security encourages the desire to have many children, especially in a region of high infant mortality thus there continues to exist several persuasive economic and cultural reasons why people desire many children in the Nigerian and West African context (Renne. 1995).

The average number of children desired by Nigerian families has remained 6.7 for over four decades (Oppong, 1989; Kalu, 1987; Aryee, 1989). Thus women with an average life span of 50 spend majority of their years between 15 and 50, con-

ceiving, carrying, delivering and suckling infants (Ware, 1983). Women expect to spend 20 years of their lives bearing a child every third or fourth year. Women between 20 – 45 years of age are therefore subject to the continual stresses of heavy reproductive and productive schedules. Maternal mortality is high and these women who survive to 50 years bear children through their 40's (Oppong, 1989). Studies in developing countries (Pebley and Millman, 1987; Omran 1987) also show a high infant mortality in Sub-Saharan Africa, and the fact that children are more likely to die if they were born less than 2 years after a previous birth, too early/too late in the mother's life span, rather than if they were born after a longer interval. These mothers are also placed at risk. Thus there is a linkage between maternal mortality and infant mortality. It is estimated that 75 000 Nigerian women die in pregnancy and childbirth every year, that is one death every 10 minutes. For every woman that dies 20 more are disabled or health impaired as a result of childbirth, an estimate of 1.5 million. A Nigerian woman therefore has one in twenty one chances of dying in pregnancy, and faces this situation about six or seven times in her lifetime. The chances are estimated at one in 10 000 for a woman in Europe or North America (Kisekka, 1990). Where the woman in Nigeria is illiterate, malnourished, and poor or has had more than four births rapidly, the chances of death and deformity are more. Where she is under 18 or over 35 years old these chances are worsened (Kisekka, 1990; Harrison, 1990).

Health factors related to women make the issue of high fertility a great concern in west Africa and Nigeria. Risks, physiological stress and health practices accorded to the pregnant woman need to be examined to understand underlying forces, influences and consequences that continue to impact on a Nigerian woman of reproductive age. This paper focuses on these and highlights ways in which situations constitute violation o the human dignity of women, both youth and adults.

Statement of the problem

The persistence of high fertility and the attendant maternal and infant mortality is considered a complex problem, a combination of several factors. The fact that it is protracted even though awareness and consciousness have been raised about it within the last decade makes it a culprit of human dignity violation. Rudimentary health measures have been identified as solutions. These have neither been properly undertaken nor have some of the reasons for high fertility been given intense scrutiny. Major factors that influence fertility include economic, political, social, technological, cultural, religious and psychological. These also influence healthcare practices and service delivery. Some influence can be negative in the sense that they constitute threats to human or female reproductive well being and rights. A particular focus of this paper is to highlight the role of religious and cultural factors.

Traditional culture and fertility

The concepts of reproduction and fertility speak of fruitfulness and multiplication. These are concepts many nations and societies can identify with, especially agricultural groups. In traditional Africa, reproduction and fertility or procreation are associated to life giving functions. Thus, barrenness or involuntary childlessness is a reproach. There is a plethora of fertility gods and goddesses worshipped throughout the land of Africa and in Nigeria. Fertility gods are the

throughout the land of Africa and in Nigeria. Fertility gods are the most common class of gods. Some fertility gods especially water based deities are pantheon gods. They receive elaborate worship with well-marked festivals or a season of rituals, sacrifices, and celebrations in various parts of the country. They are covenant gods of various communities and families. Male priests or female priestesses lead worship. The altars and shrines are located in mountaintops, near or inside streams, rivers, sea and pools of water. Apart from receiving wide based worship in the population, there are additional dedications of children and youth to these fertility gods as offerings for childbearing, fulfilment of requests or as part of a particular generational covenant. Specific families in their generations are dedicated to their service or serve as custodians of the worship places. With the spread of influence of these gods, indigenous churches are located often near waters, with a local Nigerian reference as "waterside" churches.

Thus most families in Africa and in Nigeria have some ancestral linkage or tradition of relationship to fertility gods. A number of rites in childhood especially at puberty are an acknowledgement of fertility god relationships. Many puberty, maiden dances are fertility dances and are sexual in orientation. Fertility and sexuality are sacred! This limitation of sexual activities in many African communities is hindered by these spiritual influences and by a sense of tampering with the works or blessings of the gods. Most rural couples when confronted with the need to control birth respond that their children are blessings of the gods and they cannot reject what they are given by the gods. Carvings and representation of fertility gods called fertility dolls abound in West Africa.

In such an atmosphere filled with fertility consciousness, worship and sacredness, young girls and boys become interested in active sexual life, even where male-female sexual relationships are not openly discussed in parent-child interactions. A study in Nigeria found that half of female students at both secondary and university levels have been pregnant at one point and have terminated their pregnancies. In a five-year review of patients treated for illegal abortion in the Lagos University Teaching Hospital, about 90% of them were unmarried adolescents (Nichols, Ladipo, Paxman, Otolorin, 1986). Abortion is widely practised and has often resulted in untimely death among the adolescents.

Safe motherhood and maternal health

In a culture of strong tradition in kin relationship and supportive network, even in the midst of rapid urbanisation, migration and mobility, the prevalence of motherless babies homes constitute an embarrassment. It testifies of a failure in the system that has not been adequately dealt with. Motherless babies homes serve babies whose mothers died in childbirth. Fertility gods worship explain some of the causes as a punishment of unconfessed sexual infidelity of a woman, violation of sexual or other covenant requisites and taboos. There are explanations covering the anger of the gods (Kalu, 1992). Thus such women are often deprived of the usual lavish funerals. They may be hurriedly buried and their husbands remarry within a year.

Their new-born babies are sometimes considered sources of curses for those undertaking to care for them in the household. The infants may be exposed to enough carelessness that leads to their deaths. Even when placed in homes, they may remain without visits from family members and fathers (Kalu, 1990). Motherless babies homes also serve infants who are abandoned in hospitals, roadsides,

bushes or places where they are expected to die from exposure. They are placed in such homes when rescued. These unwanted babies are products of unwanted pregnancies from unmarried mothers who may have other children already kept with families in the villages, or adolescents who want to continue attempts to etch out a living without the additional burden of premature parenthood.

These homes therefore expose some of the negative elements of fertility worship, cultural emphasis and the influence on reproductive health. A spectrum of problems are known to lead to the death of Nigerian women at childbirth but many communities remain silent about them, largely restricted by religious beliefs. Meanwhile, there is no evidence of postnatal treatment or health care for the mothers of abandoned newly born infants who simply disappear. There is no hesitation in adoption of such infants from Motherless babies homes (Kalu, 1992).

Awareness on reproductive health care practices within the last decade led to the concern for maternal health or safe motherhood. Safe motherhood describes pregnancy, birth and infant care activities where the mother's health is safeguarded. The discussions focus on the health culture surrounding pregnancy and childbirth. The emphasis is on reduction or elimination of risk of damage or death in women who are in the process of having children they want or avoiding having children they do not want (Ilumoka, 1990). Safe motherhood generally is linked to three main factors:

- Provision of basic professional ante-natal care and contraceptive technology.
- General living standards and health practices.
- Establishment of measures that ensure effective and immediate treatment is given, including operative intervention, when major complications develop in antenatal, delivery and postnatal care (Harrison, 1990b).

Without adequate provisions in these areas, motherhood is unsafe. A good measure of these provisions can be made available to women by the combined efforts of willing groups and government. Harrison (1990b) explains that current statistics on maternal mortality in Africa (6.4 per 1000 births) is what was obtainable in Europe in the 17th and 18th century. There are midwives in Europe today who have never seen a maternal death in over 20 years of practice, while this is close to a fortnightly or monthly occurrence in the practice of Nigerian midwives. He therefore considers maternal deaths as the best indicator of the standard of health care, social, economic, and political development. The disparity in socio-economic or health indicators between the least and worse affected places in the world sum the situation. In all places of high maternal morbidity, more than 80% of fatalities occur in the presence of eight (8) pregnancy complications. These are anaemia, abortion, ecclampsia, haemorrhage, infection, obstructed labour and its consequences, effects of abdominal deliveries and overriding influence of harsh conditions of living when pregnant. Such conditions of living include looking for water, working and walking for long hours, distances, under the hot sun, meagre and undernourishing meals, strenuous child and home care chores, little or no medical attention and physical rest. These are familiar features of economically troubled, deprived areas of Sub-Saharan Africa.

Case of Mrs. C

Mrs. C. was a young mother in her late thirties. She had five children and died during the delivery of the sixth child. The family lived in a two-room accommodation in the town. She had intermittently attended an antenatal clinic, but had taken care of her health based on the experiences of earlier pregnancies. Her husband is a low paid salary worker. With three of the children in secondary schools, she had to expand her trading activities in the market in order to procure enough income to pay for school fees, food and home bills. Her labour started on the expected date. She presented herself as someone in good health and expectant of the new baby several days before the delivery. At the onset of her labour in the early hours of the evening, the husband took the decision to send her to a trained birth attendant whose fees were low. When labour difficulties were presented she was transferred to a midwife. When the midwife could not handle it there was a search for a vehicle to transfer her to a doctor. The doctor did not have the equipment necessary. She needed a blood transfusion and an operation. On the way to a hospital that might of had the required facilities Mrs. C. died. She was unable to deliver the sixth baby.

Maternal health practices

Maternal health practices include those that deal with avoiding conception and those that deal with pregnancy and birth. They are practices and technology that are traditional African or Western medical based.

Traditional maternal health practices

Prevention of conception

Traditional Nigerian society has pronatalism as a cultural value. However, there is a specific interest in spacing birth and cessation of child bearing when the desired number of children has been reached. Thus there is a wide range of methods for achieving these objectives (Aryee, 1990). These include the use of: herbs / traditional chemicals / abstinence / coitus interruptus / douche / charms / amulets and belts worn around the waist / kin membership persuasion.

Failed contraceptive devices

Where the methods failed to prevent conception, other practices are brought into use. Some are mild while others are harsh. They include: abortion / infanticide (killing of deformed, disabled or ailing babies) / giving away children, to guardians or adoptive parents from the wider kin group.

Pregnancy care

Pregnancy care is the work of: older women / family / traditional herbalists / traditional priests / birth attendants.
The pregnant woman and the baby in the womb are considered vulnerable to spiritual influences and therefore certain rituals and observances must accompany whatever care they receive for protection. Depending on the pervasive beliefs in the area, many women would attempt to fulfil these religious requirements before attending to nutrition and other forms of care. Traditional birth attendants use a combination of ritual observances, pronouncements, and a choice of instruments,

herbs, and oil in the prenatal delivery and post delivery care of women. Older women and family members explain pregnancy ailments, advise on herbs, meals and activities, as well as enforce observances where possible. This way, the woman receives counselling and support. In the absence of this, the woman is left on her own to experiment on how best to take care of herself during pregnancy. Although fees may or may not be charged, gifts are expected to be given to such counsellors and birth attendants in accordance with the tradition for showing appreciation. There is no limit to the amount and types of gifts offered. But there are specifications on what is reasonable in communities. Some women therefore find the use of a conglomeration of priests, women counsellors and birth attendants' service ultimately more expensive than trips to a local clinic where this is available. Others may choose to use prayer houses of indigenous churches where prayer regimens are intended to ensure protection and safe delivery.

Postnatal care

Safe delivery calls for celebration from all women, family and neighbours, even in urban centres. This is in the form of visits, prayers of praise to God or the gods, songs, dances and use of the white chalk of victory. The woman is encouraged to rest, given herbal and peppery hot drinks and meals to aid internal and external healing recovery. She is attended to by those who cared for her during the antenatal period. She receives a special herbal wash, massage, use of a local girdle for the sagging stomach and dips in hot water or sleeping in hot rooms. Some of the latter have been known to lead to burns or worsen cardiac problems in these women with fragile health. Family encourages long term and intense breastfeeding, as well as observance of postpartum sexual abstinence rules in order to promote child spacing and safeguard health of the woman. Thus, in the absence of such as environment (which occurs in urban centres), there is an increase in frequency of conception.

Traditional maternal health practices have not yielded perfect results but remain widely practised in the Nigerian population. Where there are medical facilities like hospitals and clinics, some women combine these with some traditional services. Hostility between traditional birth attendants and midwives, the two main maternal health providers, may lead to the pressure to abandon one in favour of the other. There is evidence that traditional birth attendants do not recognise symptoms of pregnancy complications until they are severe. They are also not aware of the appropriate treatments. For example, they do not associate edema with blood pressure or ecclamptic fits. They attributed this to "bad blood, bad water, an indication of a big baby or baby's gender." They attribute convulsions in pregnancy to witchcraft and infidelity. However, their diagnosis causes with spiritual overtone women to prefer traditional treatments for pregnancy ailments instead of formal care. Their treatments include: appeasement of gods, use of a particular leaf juice in the eyes, nostrils, legs and mouth of the woman, herbs and holy water drinks and baths. (Okafor, Rizzuto, 1994).

Moreover, the choice of use of any or combinations of traditional maternal health practice depends on the husband in a culture where paternal authority prevails. Permission to change services or go to the hospital in the face of complications comes from the husband or husband's family as a last resort. Husbands therefore influence decisions on maternal health care to a great extent in Nigerian women (case of Mrs. C., Okafor and Rizzuto, 1994; Oppong, 1989; Kiseka, 1990). Where complications are not well-handled, they lead to diseases which impair fecundity. The observance of traditional postpartum abstinence period and long periods of

lactation (between 14 – 20 months), is largely dependent on husbands. (Oppong 1989) The degree of conjugal authority experienced by women is limited.

Formal medicine in maternal health practices.

Within formal medical practice, all levels of maternal health service delivery, prevention of conception, failed conception, pregnancy and postnatal care are handled by established institutions. They are: Hospitals / Primary health care centres / Private midwives clinics / Communal Antenatal clinics.

A wide range of trained and specialised personnel including doctors, nurses, attendants, technical staff, midwives and health care workers operates these.

Prevention of conception

A wide range of family planning technology which is common in Europe and N. America have recently within the last two decades been introduced with great intensity into Sub-Saharan Africa. In Nigeria and several West African countries government and communities have questioned the motives. The original objective to limit population and fertility was abandoned after a decade because it contends with basic beliefs on sacredness of fertility. The preferred concept of child spacing was adopted. However, the use of birth control devices in the population remains limited, often to educated men and women and to urban dwellers (Oppong, 1989, Maudlin and Segal, 1988). Studies found that most women in Sub-Saharan African countries do not know about these foreign contraceptive methods. Majorities of the women want more children. Thus 60% of contraceptive users are those who want to increase gaps between births (Oppong, 1989). Others express concern about the side effects like inter-menstrual bleeding and heavy menstrual flow. This for instance affects wifely services like cooking, a function which is a taboo to those menstruating in some groups. Some women also expressed fear of infertility and possible side effects of contraceptive use on future ability to conceive (Oppong and Abu, 1987). This fear has led to deliberate interruption of contraceptive use, resulting in unwanted pregnancy and causing an abortion. The most commonly used contraceptive devices in urban Nigeria are rhythm, pill, foam, vaginal tablets, condoms and withdrawal.

Pregnancy termination

Women and teenagers handle failed contraceptive use and unwanted pregnancies frequently through pregnancy termination. Abortion is legally restricted and so avoided by medical personnel and the hospital (Ilumoka, 1990). The Nigerian law allows for termination of pregnancy for the purpose of preserving or saving the life of a woman. Women practice self-induced abortions using drugs recommended through the grapevine or subject themselves to unqualified personnel who use dangerous instruments and often practice under aseptic conditions. Some doctors handle private and secret arrangements for abortion. They charge high fees because of the risks involved. Families who are desperate for a termination of an unwanted pregnancy seek out such services and the women involved have no protection when things go wrong.

Complications from spontaneous and illegal abortion are cited as among the most frequent reasons for hospitalisation of women and girls of the reproductive age (Oppong, 1989). There is a high level of sexual activity and abortion among teenagers for several reasons. These include limited information about safe contraception. The high birth rate leads to closeness in the ages of children. This means that many Nigerian families with limited incomes have to cope with provision, care

and education for four or more dependent youth at the same time. Adolescents may thus be sent to live with a relative as a house-help in exchange for education or skill training. Those who stay with their biological parents have to operate with meagre resources and so may share the limited clothes and school materials available with others. These teenagers therefore succumb to the lure of acquiring personal wardrobes in order to improve body and self-image. Thus, many young girls explore early sexual activity as an avenue to acquire material needs and money. Some move on to urban or international prostitution and use this revenue to support parents, siblings or help the family acquire property (Kalu, 2000). Young boys may join in illicit items: trading, and cults that specialise on extortion, violence and armed robbery in the society as well as educational institutions.

The culture frowns on young girls having children out of wedlock. They bring disgrace to the family name, ruin the chances of marriage for themselves and their sisters as well as opportunities for completion of their education. Thus, parents who want to protect the family name secretly encourage abortion of unwanted pregnancy in their teenage girls (Gyepi-Garbrah, 1985). Many young people simply see through the inconsistencies in family and societal beliefs on sexuality and the practices that prevail around them, and so exploit the situation. There are adult men who indulge in setting up young girls as mistresses. Unfortunately, these teenagers become vulnerable to problems of abortion and sexually transmitted diseases.

Pregnancy and post natal care

Hospitals and midwives clinics provide pre-natal care for many Nigerian women. Many seek these services two to eight months into the pregnancy and often out of fear of not being eligible for emergency treatment when necessary, because they are unregistered. Trained personnel and use of appropriate equipment lend to efficient services. However, long periods of difficulties in the country have left many clinics and hospitals with inadequate and malfunctioning equipment. Women who seek the services complain of perennial shortage of drugs, and high cost of drugs where available. Transportation may be expensive and there are crowded conditions coupled with long waiting hours at the clinic. They face harsh bureaucracy in service delivery. In addition, they consider many nurses and midwives impersonal, and hostile. They are often publicly scolded, humiliated where they do not follow instructions, have the information necessary at intake interviews, have money to pay for the drugs or bring all the required items for the delivery. They are neither told their rights nor the expectations from them. They are not allowed to pay the fees charged by instalment. Comparatively, the traditional birth attendants are seen to be friendly and kind enough to allow fees payment instalmentally. (Okafor and Rizzuto, 1994)

However, most women are aware of the fact that traditional birth attendant's use rusted or dirty instruments, poor hygiene practices, are medically weak and therefore transfer patients to midwives where there are delivery complications, like retained placenta and haemorrhage. They may also lie on bare floors at delivery. They are therefore willing to bear ill treatment for the sake of safety and relative comfort in order to be delivered by midwives at clinics and hospitals. Where government hospitals are not well-equipped women at delivery may be presented with an extensive list of things to supply like soap, dressings, infusion sets and liquids and surgical gloves. Hospitals may demand some payment before certain services are provided. Thus the period of delivery may constitute a harrowing experience for women.

Hospitals and clinics however tend to give women necessary information on life style changes, hygiene, nutrition, personal and baby health care that facilitates maternal health. Antenatal care has been associated with a 22-fold decrease in maternal mortality rate, 7-fold decrease in perinatal mortality rate and a 3-fold decrease in the proportion of babies of low birth weight in Nigeria (Harrison, 1990b).

Early teenage pregnant women

Early teenage pregnant women are found in various portions throughout the Nigerian society. They come from affluent and impoverished groups. There are some key reasons for the existence of early teenage pregnant women. These are religious, socio-cultural and economic reasons. Religious socio-cultural institutions in the Northern and other parts of Nigeria support early adolescent marriages, between 10 to 17 years of age. Household surveys of a sample of 878 married Muslim women in villages about 80 kilometres from a major national Teaching Hospital, revealed that 86% were illiterates and 44% engaged in income earning activities by using their children as intermediaries because they can only leave the compound with the approval of their husbands. Over 54% had their first pregnancy between 15 to 16 years of age and about 75% when they were 14 to 17 years of age. About 14% married at the age of 12 or below and 58% at 13 and 14 years. In this sample only 41% reported prenatal clinic attendance and 20% delivered in a hospital (Kisekka, 1990). Many reported going to hospitals only when there were delivery problems. Comparatively the mean age of delivery of first child in the Southern parts of the country is 21.4 (Kalu, 1987).

Teenage pregnant women therefore swell the number of unbooked pregnant women given emergency admission into the hospital. The mortality rate is high (29 per 1000) because of arrival at hospitals in serious conditions. The diagnosis takes some time to determine (Harrison, 1990). Harrison (1990) also found that an impoverished group of early teenage pregnant women suffered high rates of problems of eclampsia, anaemia, operative delivery, obstructed labour, obstetric fistulae (VVF) and foetal loss. When some of these women were given malaria and anaemia prevention treatment together with antenatal care, they grew faster with growth spurts of 2 cm and 16 cm, and childbirth became safer with a reduction in delivery problems. Thus, early marriage and the effect of poor economic conditions on lifestyle and nutrition, rob a considerable proportion of teenage women of the rights to growth and development, education and safe motherhood.

There are also early teenage pregnancies that occur from the vulnerabilities in child labour, especially street trading. Young girls are sexually assaulted (Akao, 1995). Street trading by youth is a means of family survival for most Nigerians (Kalu, 2000).

Some societal remedies for safe motherhood and maternal dignity

In the comparison of pregnancy outcomes with and without antenatal care, antenatal care was associated with a 22 fold decrease in maternal mortality rate and a 7 fold decrease in perinatal mortality rate (Harrison, 1990b). The rates are comparable to current European figures. Choice of antenatal care services has been associated with education in women and improved incomes or standard of living (Oppong, 1989, Kisekka, 1990). National Policy on population for development sup-

ports this and the fixing of an optimum number of children for women (Ilumoka, 1990). Antenatal care practices should therefore be encouraged especially by primary health care workers throughout the country.

The delay in treatment can be reduced with improved levels of development in terms of roads, telephones, power, water supplies, ambulances, high maintenance culture of hospital – clinic infrastructure, managerial and technological competence and well paid trained staff (Harrison, 1990b). Reform in abortion laws has been advocated toward criminalisation and not total deregulation. This will regulate the practice of abortion in the interest of women's health, eliminating procedures that lead to dangerous abortion.

There is need for bold steps to be taken in articulating aspects of socio-cultural beliefs and institutions that are detrimental to the dignity of women and maternal health practices in the country. Some of these are: husband dominance, that leads to male control of use of family planning, thus the psychological dependence of married women on their husbands for health practises. Such a relationship is deliberately cultivated in the marriage of young girls to much older men, whom they have to give the traditional respect of a father. Such psychological dependence makes women timid and unable to take decisions in emergencies. A combination of psychological and economic dependence also tends to restrict freedom of expression and ability to articulate problems properly at hospitals and clinics. The restrictions on money received from the husband and the absence of the woman's own income put several women under great stress where medical bills are concerned. Thus in the attempt to be silent over several issues, many women expose themselves to indignities in maternal health practices and mortality. These situations must be continuously publicised and discussed in health forums and the mass media.

Socio-cultural dictates on heirship and inheritance of land puts pressure on women to have male issues. Many Nigerian women want more than one male issue. The result is excessive childbearing and the risks involved in deliveries under traditional birth attendants. Planned Parenthood Federation of Nigeria (PPFN) posters and jingles encourage education of women. The implementation of appropriate plans by the government will ensure increase in women's income earnings and ability to utilise the system to address property, widowhood and other issues (Kalu, 1989).

The continued use of the traditional birth attendants is encouraged by World Health Organisation as a means of alternative medical practice. The level of training given to them does not qualify them to be considered as trained personnel. Their level of understanding of issues is low and proper midwifery training is intensive. Harrison (1990b) notes that schemes for their retraining started as far back as 1904 in India and 1921 in the Sudan. These schemes have led to a reduction in deaths from neonatal tetanus but not in overall maternal mortality. In addition, they still make referrals to midwives. Thus an increase in Primary Health Centres across the nation accompanied by intense health education campaigns by their workers on antenatal care and pregnancy complications would provide an acceptable alternative. Existing traditional health attendants should be allowed to practice only after having gone through extensive traditional birth and medical training and have their premises linked to clinics and hospitals approved by government public health officials. Their use must be gradually discouraged through effective medical health service deliveries to pregnant women. Women organisations throughout the country must devote time to seminars and information blitz,

targeting rural and urban women, teenagers, on responsible parenthood, safe motherhood practices, dangerous abortions, and signs of pregnancy complications. They must work to encourage female school enrolment and educational attainments as well as help to dispel misconceptions on family planning methods. They can also give pregnant women substantial support (financial) to enable them relieve them of heavy workloads during pregnancy and to assist them seek medical help promptly. Women must be educated on how to handle hostile medical and paramedical personnel and understand their rights to handle their bodies and to conduct their affairs with dignity. Women organisations in the country have also begun to establish centres for pregnant and nursing teenagers that encourage them to return to school and complete their education.

Pastoral care challenges

Some of the indignities of maternal health practice can be handled within structures that exist in Nigerian churches. For instance, Christian education programs have family emphasis week and couples forum, where education in maternal health can take place and childbearing issues can be discussed. Churchwomen wings can establish funds for assistance to impoverished pregnant women to enable them attend clinics and buy drugs. Some mother's day celebration themes can focus on safe motherhood, family planning, and education of women. Churchwomen can effectively influence and supervise women's health-seeking behaviour in the course of pastoral visits.

Youth and young girls group meetings serve as context for education on problems of early marriage, teenage pregnancies and unsafe abortions, utilising nurses and medical personnel in the church membership. This will expand their educational activities beyond homemaker and childcare training and make them relevant to current societal changes.

Pastoral counselling services in the church must be backed by the acquisition of leaflets, fact sheets, and magazines, books and materials that provide information on nutrition, fertility and maternal care practices. This should be made available to membership and wide readership encouraged. Church workers and representatives must be sponsored to attend community – wide based health education programs. The church continues to receive encouragement on rediscovering elements of African culture, which are not in opposition to the gospel. It must not however, shy away from discussions on negative elements of traditional practices that impact on family and marriage life. It must sensitise members on vulnerabilities of women and youth as well as document pregnancy problems in order to get adequately involved in safe motherhood projects in the community.

Conclusion

There is a general need to raise awareness and sensitisation of Nigerian population and societal institutions to new heights that would assist the break with negative maternal health practices. The importance of women education and the connectedness of maternal mortality to cultural practices, poverty alleviation, and communal health programs and facilities need to be reassessed. Community and church leaders need to document problems in order to exercise pressure on officials for a change. Current practices in maternal health have often violated women

rights to life, personal liberty, and dignity. Nigerian women have faced great distress, embarrassment and sometimes harrowing experiences in the course of childbearing and yet have been unable to deal spiritually and physically with affinity to fertility and the risks involved. Women need to become watchdogs on policy change and implementation programs.

References

Akao, A (1995) "Oju Ina's game of shame". *Women Rights Monitor vol. 1*, 2, 16 – 18.

Anozie, G. (1990) "75 000 Nigerian women die yearly in pregnancy". *Classique*, July 9, p. 14.

Aryee, A.F. (1989) "Socio-cultural policies and programs for efficient family planning in Africa". In *Developments in Family Planning Policies and Programs in Africa*; Proceedings of Colloquium on Family Planning Programs.

Berry, S. (1985) *Fathers Work for Their Sons: Accumulation, Mobility and Class Formation in an Extended Yoruba Community.* Berkely, Univ. of California press.

Gyepi-Garbrah, B. (1985) *Adolescent Fertility in sub-Saharan Africa*. Massachusetts. Pathfinder.

Harrison, K.A. (1990) *Maternal mortality in Nigeria*. Paper presented at the International Conference of the Society of Gynecology and Obstetrics of Nigeria, (SOGON) September, Abuja.

Harrison, K.A. (1990b) Safe Motherhood: Preparing for the 21st century. *The Guardian*, May 10, p.13.

Ilumoka, A. (1990) *Legal issues in maternal mortality*. Paper presented at the International Conference of the Society of Gynecology and Obstetrics of Nigeria. (SOGON) September 19, Abuja.

Kalu, W.J. (1987) "Childbearing experiences of contemporary Nigerian working mothers". *Women's Studies. International Forum 10*, 2, 141 – 156.

Kalu, W.J. (1989) "Widowhood and its process in Contemporary African society: A Psychosocial study". *Counselling Psychology Quarterly 2*, 143 – 152.

Kalu, W.J. (1990) *Responsible parenthood: Issues in fertility of the Nigerian woman*. Unpublished manuscript.

Kalu, W.J. (1992) *Intervention work with infants in long-term institutional care in Nigeria*. Unpublished manuscript.

Kalu, W.J. (2000) *Change and the family: The Nigerian experience, 1960-1999*. A paper presented at the International Conference of ICMIR, Berlin, Germany. May 7-10.

Kisekka, M.N. (1990) *Social Inequality, health and safe motherhood*. Paper presented at The International Conference of the Society of Gynecology and Obstetrics of Nigeria. (SOGON) September, Abuja.

Maudlin,W.P & S.J.Segal (1988) *World Trends in contraceptive use by Method and their relationship to Fertility*. Center for Policy Studies Working Papers,139.New York; The Population council.

Nichols, D., Ladipo, O.A., Paxman, J.M, Otolorin, E.O. (1986) "Sexual behaviour contraceptive practice and reproductive health among Nigerian adolescents". *Studies in Family Planning, 17*, 2, 100-106.

Okafor, C.B. and Rizzuto, R.R. (1994) "Women's and health-care providers' views on maternal practices and services in rural Nigeria". *Studies in Family Planning,* 25, 6, 353-361.

Olusanya, P.O. (1989) "Human reproduction in Africa: Fact, myth and the martyr syndrome". *Research for Development 6*, 64-67.

Omran,A.R.(1987) "Health aspects of family planning: The evidence from Africa". In A.R. Omran, J. Martin & B. Hamza(eds.) *High-risk mothers and newborns: Detection, Management and Prevention.* Thun: Otto Berlag. Pp 203 -210

Oppong, C. (1989) "Women's roles and gender issues in family planning in Africa". In *Developments in Family Planning Policies and Programs in Africa.* Proceedings of colloquium on Family Planning Programs in sub Saharan Africa. Legon, Univ. of Ghana.

Pebley, A.R and Milman, S. (1987) "Birth spacing and child survival". *International Family Planning Perspectives 12,3,* 71-79

Renne, E.P. (1995) "Houses, fertility, and the Nigerian land use Act". *Population and Development Review, 21*, 1, 113-125.

Ware, H. (1983) "Female and male life cycles". In C. Oppong (ed) *Female and Male in West Africa.* London, George Allen and Unwin.