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Chapter VIII

Women, Pregnancy Risks, and Birthing-Related Complications: Conversations with Traditional Birth Attendants (TBAs) in Nigeria

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Abstract

Although studies have shown sub-Saharan African traditional birth attendants (TBAs) to be quite aware of the hazardous nature of the periods of pregnancy and birthing, very little is known about their notions of pregnancy and birthing-related complications and of women at risk of such complications. The present paper reports the findings of a qualitative study of TBAs' constructions of obstetric complications and representations of women likely to suffer them. Traditional midwives have broad knowledge of obstetric complications and associate them with the socio-cultural and bodily realities of women. TBAs' notions of obstetric risks present an important entry point for programmes aiming to improve the role of indigenous health care providers in maternal and child health initiatives.

Keywords: TBAs, pregnancy and birthing-related complications, Nigeria

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Introduction

In the past three decades, considerable scholarly attention has beamed on the practice of traditional midwifery in the global south (Obermeyer, 2000; Walraven and Weeks, 1999; Izugbara and Ukwayi, 2003, 2004; Leferber and Voorhoever, 1997). This is not surprising. In spite of the widespread introduction of western medicine, the bulk (recent estimates say two-third) of births in southern countries continues to be managed and supervised by traditional birth attendants (TBAs) (Ramson and Yinger, 2002). Usually self-taught or informally trained, TBAs have been shown to not only attend to women throughout pregnancy, childbirth, and the post-partum period but also to be patronized by women and girls seeking abortion services and cures for infertility, sexually transmitted infections (STIs), and menstrual disorders, and also advice on the management of neo-natal conditions (Good, Hunter, Katz and Katz, 1979; Walraven and Weeks, 1999, Izugbara and Ukwayi, 2003, 2004).

Earlier studies of TBAs depicted them as a critical part of the problems of southern women. They were seen as providers who lack awareness of the hazardous nature of pregnancy and birthing, and who possess limited or insufficient knowledge to manage life-threatening complications or and prevent maternal mortality (Good, *etal*, 1979; Ityavyar, 1984; Iweze, 1983; Ibanga, 1992; Harrison, 1996; Igun, 1989). In sum, TBAs' old ways of supporting women were seen as crude and potentially dangerous to women's health. However, more current studies (such as those by Obermeyer, 2000, Walraven and Weeks, 1999; Leferber and Voorhoever, 1997) which favour direct examinations of the knowledge, beliefs, and practices of TBAs, and the firsthand articulation, by TBAs themselves, of their notions and views regarding pregnancy and birthing have consistently shown that the so called old ways of supporting women reflect an awareness, by TBAs, of the precarious nature of the periods of pregnancy and birthing. But not much is currently known about TBAs' representations of the specific complications that may occur during pregnancy and childbirthing, and their lay characterizations of women inclined to these complications. So far, only one anthropologist, Obermeyer (2000) has attempted to investigate lay notions of maternal complications (among Moroccan TBAs). But she admitted that when she directly asked her respondents what some of the problems or complications that occurred during pregnancy and labour were, she drew 'blank looks, polite excuses, and responses such as 'I don't know' or 'I haven't studied' '. She did not achieve much, not because the women were unable to conceive of risks. She underestimated the power of Islam; all she obtained were 'denials that there were ever any problems and reiterations that all was in the hand of Allah' (Obermeyer, 2000).

However, there is now emerging information to fill this yawning gap in the literature. The information comes from a recent qualitative research conducted among TBAs in rural southeastern Nigeria. In the study, TBAs were directly asked to explain what they thought were the complications that occurred during pregnancy and birthing and the categories of women they considered at risk of these complications, and very interesting narratives were elicited. Apart from coinciding with increasing anthropological interests in lay constructions of risks, the study has potentials to generate information that can direct maternal health agendas and ultimately improve policy for women in developing countries.

Women and Healthcare in Nigeria

Nigeria, the demographic giant of Africa lies in the west coast of the continent. The country has an estimated population of 130 million persons and a landmass of 923770 km^2. Nigeria's Gross National Product (GNP) currently stands at 770 USD and thirty-six percent of Nigerians live below the poverty line Access to safe water is only available to 44% of Nigerians while only 49% have access to sanitation. Women and girls comprise almost half of the population of Nigeria. Literacy rate among Nigerian women currently stands below 50 with only 29% and 26% of all current primary and secondary school enrolment being females. In Nigeria, poverty is higher among women. Only 48% of Nigerian women are in the labour force and they are found mainly in low income and unskilled professions.

Women's access to formal and quality healthcare services in Nigeria is quite low (Imogie, 2001). The two main providers of western biomedicine in Nigeria are the state and private medical entrepreneurs. The efforts of these providers are, however, concentrated in the urban areas where only about 40% of Nigerians live. Only about 2% of all formal healthcare services in Nigeria are located in the rural areas. Most Nigerians live in remote rural communities and geographical mobility is also difficult owing to intractable transportation problems (Izugbara, 2000d).

Alubo (1995) contends that most private medical establishments in Nigeria are poorly equipped. They often lack basic health equipment from sterilizing units to incubators. Private medical services in Nigeria are also quite expensive. Recent studies currently put the service charges of private medical establishments in Nigeria at 800 to 1500% higher than the rates in the public health sector (Alubo, 1990b, 1995; Amachuce, 1987; Jegede, 1997; Ekwempu, 1990). Research conducted in the 1990s shows that only about 4% of Nigerian women have any steady access to private medical care (Harrison, 1995, 2001). The services of private medical enterprises are often on a 'pay-before-service' or 'cash-and-carry' basis. Before the commencement of treatment, care-seekers are often required to make cash deposits. In Nigeria, there are several reports of people especially children and women dying at the doorsteps of private hospitals and clinics for not being able to met the initial deposit requirements or while their companions are still haggling over initial deposits. When such initial deposits are exhausted, treatment is frequently withheld and or patients held hostage until more payments are made (Alubo, 1995; Anonymous, 1984).

The Federal Ministry of Health and its agencies at various levels of government run the public health sector in Nigeria. Under-funding, maldistribution, and inefficiency currently characterize the Nigerian public health sector. Alubo (1995) reflects on the situation thus:

> Nigeria depends on imports for about 90% of medical supplies ... The availability of which is now rendered precarious because of foreign exchange difficulties and overall economic crisis ... There are (now) crippling and pervasive shortages of drugs and equipment and other basic essentials.

Government's response to the situation has been to rationalize and commercialize public health facilities. One result of this response is the introduction of high user-fees. This has had the effect of further constraining women's access to public health services. Shortages of basic essentials, the rise in the incidence of fake drugs, and the flight of formal service providers from government health establishments have further worsened matters in the sector, leading

to drastic loss of faith in public health facilities among Nigerians (Izugbara and Ukwayi, 2003; Alubo, 1990a, 1995; Imogie, 2001). Most skilled formal care providers are now in the private sector where better wages and service conditions are guaranteed. Negative attitudes of public health service providers towards patients, arising largely from frustration, lack of incentives, and inadequate materials to work with, as well as poor remuneration have also continued to constitute a disincentive to Nigerian peoples' use of public health facilities. Currently, only about 21% of Nigerian women go to public hospitals to deliver children or for other obstetric conditions. In a recent study, Asuquo et al. (2000) found the harsh attitudes of health staff in public hospitals to be the major reason for women not patronizing government hospitals for obstetric care (see also Etuk et al., 1999).

In Nigeria, itinerant medicine hawkers, injectionists, and patent medicine storekeepers are also common sources of healthcare. Iyun (1988) notes that these care providers administer or sell medicine in small quantities with very little regard for treatment procedures. Alubo (1985) observes that his category of care providers often administer injections on people for a fee, sometimes in buses, market places, streets, motor parks – with patients fully dressed. Ekwempu (1990) points out that Nigerians go to these informal service providers because of ignorance and illiteracy because of their low charge. A recent and study of the clientele of patent medicine stores in Nigeria has shown that poor women are their major users (Izugbara 2001b). Ukpong (2002) also shows that owing largely to distrust in public healthcare services, high cost of formal services, and lack of geographical access to modern health services, many women in Nigeria go to chemist shops to have births. Currently, injectionists, medicine hawkers and patent medicine stores are estimated to be the major source of healthcare for about several millions of Nigerians (Harrison, 2001; Stock, 1983; Ityavyar, 1984; Ibanga, 1992).

Spiritual healing involving laying of hands, holy water, oil, and prayer is also a prominent therapeutic option among Nigerians especially women. Uyanga (1979) notes that spiritual healing is sought by many Nigerians especially women. He writes:

> Healing services ... are always held on Fridays and or two evening during weekdays till late at night. Common at these services are prophecies, spiritualistic revelations, incantations, and speaking in (unknown) tongues, spiritual choruses, and shouting.

Alubo (1995) adds that spiritual healing also takes place during open-air rallies and crusades and those occasions are advertised in the mass media as opportunities for barren women to conceive, the bewitched to be freed, the blind to see, lame to walk, and demonized to be exorcised. Duke (2002) reports that about 80% of women presenting in *Tekewaris*, spiritual healing homes, among the Kalabari of Nigeria were women. Women have also been reported as the majority of those who seek healing in spiritual churches and centers in Lagos, Nigeria's most populous town (Adekunle, 1999).

Perhaps, the most popular source of health care among Nigerian women is traditional medicine (Izugbara, 2002a). Recent research shows that over half of the people in Nigeria rely steadily on indigenous treatments to meet health needs ranging from bone-setting to birthing (Imogie, 2001; Alakija, 2000; Onigar, 2000; Izugbara and Ukwayi, 2003).

Izugbara and Brown (2003) have uncovered also that formal health service providers in several hospitals in Nigeria often openly advise patients to seek traditional treatments when western medicine fails. Many Nigerians also actually believe that traditional medicine is

capable of curing all categories of diseases and misfortunes, including HIV/AIDS (Izugbara and Brown, 2003).

TBAs are one of the important indigenous health care providers in Nigeria (Ityavyar, 1999; Izugbara and Ukwayi, 2003, 2004; Izugbara, Etukudoh and Brown, 2004). Studies show that two-thirds of all births in rural Nigeria take place with the help of TBAs (Ransom and Yinger, 2002; PRB, 2002; Ityavyar, 1999). In Nigeria, TBAs do more than support women through pregnancy, childbirth, and the post- partum. They also provide services, ranging from child sex selection and abortion to family planning and cures for vaginal bleeding. The commonest type of TBAs in Nigeria is the full-time professional provider. She can be called upon by anyone and expects to be paid in cash or kind. Sometimes, she has a traditional birth house, where she receives and attends to her clients. In other instances, the TBA may be an elderly woman living next door, who does not make a living from her work but may receive a gift or token of appreciation. Or the TBA may be a family TBA who only delivers babies of her close relations. Most Nigerian TBAs have no links to formal health services (Izugbara and Ukwayi, 2003, 2004; Ityavyar, 1999). Also they are often women with very little or no formal education. Izugbara and Ukwayi (2003, 2004) argue that majority of TBAs in Nigeria lack any form of formal education. In one study, the age of TBAs in Nigeria averaged 61 and their length of professional practice 18 years (Izugbara and Ukwayi, 2004). Majority of Nigerian TBAs learn the work from their own mothers, mothers-in-law, friends, or close female relations. There are also those who are self-taught.

Owing primarily to their lack of formal health education, the potential of TBAs' to promote health and well-being among their clientele has received considerable scholarly attention. Many scholars have argued that the average southern TBA lacks awareness of the hazardous nature of birthing and pregnancy and can therefore do little to promote maternal health and survival. But, as earlier noted, recent research has shown that the low-level formal education of TBAs notwithstanding, they are often quite aware of the hazardous nature of pregnancy and birthing and also try to do something about it.

Although several studies have explored the ways in which the old practices of TBAs indicate an awareness of the potentially-risky nature of pregnancy and birthing, TBA's notions of the specific complications associated with pregnancy and birthing, and their characterizations of women at such risks remain largely unexplored. Consequently, questions about TBAs' perceptions of at-risk women and the complications likely to occur during pregnancy and birthing are currently difficult to answer. To this end, the present study pursues the following objectives:

i. to explore TBAs' views of potential complications in pregnancy and birthing
ii. to investigate TBAs' notions of the causes of complications during pregnancy and birthing, and
iii. to examine TBAs' characterizations of women at risk of complications during pregnancy and childbirthing.

The Research Process

The Study Sites and Sample

The study was carried out in four rural Ngwa-Igbo villages (Ntighauzor Amairi, Akpa Mbato, Ohanze Isiahia, and Abala Ibeme) in Obingwa Local Government Area (LGA) of Abia State, Nigeria. There is an average of 14,500 persons in each of these villages. Although predominantly Christians, there are a few animists in these communities. The inhabitants of the communities speak Ngwa-Igbo, which belongs to the Kwa sub-family. They are predominantly subsistence farmers involved in the production of maize, cassava, yam, cocoyam, palm produce, etc. Most people in the study communities are poor. They live in houses shared with livestock such as poultry, goats, sheep, etc. Modern healthcare facilities, such as well-equipped schools, good roads, postal services, electricity and modern communication services are absent. Their main sources of drinking water are rainwater, muddy streams, and open ponds.

The sample comprised 13 TBAs recruited through the help of key informants who were selected during initial visits to the study sites to build rapport with local people. The TBAs (all of whom were women) were met individually and interviewed. Information sought from them related to their views of risks associated with pregnancy and birthing, their notions of the causes of maternal complications, and their representations of women at risk of these complications.

Instruments and Analyses

The tool for data collection was a 27-point open-ended interview schedule validated by three university expert methodologists blind to one others' assessment. All the interviews were audio taped. As with most qualitative studies, the research generated copious body of descriptive data, which affords multiple thematization (Izugbara, 2004c, 2005b). Audiotapes were later transcribed into English with the help of the fieldworkers and six English-speaking Ngwa persons. Transcribed responses were then further examined for significant themes relating to the study objectives by a separate group of analysts, comprising the authors and two other anthropologists. The team of analysts wrote memos and notes, continually analysing the emerging themes for categories, properties, and linkages. The categories were contrasted with one another to ensure mutual exclusivity and specificity of the properties. Colleagues in the Faculty of Social Sciences, University of Uyo, Nigeria were also asked if our analysis rang true. Verbatim quotations of the TBAs on relevant themes and issues are cited to illustrate key ideas and points. Three limitations of the study should be noted here. First, the sample is rather too small, comprising only 13 TBAs. Two, the study is based on self-reported data, and thus subject to reporting errors. Three, the study does not cover how TBAs manage the complications associated with pregnancy and birthing, which suggests an area for further investigation.

Results

Characteristics of TBAs

TBAs in the study were women ranging in age from 51 to 79. Their average age stood at 61 and they had an average of 18 years of practice. Sixty-nine percent of the TBAs learned the profession from their own mothers. Fifteen percent were taught by their mothers-in-law. One was taught by a friend and yet another was self taught. Only one of the TBAs has some formal education, completing primary schooling. The religious profile of the TBAs indicates that they were largely Catholics (30.7%) and Protestants (53.8%). Fifteen percent of the TBAs were, however animists. Nwaghghi (1996, 1996) estimates that there are more Protestants than Catholics in rural Abia State. He notes further that while there are hardly any Muslims in this area, a handful of animists can be readily found.

Most of the TBAs were currently married. Five of them were however widows. The TBAs also described themselves as farmers, housewives, housekeepers, and petty traders. All TBAs in the study claimed they deliver babies, provide ante and post natal care services, treat infertility in men and women, vaginal bleeding, miscarriages, STIs, and pregnancy-related morbidity. One of the TBAs told us:

> Women and girls come to me for several reasons; birthing, treatment for infertility, traditional family planning services, ante and post-natal services ... I also have male patients they come for many reasons. Some have weak erection. Some can't get their wives pregnant ... I treat them all ... it is my job; my mother taught me.

And yet another;

> While most of those who come to me are women and girls, boys and men also come to me for advice and treatment. I have personally treated several boys and men for *nsi nwanyi* gonorrhoea and *onwu amu*, penile weakness. I have learned to treat different kinds of diseases and to provide different kinds of reproductive care services.

Pregnancy and Childbearing as Perilous Missions

TBAs were agreed that pregnancy and childbirthing were potentially risky. The periods were believed to put women at the crossroads of life and death, and were described as 'journeys of uncertain outcomes', 'risky businesses', 'perilous tasks', 'hazardous jobs', etc. One TBA remarks:

> A pregnant woman is never sure of her status. She is half dead and half alive. The outcome of pregnancy is one thing no one can be certain about. A pregnancy may kill a woman, injure, or disable her. It may also be the basis of her survival, joy, happiness, and respect ... Childbearing is a very critical period ... during this period women have one leg in the world and the other in the grave.

Another notes,

> Just as men risk their lives climbing trees or fighting wars, women risk theirs during pregnancy and childbearing ... Childbearing is a big war. You may lose, win, get hurt, injured, killed etc.

The periods of pregnancy and birthing were depicted as the most risky periods of women's lives. TBAs could not imagine any other event that put women at greater risk. They believed that childbearing and pregnancy have always been risky for women and did not believe that it was possible to eradicate all the risks that go with these periods of women's lives. Most of the TBAs however wished that it were possible for all the risks, which face pregnancy and birthing women to be eradicated. They study participants did not believe that women's use of formal health services during periods of pregnancy and birthing will make these periods less risky pointing out that even in big hospitals women die during childbirth. We were told:

> Our own mothers faced risks and even had complications while pregnant or giving birth to us as did their own mothers while giving birth to them. It is the same with us, and our daughters may be no less different.

TBAs recognized pregnancy and childbearing as the basis of women's self-actualization and societal continuity, and associated them with women's role purpose and identity. Getting pregnant and bearing children successfully accorded women higher status, cultural value, and honour. TBAs argued that most things that bring joy to humans involved risks, hazards, and pains, and that joy and happiness often come when these risks and hazards are successfully negotiated. This was how one of the TBAs put it;

> Take a close look at life generally; you will see that nothing good comes easy. It is there in marriage. When a man marries, he is not sure that his wife will give him children, until she comes into the house. If you plant your crop, you can't be sure it will do well until harvest time. It is also the case with pregnancy ... its outcomes are very uncertain.

Another said;

> Life is itself a risk. You can only control what you can, not the ones you cannot. The periods of pregnancy and childbearing are hazardous but what can we do? ... We do our best, but humans are not God ...

Maternal complications were framed in terms of the negative outcomes that can result from pregnancy and child bearing, and TBAs tended to see these periods as inevitably risky. 'Everything we do on earth is full of risks, why should the periods of pregnancy and childbearing be different?' queried one of the oldest TBAs in the study.

The TBAs argued that pregnancy and childbirthing were not themselves threats to women's life and health. They were in fact viewed as good and desirable, and only made hazardous by the conditions surrounding them. These critical conditions could be supernatural, natural, hereditary, biological, or situational.

Supernatural factors likely to cause complications during pregnancy and childbirthing were said to include witchcraft (*nsi*), spells (*ani*), curses (*ivu onu* or *igba akwukwa*), and falsely swearing to oaths (*idu isi ugha*). Others include infraction of taboos (*iru ala*), being

disobedient to one's husband, elders, or and parents, extramarital sexual affairs (*ikwa iko*), and involvement in witchcraft (*igwo nsi*). TBAs noted that witches and wizards (*ndi nsi*) possess special powers and can use such powers to visit problems and complications on women during pregnancy and childbirthing. Witches and wizards can also cast spells on women to make them experience difficulties or even die during pregnancy and childbearing. Curses pronounced against women can also be a source of risk during pregnancy and childbirthing. We were told;

> If her father or mother or an elder curses a young girl, it may work against her during pregnancy or childbirthing. If my daughter offends me and I say, 'you bad girl, you will die during childbirth or you bad girl you will suffer in this world ...' it will certainly work. Curses are bad. That's why good parents don't curse their children ... Curses are powerful especially when pronounced by elderly people that one has truly or actually offended.

Respondents also mentioned that evil children (*umu ojoo* or *ogbanje*) occasionally find their way into women's womb to cause them problems. Such children, often from the spirit world (*ala mmuo*) may be on a special mission to kill, torture, or cause complications for these women. Witches, wizards, and evil spirits (*umu mmuo*) were sometimes responsible for sending such children into women's womb. It was also believed that some women are linked to the world of spirits as wives of deities, spirit beings, or other godlings. When such women get married to humans, the spirits get envious and may wait until when they are pregnant to seek revenge. Often, such women die at childbirth.

According to the TBAs, maternal complications can also result from natural events such as lack of rest, poor nutrition, violence against women, excessive use of alcohol, excessive use of western medicine, poor personal hygiene, falls, malaria, and carelessness. Women's biological characteristics could also put them at risk during pregnancy and birthing. Smallness of the womb and vagina, and shortness of height were the frequently mentioned biological characteristics that put women at risks during pregnancy and childbearing.

It was also observed that some of the complications women suffer during pregnancy and birthing were inherited. Some health conditions were believed to run in some families and were transferable from parents to offspring. One TBA gave us her personal insight thus;

> There are maternal complications that run among women from particular families ... I know of a family in which the women often have problems expelling the placenta. Any woman from that family is at risk of this problem during childbirth.

TBAs also noted the place of birthing and the people who attend to women during deliveries may be potential sources of complications. Home deliveries were viewed as generally safer because they had more secrecy surrounding them. Hospital births were viewed as potentially dangerous as they exposed women to several strangers whose motives may be difficult to determine. We were told;

> Most of the women that I attend to are from this village. They know me and I'm trusted ... I know their families and I am careful not to fail them. I give them prompt attention. When it is birthing time, I am careful not to fail them. I also make sure they deliver without being exposed to several persons. If several persons are present when birthing is

> going, it is difficult to control the outcome ... I tell you if somebody crosses her/his leg near a woman in labour. She will have prolonged turbulent labour... In the hospitals, all kinds of strangers attend to women. You don't know who is a witch or wizard. They may appear to be helping the woman but may have other motives. It happens ... that's why many women die in hospitals while giving birth ...

Another TBA similarly notes,

> Pregnancy is a precarious thing. It can take the life of a woman. So care is needed in handling it. It is not just everybody that should touch a woman's stomach when she is pregnant and it is not just everybody that should come in when birthing in going on. In the hospitals, women are exposed to all kinds of people especially strangers and they can harm them under the pretext of helping them. The nurses or doctors that examine them are always strangers. Yet you don't know what they (nurses or doctors) have in their bodies. Some of them carry charms that are hazardous to pregnant women.

TBAs believed that complications caused by natural event can be managed in hospitals and also by TBAs, but that only traditional practitioners knew how complications caused by heredity and supernatural factors can be successfully managed. This, according to the TBAs was because hospitals do not believe in supernatural factors and cannot therefore do anything about them.

Constructing Complications: Hazards in Pregnancy and Birthing

What are the complications that can occur during pregnancy and childbirthing? TBAs' responses to the above question indicate their high-level awareness of complications during the periods of pregnancy and birthing. The most frequently mentioned complications associated with these periods were, miscarriage, premature labour, prolonged or obstructed labour, vaginal bleeding (post partum hemorrhage), *nnojo nwa* (wrong positioning of the fetus), retention of the placenta, and *otila ure* (vaginal decay, sepsis?). The complications were viewed as potentially dangerous for the lives of women and the babies. One of the TBAs observed;

> Pregnant women are prone to a number of complications: she may suffer a miscarriage, labour may begin long before it is expected and she may have a premature baby ... The labour may also come on time but may be prolonged, sometimes lasting for days. This often leaves the women exhausted and she may not be able to push the baby out. This can kill her and her baby.

TBAs believed that miscarriages (*ime ikwe*) can occur at any time of the pregnancy, and described it in terms of sudden loss of pregnancy. Miscarriages were associated with heavy loss of blood, which can kill women. 'When a pregnancy has refused to stay', a TBA told us, 'blood of both the mother and foetus flows out through the vagina ... the women can lose too much blood and die ... blood is life. This can also cause her infertility'. The TBAs we interviewed agreed that the older a pregnancy, the more critical the effects of miscarriage

would be. Miscarriages occurring in early pregnancy were viewed as easier to survive and manage than ones occurring in late pregnancy. 'It is often not easy to survive miscarriages occurring from the fifth month of pregnancy ... it almost certainly kills women' observed one of the respondents. When questioned on the specific factors that can cause miscarriages, TBAs maintained that the causes were several and ranged from, eating certain foods, restlessness, doing strenuous work to accidents, heredity, and supernatural actors such as witchcraft and spells. Wrong positioning of fetuses, false swearing, poor nutrition, sex during pregnancy, curses, heredity, and violence against women were also mentioned as potential causes of miscarriages. We were told;

> Miscarriages can be caused by several factors. It depends on the women. For some women, their own behaviours during pregnancy may be the cause. A woman who is beaten by his husband or has a fall may also suffer it. Witchcraft can also cause it as can eating certain types of food ... the causes are many.

Premature labour was viewed in terms of labour occurring earlier than usual. It was believed that labour should normally not occur until late into the eighth month. Premature labour was viewed as a critical complication in pregnancy that could result in the death of a woman and or the unborn child. Like miscarriage, premature labour was associated with too much hard work, excessive toiling, accidents, witchcraft, spells, evil spirits, infraction of local taboos, violence against women and heredity. Premature labour could result in miscarriages, stillbirth, and birth of pre-term babies.

Prolonged labour was another commonly mentioned complication in pregnancy. TBAs viewed it as a labour lasting longer than normal. 'If labour lasts too long and the baby does not come out, it is dangerous', offered one respondent. 'Labour shouldn't last a very long time', but when it does it is a problem', offered another. 'Well, I can't say this is how long labour shouldn't last but I always know when it is longer than necessary' observed yet another. One TBA puts it more succinctly;

> Labour normally means the baby is mature enough to come out. So nothing should keep it back. Some women have their babies very shortly after labour begins while for other it takes some further time. But there are situations where labour goes on even for days and the baby doesn't come out.

Prolonged labour can exhaust, kill, or hurt women. It was also believed to be capable of causing women disability. More often than not, argued the TBAs, prolonged labour leaves the baby dead, hurt, or disabled ... Frequently mentioned causes of prolonged labour included evil children, false swearing, wickedness, witchcraft, extramarital sexual relations, infraction of cultural taboos, and norms, poor nutrition, spells, wrong fetal positioning, smallness of the vagina, and curses. It was also believed that prolonged labour sometimes runs in some families. That is, that some women in some families normally have prolonged labour.

Vaginal bleeding, framed by the TBAs in terms of excessive and sometimes, prolonged bleeding following childbirthing was another critical complication associated with pregnancy. It was generally accepted that women should lose blood following birthing but that it should neither be excessive nor prolonged. 'In my many years of helping women deliver their babies, I have not seen a birth that is not followed by a flow of blood' offered a TBA, 'but sometimes, the flow of blood becomes dangerous in which case the woman loses so much

blood'. Excessive bleeding puts women at risk of losing so much blood and blood was viewed as the basis of life by the TBAs. One TBA recounted seeing a homebirth during which the woman fainted after losing so much blood. Bleeding could start during birthing, or even hours and days after birth. Excessive bleeding was believed to result from both supernatural and natural factors and heredity, as reported by this TBA:

> Excessive bleeding after childbirthing may have several causes. After birthing women should rest and keep their bodies warm. If you don't rest and you start working immediately bleeding can start. The things you eat after birth can also cause it. It can also result from internal wounds sustained during birthing. Witches and wizards, magical spells, and improper behaviours can cause it too.

Retention of the placenta after birthing was also viewed by TBAs to be ominous. The placenta, it was widely reported, should also be 'born' a short while after the baby. But sometimes, this fails to happen; the placenta fails to be expelled, staying back inside of the woman. TBAs believed that this could lead to the death of a woman, cause her to suffer vaginal bleeding. Etiological issues in placenta retention include, witchcraft, heredity, infraction of local taboos, poor nutrition and eating of tabooed food items during pregnancy, spells, false swearing, curses etc.

Other hazards associated with pregnancy and childbirthing include *otila ure* (vaginal decay, sepsis?), *ihe ido nwanyi* (convulsion), *Ajaka nwayi* (vesico vaginal fistula, VVF). *Otila ure* was associated with bad air entering a woman's body. Respondents argued that birthing opens up a woman's body, exposing it to bad air. *Otile ure* causes foul vaginal odour, and may result in death, or sickness. It was also believed to cause also infertility in women. *Ihe ido nwanyi* was associated with excessive bleeding, bad spirits, witchcraft, spells etc. *Ihe ido nwanyi* was believed to be a common risk faced by women during birthing or soon after it. *Ihe ido nwanyi* could result in deaths and stillbirths. It could also cause disability for women.

Ajaka nwanyi (vesico vaginal fistula) was described by the TBAs as a rare but potential hazard associated with birthing. TBAs associated the conditions with women giving birth for the first time. It was commonly associated with smallness of the pelvic and birth canal. Multiple births and very fat and large babies were also believed to cause the condition. Short women were a frequently mentioned at-risk group for the condition. The problem was believed to be caused by the dislocation of some vital internal organs especially, the urine bag during birthing as a result of prolonged labour, smallness of the vagina and pelvic, or and large-sized babies.

Ajaka nwanyi results in the sufferers' inability to hold urine, and could also cause infertility. TBAs generally described the condition as shameful and disgraceful and also believed that witchcraft, spells, and other supernatural factors might also cause it. *Nnojo nwa*, wrong fetal positioning was also mentioned as a pregnancy-related complication, and most of the TBAs said they had skills to properly position fetuses in the womb. *Nnojo nwa* was believed to cause miscarriage, stillbirth, preterm and prolonged/obstructed labour. It also causes excessive bleeding and could kill women.

Representing the Vulnerable: The at-Risk Woman

Who are the women at risk of pregnancy and birthing related complications? In the interviews with the TBAs, several categories of women were mentioned as being at risk of complications during pregnancy and birthing. The most commonly mentioned category of women at risk of complications during the periods of pregnancy and birthing were women from poor households, teenage mothers, women in communities where many witches and wizards live, women in abusive relationships, women who infract cultural norms, and women who do too much strenuous work during pregnancy or immediately after birthing. One TBA noted that although all women faced risks of complications during pregnancy and childbirthing, some were at greater risks than others. For her,

> Women in poor households who cannot feed adequately, do so much hard work even when they are pregnant or immediately after birthing, are frequently beaten by their husbands, and those in communities where there are several witches and wizards and wicked people such as, sorcerers, usually experience problems during the periods of pregnancy and birthing.

TBAs agreed that poverty often hindered women's ability to feed very well and thus their ability to withstand the rigours and hazards associated with the periods of pregnancy and birthing. Poverty also often forced women to work too hard during pregnancy or immediately after birthing thereby making 'their blood lighter' or 'their body weaker'. Women who were in physically-abusive relationship were also mentioned as vulnerable to complications during pregnancy and birthing. Beating of women was believed to cause stillbirths, premature and prolonged labour, and miscarriages.

Women who infract local cultural taboos by swearing false, engaging in extramarital sex, and or who eat what they are not expected to eat during pregnancy were also viewed as a high at- risk group for complications. We were told;

> Women who infract the norms of the land, are also often at risk ... A woman who sleeps with another man when her husband is alive, or swears falsely or insults her elders, or offends the gods in one way or the other can have problems during pregnancy and birthing. Also there are certain food items pregnant women should not eat ... women who eat everything they see, when they are pregnant are at risk of different problems.

TBAs also mentioned teenage mothers, short women, and women giving birth for the first time as other groups vulnerable to maternal complications. Teenage girls were believed to be physically unready for the rigours of pregnancy and childbearing. They were considered physically fragile. TBAs agreed that women needed to be biologically mature and ready before venturing into pregnancy and childbirthing. The womb, pelvic, birth canal etc were expected to be well developed, mature, and properly formed before pregnancy and birthing should occur. Getting a teenage girl pregnant was framed in terms of 'sending someone to war without equipping her properly' and was associated with stillbirths, miscarriages, premature and prolonged labour, bleeding, VVF, etc. TBAs believed that women who were very short and fat were also often at risk of complications during pregnancy and birthing. Short women were believed to have small pelvises, vaginas, and wombs, and thus often at risk of prolonged labour, VVF, stillbirths etc.

One of the TBA tells us;

> Tall and older women often have easier births. Tall women have wider birth canals, larger pelvises, and bigger wombs. They also often have more strength ... But short women often have small birth canals, pelvises, and wombs ... They find it harder to give birth ... and normally have complications ... Fat women often are not very strong ... they often do not have enough strength to push out babies ... many of them normally have prolonged labour.

Other categories of women viewed as being at risk of maternal complications include those from families with histories of maternal complications, women who maintain very low personal hygiene, who practise witchcraft, or did not have supportive kins or relatives. Others include women who took too much alcohol, gave birth at close intervals, and who used too much orthodox drugs. Women who regularly suffered malaria, married too early, did not have blessings of their parents, married against parental advice, and did not have their traditional marriage rites completed before moving to the house of their husbands were also frequently mentioned at risk groups.

Concluding Thoughts

This exploratory study investigated notions of maternal complications held by Nigerian TBAs. Due to issues of recruitment and sampling, the participants were not as diverse as we would have liked. There were only 13 TBAs recruited through the help of key informants in local villages. Further, the present study did not examine how TBAs manage or try to prevent maternal complications among their clientele. It only addressed TBAs' perspective of maternal complications and women prone to such. Yet, given the paucity of anthropological research on lay notions of maternal complications, the present study has shed some light on this under-explored problematic. But precisely what have we learnt from the study? Emerging from the study is evidence that local TBAs are not unaware of the hazardous nature of the periods of pregnancy and birthing. TBAs surveyed in the research viewed pregnancy and childbearing as risk-laden, and framed them as periods of uncertainties, during which women 'stand one leg in the grave and the other out of it'. They were clear on the fact that these periods were not themselves threats to the life and health of women. Pregnancy and childbearing were, in fact, viewed as good and desirable and only made hazardous by the circumstances and situations surrounding women. Izugbara (2000d, 2003c) suggests that their varying levels of development, notwithstanding, most human societies often have notions depicting pregnancy and birthing as precarious activities, indicating that ideas of obstetric risks are in no way a modern discovery. In her study among Moroccan TBAs and women, Obermeyer (2000) observed that they supported the opinions that 'during pregnancy women have one foot in the world and one in the other world' and that 'women's grave remained open for forty days after birthing'. In the expert public health discourse surrounding homebirths, TBAs are often depicted as providers who are ignorant of the hazardous and precarious nature of the periods of pregnancy and birthing. Yet in the present study, TBAs viewed the periods as risky, offered insights into specific maternal risks and hazards, and

analysed the scope, which biological, social, psychological, natural and mystical factors and conditions offer for the emergence of these risks.

Further, TBAs depict obstetric complications as inevitable. They believe that pregnancy and birthing were inherently risky. But they do not however believe that the outcomes of these periods were impossible to determine or control. As they clearly implied, pregnancy and birthing could be made safer for women if the different etiologies of material complications were addressed. They also wished all the risks in pregnancy and birthing can be addressed. In their narratives, TBAs mentioned women themselves, husbands, relatives, communities, health providers etc as key to the successful amelioration of obstetric risks. All these indicate high-level awareness among the TBAs regarding the considerable and multiple chances of obstetric complications as well as the need for a multi-pronged approach to the management and prevention of maternal risks. Their eloquently-expressed wish to see all maternal complications prevented offers a critical entry point for programmatic actions aimed at equipping them to be able to identify and manage pregnancy-and birthing-related complications.

Maternal complications identified by the TBAs are consistent with medico-epidemiological views. TBAs are aware of the common obstetric complications such as bleeding, placenta retention, labour problems, and VVF. They also mentioned wrong fetal positioning, stillbirths, miscarriages, vaginal decay, overdue pregnancy and eclampsia as other possible obstetric complications likely to be suffered by women. Indeed, the perspective of maternal complications addressed by the TBAs was broad, raising doubt over the correctness of the frequent depiction of lay notions of health issues as irrational. In the mainstream discourse on health risks, lay views tend to be depicted as incorrect and unscientific. Also hardly do they get acknowledged or mainstreamed in programmes. Good, et al (1979) argue that whereas current health initiatives often readily demonstrate the inappropriateness of specific traditional medical views, they hardly recognize that out of experience traditional medical practitioners are often able to develop formidable scientific knowledge of the nature of the human body and diseases. They argue that African traditional midwives, like other indigenous health practitioners in the continent exhibit a diverse complement of professional awareness which reflects ingenuity, trial and error experimentation, and the gradual but steady accumulation of empirical knowledge over time. We contend that this rich body of local empirical wisdom and knowledge, which ultimately becomes the basis of what anthropologists call lay expertise, is a resource that current initiatives need to harness to make motherhood safer for women in marginal areas of the world.

TBAs also advance a broader perspective of the sources of obstetric complications than is presently acknowledged in formal public health discourse. Their explanations of the causes of pregnancy and birthing outcomes encompass a focus on the socio-cultural, biological, supernatural, behavioural, and organic. These etiologies are not mutually exclusive. They overlap, reflecting TBAs' ability to generally recognize the interface between the outcome of pregnancy and birthing and women's day-to-day existential realities in a socio-cultural milieu. The potential of lay perceptions of risks to be inherently multidimensional and much more sensitive to the context and unique realities of at-risk groups has been noted in the literature. In defining lay risk perception, Pidgeon (1992) aptly sees it as 'people's beliefs, attitudes, judgments, and feelings as well as the wider social and cultural values and dispositions that people adopt toward hazards'. However, it often happens that formal notions

of risks are hierarchically placed above lay knowledge. The process by which clinical/epidemiological concepts of maternal risk came to overshadow lay notions of risks is a contested issue in the literature. It has been suggested that contemporary risk discourse is a struggle among rationality claims and thus a political process (Beck, 1992; Obermeyer, 2000; Izugbara, 2005B). The choice of a definition of risk can affect the outcome of policy debate, the allocation of value and safety measures, and even the distribution of political power. The ambivalence towards traditional health models and *de-jure* non-recognition of alternative health systems which modern medicine rationalizes through its own cult of science and professionalism can thus be seen as aimed at ensuring that resources and recognition flow in certain directions. But this cannot diminish the *de-facto* contributions of lay health etiologies and notions of health issues (Good, et al, 1979). Working to achieve a balance between lay perceptions and formal medical ideas of maternal complications should be the aim of current maternal health efforts directed at local southern people.

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