REPORT

OF

THE UNH4 2012 QUALITATIVE BASELINE AND GENDER NEEDS ASSESSMENT ON MATERNAL, CHILD AND NEWBORN HEALTH IN AKWA IBOM STATE, NIGERIA

1ST – 18TH JUNE, 2012

BY

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1.0 BACKGROUND STATEMENT ON AKWA IBOM STATE

Akwa Ibom State, created on Wednesday 23rd September, 1987 after 60 years of struggle, from 1927 to make it a social and political expression, is very rich in religious and cultural heritage as a way of life. Visitors to the State have often viewed its people as very honest, trustworthy and culturally homogenous. Long before the Rev. Hope M. Waddell arrived Calabar and commenced the Church of Scotland Mission (now The Presbyterian Church of Nigeria) in 1846 and which was later followed by the Rev. Samuel Alexander Bill's Qua Iboe Mission – an Offshoot of the same Scotland Mission in Qua Iboe River (or Estuary), the indigenes had already had a good notion of a Supreme Being who was worshipped in their native way known as Traditional Religion. Three types of religion are dominant in today's Akwa Ibom State following the 19th Century Missionary activities which are Christianity, Islam and Traditional Religion. Pockets of Judaism, Buddhism, Hinduism, Zoroastrianism, Shintoism and Confucianism can be felt but not widespread as the former. Infact, the name of the State itself is named after the Supreme Being – Abasi Ibom hence – Akwa Abasi Ibom State – as a reminiscence of their notion, believe and worship of this Supreme Being – God.

Akwa Ibom State is one of the States in the South-South Geo-Political Zone of Nigeria. It is bounded in the North by Abia State, in the South by the Atlantic Ocean, to the East, it is bounded by Cross River State and in the West by Rivers State. It has a landmass of 8,421 square kilometers.

POPULATION, GENDER AND HEALTH INDICATORS

With a population growth rate of 2.8 percent between 1952/53 and 1991 upto the 2006 census, Nigeria has one of the fastest population growth rates in the world. Essentially, population characteristics refer to the measurable

characteristics of the human population such as sex, age, literacy, religion, occupation and marital status. These characteristics, as is known, have bearing on regional or level of development of a state and or society.

Nigeria's socio-demographic indicators show that the population is young and the reproductive health (RH) indices are very poor; there is gender inequality, high poverty level and a generally pervasive gender based rating. Of the 8,421sq.km landmass, Akwa Ibom State has a population of 3,920,208 (2006 census figure). There is slightly more males than females at the ratio of 103 males to 100 females.

For Akwa Ibom State, as is the case with other States of Nigeria, four age groupings from our study and analysis of the 2006 population characteristics have been identified namely: infants aged 0–9; adolescents aged 10 – 19 yrs, adults aged 20-64 years and the aged 65 years and above. The first two groupings or classes 0 – 19 may actually be seen as the youthful population with high dependency burden on the 20–64 age bracket. The separation has been shown to highlight in greater detail the key component parts of the population as depicted in the table below:

Akwa Ibom State: **Population Distribution by Age Groups**

Age Group	Description	Percentage
0-9	Infants	35.67
10-19	Adolescents	24.08
20-64	Adults	36.29
65+	Aged	3.95
Total		**100.00**

These two sub-classes constitute approximately 60 percent of the entire population. To a large extent, this age bracket 0–19 years is both non-productive and non-reproductive and as such is dependent on the adult population 20 – 64 years which constitutes only 36.3 percent of the total population. As can be observed, the 20-64 years group is made up of the mature segment of the population in terms of administration, governance and economy. The aged, i.e. 65 years and above, form about 4 percent of the total population. This group also to a large extent is dependent on the adult group for sustenance.

Some 90% of Akwa Ibom people live in rural areas. The sentinel survey carried out in 2005 revealed a HIV/AIDs prevalent rate of 8%, ranking it second, after Benue State, in the country. About 75% of the State's population lives a life that is below the poverty line, inspite of government's uncommon transformation agenda.

In terms of the health indicators, it needs be noted that health is central to human development. It refers to the overall well-being of a given community. The provision of health care services is often regarded as a cardinal index of human development. Basically, the Nigerian health care policy recognizes three levels of health care which are the Primary Health Care (PHC), Secondary and Tertiary Health Cares. While the primary health care is the most popular since it involves the majority grassroots population, (i.e. local group), the Secondary and Tertiary levels lie with the State and Federal Governments respectively. For Akwa Ibom State, the Primary Health Care services are provided at Health Centres, Primary Health Centres, Comprehensive Health Centres, Community Health Centres, Health Posts and Clinics that are located in all the Senatorial Districts while Secondary and Tertiary Health Care services are provided in General, Cottage and Teaching

Hospitals found at Anua, (Uyo), Ituk Mbang (Uruan), Etinan, Eket, Oron, Ikot Ekpene and Abak while the Teaching Hospital is at the University of Uyo Teaching Hospital (UUTH), Uyo.

From the above, the Health indicators give a clear picture of the status of health in the State. Information obtained from the Ministry of Health provides the following health profile for the State.

Health Profile of Akwa Ibom State

Indicators	Rates
Population Doubling Time	25 Years
Crude Death Rate (CDR)	12 Per 1000 Population
Infant Mortality Rate (IMR)	67 Per 1000 live births
Under 5 years Mortality Rate	30 per 1000 population
Maternal Mortality Rate (MMR)	800 per 100,000 births
Total Fertility Rate (TFR)	6
Life Expectancy at Birth	54 years
Level of Maternal Malnutrition	7%
HIV Prevalence Rate	8%
Female Contraceptive Prevalence	4%
Access to Safe Water	23%

Source: AKSEEDS – MOH. Uyo.

Life expectancy at birth represents the average number of years a new born infant can be expected to live under current mortality levels. Infant Mortality Rate (IMR) is the annual number of deaths occurring to infants during the first year of life per 1000 live births. Total Fertility Rate (TFR) represents the average number of children a woman would have assuming

that current age specific birth rates remain constant throughout the childbearing year-usually ages between 15 and 49.

When compared with other cultures – especially advance cultures of the West - most of the health indicators in the table above depict very low health status. As opposed to 78 years in the West, the life expectancy in Nigeria and by extension Akwa Ibom State is 44 years, IMR at 100 per 1000 and a large number of all deaths in the State occur to children under 5 years of age with most of the deaths resulting from preventable and parasitic diseases.

Besides the health indicators shown above, often mentioned Disease classification in the State are infectious diseases, Neoplasm, Endocrine/immunity disorder, Diseases of the blood, mental disorder, diseases of nervous system, Diseases of circulatory system, diseases of Respiratory System, Diseases of Digestive System, Disease of Genito-urinary System, Pregnancy and Puerperium, Disease of Skin, Muscular-skeletal, congenital anomalies, Perinatal and ill-defined conditions.

EDUCATIONAL STATUS

Generally, education is 'seen' as a springboard for national development. In order to attain this goal, the State sets up the Ministry of Education to carry out the role of having the citizenry educated. The Ministry formulates policies and guidelines, moves towards quality control and maintenance of standards as outlined in the National Policy on education.

Todate, there are over 1096 primary schools with an enrolment figure of over 1 million, 246 Public Secondary Schools, One Remedial School, 2 Polytechnics, a Maritime Academy, a College of Education and three Universities (1 private, 1, State and 1 Federal) in the State.

Following this figure, this is perhaps the reason the State is classified among the educationally advantaged states in Nigeria. With the exception of the tertiary institutions that are strategically located, all the 31 Local Government Council Areas have Creche, Nursery/Primary and Secondary Schools located in their domain for accessibility by the educand. Adult Education centres can also be found all over the State. The literacy – illiteracy ratio in the State is quite commendable. This is due to the policy of free and compulsory education pursued by the present administration in the State. Efforts are vigorously pursued to bridge the gap between the literate and illiterate members of the population.

POPULAR OCCUPATION

With the exception of a few or negligible urban centres, Akwa Ibom State has well over 70% of its population residing in the rural areas. To this end, the popular occupation of the people are farming, fishing, trading, oil and gas, forestry and lumbering with less than 2% engaged in the Formal Sector (i.e. Civil Service) of the economy. Again, others are engaged in the Non-formal sectors-such as tailoring, mechanics, spare parts sales, shoe mending, typing/stenographic/computer-photocpying businesses, etc.

NUMBER OF LOCAL GOVERNMENT AREAS

Akwa Ibom State was carved out of the old Cross River State in 1987. At inception of the 17 (seventeen) Local Government Areas that made up Cross River State, 10 (Ten) made up Akwa Ibom between 1989, 1991 and 1997, the number had increased to 31 (Thirty-one) Local Government Areas namely:

	Local Government	Headquarters
1	Abak	Abak
2	Eastern Obolo	Okoroette
3	Eket	Eket
4	Esit Eket	Ikpa
5	Essien Udim	Afaha Ikot Ebak
6	Etim Ekpo	Utu Etim Ekpo
7	Etinan	Etinan
8	Ibeno	Upenekang
9	Ibesikpo Asutan	Nung Udoe
10	Ibiono Ibom	Oko Ita
11	Ika	Urua Inyang
12	Ikono	Ikono
13	Ikot Abasi	Ikot Abasi
14	Ikot Ekpene	Ikot Ekpene
15	Ini	Odoro Ikpe
16	Itu	Mbak Atai
17	Mbo	Enwang
18	Mkpat Enin	Mkpat Enin
19	Nsit Atai	Odot
20	Nsit Ibom	Afaha Offiong
21	Nsit Ubium	Ikot Edibon
22	Obot Akara	Nto Edino
23	Okobo	Okopedi
24	Onna	Abat
25	Oron	Oron
26	Oruk Anam	Ikot Ibritam
27	Udung Uko	Mbukpo Eyo Akan
28	Ukanafun	Ikot Akpan Nkuk
29	Uruan	Idu
30	Urue Offong/Oruko	Urue Offong
31	Uyo	Uyo

STATUS OF WOMEN/GENDER ROLES

Gender concerns the psychological, social and cultural differences between males and females. It is linked to social construct of masculinity and femininity. This is (i.e. Akwa Ibom State) an essentially male dominant society where hitherto the women were to be seen and not heard. With changes in the economy, education and culture contacts, inferiority complex women were made to feel have now been relaxed. Eventhough there exists Gender

inequality; women perform essentially roles prescribed by the culture all over the State.

In the light of all the above, the UNH_4, it would appear, decided or chose to authorize this study or survey in order to obtain baseline information for 15 States of Nigeria and the FCT, with this state – Akwa Ibom – being one of them.

OBJECTIVES OF THE STUDY

The specific objectives of this survey were to:

i. Collect, collate and analyze current data on the indicators of the themes covered by the UNH_4 baseline and gender needs assessment on maternal, child and newborn health in Akwa Ibom State.

ii. Collect current data on all objectively variable indicators of (i) above.

iii. Provide information to guide decision makers (our sponsors) on the strategy and operations of gender needs on maternal, child and newborn health in Akwa Ibom State for better results and judicious use of resources available (provided).

METHODOLOGY

Preparation:

From April 18th – 21st, 2012, I participated as State Co-ordinator (Qualitative) in the UNH_4 training workshop at OAU, Ile Ife.

For obvious reasons, I recruited and trained upon return, Research Assistants, for field work. In the interim, an office in the Department of Sociology and Anthropology, University of Uyo, was to serve as the

operational base for the UNH_4 2012 baseline survey – where the survey instruments (materials) were kept and distributed to the field operatives. This same office also served as the take off point for our survey activities around the State.

Monday May 21st – Wednesday 23rd May, 2012 served as the training sessions for the Research Assistants on the mechanics of the baseline survey. This successfully accomplished, 24th – 31st May, 2012 were used to identify our Research locale and supportive Operatives (i.e. the Logisticians, CLO^s, etc) and letters informing them of the baseline survey were duly given to the concerned (Appendix 2) for adequate sensitization.

RESEARCH DESIGN

The baseline survey was designed to cover communities where Health Facilities (HF) are located. It covered the 3 Senatorial Districts of the State. Of the four health facilities clustering around 1 GH, we administered our questionnaire to 2 carefully selected communities in order to elicit the needed information that touch on the themes of UNH_4 programme. Howbeit, qualitative data were gathered from 10 out of the 16 clusters in 6 Local Government Areas.

SAMPLE AND SAMPLING PROCEDURES

Following the guidelines for qualitative data collection, a total of 40 FGDs and 24 IDIs were conducted in 10 communities spread into 6 Local Government Areas of Akwa Ibom State from 5th to 18th June, 2012. The steps used and adopted in selecting the respondents were purposive. Eligible discussants were chosen according to the criteria for their groups (i.e. by Form No.) from the clusters drawn by our sponsor. The discussants (D^1 – D^{12})

were carefully selected based on the criteria which our 6 Logisticians anchored.

DATA COLLECTION METHOD

The method we used in collecting data was the discussion guide arranged around themes (forms) which we decoded into the local language during and immediately after the training sessions prior to proceeding to the field. 8 Forms were raised to cover 5 FGDs and 3 IDIs with themes which the RAs used to guide discussions. Over 95% of the sessions were conducted in the Local language. A minimum of 8 and maximum of 12 discussants formed an FGD and a minimum of 1 for the IDI, Six (6) Research Assistants, the State Co-ordinator (Qualitative) conducted/ guided discussions with assistance drawn from Local peculiarities added to the ready hands of engaged Logisticians. The vari1ous community leaders, Village Heads, Village/Community Council Leader/Chairmen, Secretaries and Youth Leaders assisted the Logisticians in mobilizing discussants not forgetting the inducements from UNH_4 to boost their participation.

Thus, there were 40 FGDs and 24 IDIs conducted within our frame of reference. A breakdown shows FGDs with 8 groups of mothers, 8 groups with fathers, 8 groups with Adolescents and 8 with Opinion Leaders (males and females) while IDIs were conducted on KI at each of the Local Government Area Council Headquarters and State Ministry of Health Headquarters, TBAs and CHEWs.

I should state however that the most common method or tools used in qualitative research are focus group discussion (FGD), in-depth interview (IDI) and participant observation, all of which were employed effectively in this study. Richard Grinnell et al (2005:432-435) agree with authors like (Layi

Erinosho et al (2002) that FGD, as a research method, is a technique of qualitative data gathering that inclines towards administering open-ended questions to a carefully selected target group which ideally consist of 8-12 persons with similar background. The discussions are frequently tape recorded, transcribed and analyzed. IDIs use the same principle as the FGD as it is wide ranging, probing issues in detail but respondents are interviewed individually. Community meetings, diary method, role play, card sorting and case study are the other methods.

FACILITATING FACTORS

Among others, one of the facilitating factors was the RAs, other supportive staff and field operatives helped out when reasons and occasions to do so arose. More importantly, like the Hawthorne studies, the fact that the sponsor appreciated their roles (contributions) to the success of the study via the DSA, movements, etc spurred the RAs to serve with enthusiasm.

CHALLENGES

A study of this nature cannot be devoid of challenges. The participants for the FGDs felt there would have been improvement on the stipend to get them better involved in the study than what was offered. Recorders often times had difficulties understanding discussants' submissions when cast in local proverbs.

Partisan interests through the Local Government elections and involvement of the RAs (being lecturers) in semester examinations protracted the study beyond the 10 days. Also, the very busy and tight schedule of the Honourable Commissioner for Health in Akwa Ibom State rendered appointments with him as KI nugatory except almost at the conclusion of the

report. Meeting with him made for all the apparent loss in time. Presented hereafter are the groups summary findings of the 40 FGDs and 24 IDIs.

2. DESCRIPTION OF LOCATION OF STUDY

The study involved 12 communities in 6 Local Government Areas of Akwa Ibom State spread into the 3 SDs. The communities are within the locations of HF clusters. They are Anua, Mbak Obio Etoi (Uyo Local Government Area), Ikot Ada Idem (Ibiono Ibom Local Government Area), Idung Inang and Efoi (Eket Local Government Area), Ikot Akpan Abia – Ifuho, Adiasim and Amayam (Ikot Ekpene Local Government Area), Ikot Usop and Ikot Akan (Ikot Abasi) and Afaha Obong in Abak Local Government Area.

Anua, Mbak Obio Etoi and Ikot Ada Idem communities are in Uyo Senatorial District (i.e. Akwa Ibom North-East SD), Idung Inang, Efoi, Ikot Usop and Ikot Akan are in Eket Senatorial District (Akwa Ibom South SD) while Ikot Akpan Abia-Ifuho, Adiasim, Amayam and Afaha Obong communities are in Ikot Ekpene Senatorial District (Akwa Ibom North-West SD).

The population of the study area – namely Akwa Ibom State – had been put at 3,920,208. The picture painted on sub theme 1.1 describes issues raised under this sub-section.

The above notwithstanding, the discussants fell within the age categories of 13-19 (Adolescents), 20-60+1 for other categories (parents – mothers/fathers). Opinion leaders, CHEWs and Health Officials. All the discussants in FGD and IDIs were well informed in terms of formal education and were actively involved in the labour force in varying degrees – all of which contributed to making the sessions stimulating. For mothers/fathers and certain adolescent groups where sufficiently exposed to western or formal

education, the instruments necessitated the use of local language to drive the points home as intended by our sponsors.

3. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS

Thematic Layout by Instruments

a. Male and Female Parents/Opinion Leaders

- Value of children

> *"I love all my children equally because they mean so much to me"* (FGD – Ikot Ada Idem, Ibiono Ibom).
>
> *"without a child, you are not a complete woman"* (Ditto). Another said, *"we celebrate female children the same way the males are celebrated because both are from God"* (FGD – Ikot Ekpene).
>
> *"People are happy any moment a child is born irrespective of the gender or position in terms of order of birth, a child is a child"* (FGD with opinion leaders – Uyo).

In Idung Inang and Efoi communities (Eket), the opinion leaders (male and female) and parents of both gender on FGD agreed that 'a long awaited male child is celebrated more in the midst of girls."

In both Abak and Ikot Ekpene, the birth of twins are welcome but participants in Efoi (Eket), Ikot Ada Idem (Ibiono) and Mbak Etoi (Uyo) mostly opinion leaders frown at the birth of twins to relatively poor parents. This, they reasoned was because of the associated costs and inconveniences they cause such parents. Participants in the FGD sessions in all the communities in the State reported/attested to the high premiums or values placed on children in the State.

- **Socio-cultural practices predisposing pregnant women to risks**

In all the FGD studies (with male, female and opinion leaders), participants concurred that 'EKPO NKA OWO (meaning married women who commit adultery surely die when under pregnancy because spirit of the dead is invoked them) and marrying many wives are the dominant socio-cultural practices that put pregnant women at risks. In Efoi as in Anua, Idung Inang, Ikot Ada Idem, Afaha Obong and Ikot Usop communities, FGD discussants chorused that 'No woman should have a child before getting married, otherwise, "you are seen as being wayward."

Probing further to locate window of escape from socio-cultural practices predisposing women who are pregnant to risks, FGD discussants at Ikot Ada Idem, Anua and Ikot Abasi said inter-alia

> *"We like what the health workers are doing to stop some of these cultural practices."* They also said that *"Our churches also preach against them."*

- **Knowledge of women about pregnancy care**

The general attitude of community members towards modern pregnancy care from FGD studies with men, females and opinion leaders had some of these as reactions:

> *"We are grateful about modern pregnancy care"* (FGD Afaha Obong, Abak).

> *"It is good, it has improved, our husbands are not helping us"* (FGD, Ibiono with mothers).

In Efoi (Eket) FGD with the 3 groups of male, female and opinion leaders had a consensus that "most women go to the health centres while some go to the TBAs and still others visit faith based organizations."

Concerning reasons for some choosing to patronize the TBA, FGD discussants in Efoi, Afaha Obong, Amayam and Uyo said

> *"It was better, affordable and less time wasting than the health facilities." Most often, you wait for hours unend without seeing the doctors and at other times, the drugs are not available."*

As for the symptoms and emergency signs, discussants throughout the State listed

(a) Lower abdominal pains

(b) Discharge of fluids

(c) Swollen legs while emergency signs include (a) discharge or bleeding (b) vomiting.

As to who decides when a pregnant woman should seek treatment during emergencies, most discussants agreed it's the husbands, some said both husband and wife decide while others said especially mothers, that their husbands show little interest and so they go to where they are sure of services. The above besides, finance is an important deciding factor.

- **Knowledge, attitude and practice towards MNCH services**

The communities' attitude towards seeking pregnancy care at the hospital from the 3 sets/groups of discussants expressed the view that;

> *"It was not so impressive prior now but with changes taking place across the State, it is better now."*

In Ikot Ada Idem (Ibiono), Anua, Eniong, Mbak Obio Etoi (Uyo), Ikot Ekpene, Ikot Abasi and Abak FGD groups agreed that "negative attitudes towards MNCH services will be developed when no information is at our disposal.

more so when we would be subjected to operation. But with sensitization, the health centres have provided the needed services at cheaper, affordable and accessible costs hence we patronize them" chorused the 3 sets/groups of FGDs across the communities.

- **Assessment of Quality of Care**

  Antenatal

Opinion leaders (males) from Efoi (Eket), Anua (Uyo) and in a number of the FGD communities commended antenatal services provided their wives. Female parents in Ikot Ada Idem (Ibiono) and males in Abak agreed with the above. For instance, one of the parents in Ikot Ada Idem said 'I was well attended to before and during delivery.' In Afaha Obong (Abak), the consensus was that

> *"The antenatal care is available, accessible and affordable, in the community".*

Among the participants were those who felt displeased with the waiting time where

> *"you have to wait and wait until it is your turn to buy card, wait and wait again to see the doctor or some health official"* FGD – Afaha Obong with concurrence from Amayam.

> *"Some drugs are not available after waiting or queuing to get to the pharmacy"* said one discussant of the FGD with mothers in Ikot Akpan Abia – Ifuho axis of Ikot Ekpene.

❖ Delivery

> *"They are now taking care of us after delivery and our babies are well"* (FGD with mothers – Ikot Ada Idem (Ibiono).

She went on to add that

> *"some drugs are available but we have to pay for the drugs."*

A group of mothers across the State in focus noted that

> *"Facilities are inadequate in the health centre. Nurses are non-resident, security is poor, encroachment into the hospital land, lack of constant or epileptic supply of electricity, some important drugs are not available"*

were instances of sharp or adverse remarks against services available at the HF in Ibiono, Efoi and Ikot Akan communities.

- **Postnatal**

Discussants from Uyo, Amayam (Ikot Ekpene) and Idung Inang (Eket) agreed that women were well cared after, advised on birth control and children care. No negative experience was reported from all the levels of discussions concerning postnatal care.

- **Public/Private Dichotomy**

This is very obvious. The waiting period and attention span between public and private HF are polar opposite. While it is relatively quicker and more efficient cum effective securing health care in the private domain, it is not so with the public health providers. Services in the public are far cheaper, a number of the nurses are very rude and lack etiquette while courteous ones though less qualified except the doctor is the case in the private health facilities. It is more expensive getting health services in the private facility. There are array of qualified health personnel in the public health facilities but are not willing except by persuasion/compulsion to function in rural communities. All these are a summation of discussions, in focus across the communities in the State.

❖ **Neonatal Care**

Breastfeeding, circumcision, cord care and related practices are sustained, encouraged and are in vogue all over the State. Indeed, it is a norm that these be practiced. Both at the HF and TBAs, these practices portend. Breast feeding is the best practice for the baby's health

> *"Exclusive breastfeeding is good for the rich because they have money to eat good food."*

There is restriction of women from eating some kinds of food or visiting certain places immediately after child birth "FGD (Ibiono, Afaha Obong, Amayam and Uyo)

> *" We take our babies to the Health Centre when they are sick and we are advised to protect their cords."*
> - (FGD Ibiono).

❖ **Male involvement in Child Care**

While some women in focus claimed their husbands show no interest in child care, others say "our husbands become "pregnant" too when we are pregnant." This implies there is male involvement in child care. For example, the FGD discussants from Ibiono, just as those from Ikot Akan, Ikot Usop (Ikot Abasi) and those from Mbak Obio Etoi, Anua (Uyo) and Efoi (Eket) conceded the fact that the males help a lot in looking after the baby when mothers are not around or are out for work. The discussants continued by saying

> *"They (males) assist in bathing the baby, take care while wel go to work or cook. We expect them (males) to continue to assist because it is not easy."* – (FGD Females)

❖ Immunization

All the groups in focus in the State submitted that immunization "is very good. We all immunize our new born babies. It helps to protect the babies

against killer diseases. It makes the child strong and walk faster. All children should be immunized against polio, measles, cholera, etc from birth to the required age of 9 according to medical rules." – (FGD, Uyo, Eket and Abak).

- **Knowledge, attitude and Practices towards prevention of childhood diseases**

On these phenomena, actions towards preventing such childhood diseases as measles, malaria, chicken pox, rashes, polio, cholera, etc are taken early by the parents.

- Giving children non artificial food, exclusive breast feeding, good feeding and adequate medical care are the necessary steps taken by participants and communities at large to prevent childhood diseases.
- Recourse to faith based organizations (FBO) the spiritual or syncretic churches are other ways parents adopt to 'send' diseases away from their midst through fasting and prayers.

In Ibiono, Amayam and Efoi which also replicate in other communities, FGD discussants are quoted thus:-

> *"As we go to the health centres, we are advised about the problems of childhood diseases. Women groups/organizations, churches, market places as well as interactions with women who have passed through this stage are our usual channels of knowledge, attitude and practices towards preventing childhood diseases."*

❖ **Rights of Women/Children to MNCH Services**

In Afaha Obong as in Ikot Ada Idem, Ikot Ekpene and Amayam, the decision as to pregnancy is dual (i.e. husband and wife). Indeed all were agreed that often time, it is circumstantial. When it comes, it is taken as Divine decision. Because of evolutionary trend or progressive ascension of women to 'power' positions, the Woman DECIDES.

On the decision of number of Children, it is the family economy that determines the number of children. This is in an elitist home but for the poor, children are gifts from God and as many as come "we will take." FGD – Ifuho (Ikot Ekpene) Mothers and grand mothers have relatively no influence over the number of children a couple should have. On the issue of rape and wife battery, no FGD group agreed such ever happened to their knowledge in the communities. The groups submitted that poverty is often associated with inability to pay the moderate bills charged in public health centres or hospitals.

FBO (Faith based organizations) thus thrive to handle the myriads of health challenges people face alternatives to HFs in the remote communities.

Rights of Newborns

Discussion groups conceded that the rights of newborns are often violated due to the fact that they (new borns) do not feed on time, their feeding is poor in quality and are fed mostly with carbohydrates and are not given timely medical care when they are sick and-immunization not carried out as scheduled (FGD Ikot Ada Idem, Ikot Akan, Ikot Usop, Mbak Etoi, Efoi and Anua).

When not satisfied with the quality of care to newborns, mothers persuade husbands to (consult) see private practitioners with the baby if the means is there, when it is not there, they resort to FBOs for help.

❖ General Health

- Contraceptives

"Abstinence, pills have been recommended for us" FGD every where in the State as to the common contraceptives to use. The decision as to what

and when to use condoms or other contraceptives are decisions of women mostly.

D_1 and 7 (FGD, Afaha Obong – Abak) said they procure from a patent medicine store. Referring to the categories of men who should use contraceptives, the consensus of opinion statewide was the married men and the singles alike for safety sake. For men, when ready to impregnate his wife, he has no need for contraceptives.

- **Knowledge, attitude and Practices to long lasting insecticide treated nets**
  - Discussants who used this facility agreed that

    "it is very good; it prevents mosquito bites."

    Discussants complained that

    "it is not popular among the people, especially the elders. The people do not like to use it and so they do not rush for it" - FGD from Eket, Uyo and Ikot Ekpene.
  - Prevention of Mother to Child transmíssion of HIV/AIDS

    It can be prevented if one sticks to one partner. There is no reported case of mother to child transmission in all the communities in our focus.

b. CHEWS/TBAs

- **Value of Children**

Concerning how people celebrate the birth of newborns in the communities, the CHEWS/TBAs in focus had these to say

"It depends on the family. If they expected a male, it calls for celebrations. Otherwise, a female child is also celebrated. Besides, it does also depend on the birth order. Our experience thus far shows that mostly the first child is celebrated. But if there had been delivery of

similar gender over time, the recent delivery that is different from others would be much celebrated" (CHEW/Peer Educators/TBAs (Abak-Afaha Obong).

Contributing to the idea of single/multiple births and number of children in the family, most CHEWS/TBAs said that most times, from experience and interactions, in the communities, single birth is preferred to multiple births for reason of RESOURCES.

While a family with an improved socio-economic status may wish for twins, this most often, would be a function of availability of maids or house help or baby seater.

Even at this, it is scuttled because with the government in power in the State, no child labour or house maid syndrome is tolerated statewide. The government in Akwa Ibom State encourages all to be literate by enrolling in schools at no cost to the educand. And so, families with willing relations to assist in baby seating, multiple births are welcome.

Above remarks besides, the CHEWS/TBAs across the State admitted that communities place high premiums on children, seeing children as "investment" and special privilege and blessing from God, although having children carries great responsibilities.

They concluded that

"every child comes with his/her meal ticket" and so no basis for man on earth to discriminate either gender or birth order for "he who gave them will open the window of care."

- **Socio-cultural practices which put pregnant women at risks in the community.**

The statewide opinion of discussants of the CHEWS/TBA Categories was that pregnant women today enjoy limitless freedom. They are free to eat

any food, indulge in any activity provided such activity would not inflict medical harm.

"In the past, pregnant women were restricted from participating in masquerade celebrations and urinating in areas close to family shrines (or worship centres) but nowadays, such cultural issues are no longer observed" CHEWS/TBAs in Abak, Ikot Abasi and Eket as well as in Ikot Ekpene noted that

> *"Most times in the community, there is this belief that when a woman is pregnant, she should not eat much foreign food, she is not expected to indulge in palm oil preparation process or fry garri, she is not expected to go to the stream on a "forbidden day" nor is she expected to watch or "see" certain masquerades to avoid giving birth to masquerade looking children"*

All these socio-cultural practices have been taken care of by culture contacts, exposure and benefits from western education, missionary or Christian activities and the "miracle" associated with science and technology.

Distances to health facilities, lack of pecuniary power to purchase the few drugs that are available, waiting period to see health officials or obtain cards are some of the challenges faced by women of child bearing age in the communities.

On how women with positive pregnancy outcomes are treated here, all reported they were treated with love, care, affection and attention. They are not permitted to be involved in hard household chores. Their social status is enhanced and is treated with great respect. They are said to "have arrived"

On not having children, such women are often treated with disdain. Even their husbands are encouraged to go to bed with their maids so that the barren woman can have "a place in the community". In extreme

circumstances, she is mocked at and excluded in discussions and decisions involving mothers.

In contemporary times, both husband and wife resort to child adoption. All were agreed that the social esteem of women with no children is low.

- **Knowledge of women about pregnancy care**

The CHEWs/TBAs in focus remarked that their experience shows that a greater percentage of women embrace modern pregnancy care and endorse ante natal care due to the benefits they and the communities derive. Some go to the PHC while others visit the general hospitals. Still others prefer the TBAs. This awareness or patronage was not so before now. The TBAs even reported having fewer cases these years than was the case twenty to thirty years ago. However, reasons proffered for the divergent choices of type of care are

- Finance
- Nearness/proximity to the available facility
- Acting or responding to the promptings of those who give them antenatal care

In terms of symptoms to show a pregnant woman needs urgent medical attention upon emergency signs such as:

- Fever
- Malaria
- Cough
- Vomiting, she will go to the health facility nearest to her (CHEWS/TBA) in Eket, Abak and Uyo chorused. As to who decides where a pregnant woman should seek treatment during emergencies, all was agreed that the cultural demand puts that responsibility upon the husband who is the head of the

family. Where the mother of the pregnant woman is knowledgeable and influential, her contribution to the decision would be acknowledged.

❖ **Role of CHEWS and Challenges**

Said the CHEWS all over the State:

> *"Our role in the communities is to move around and inform/educate community members about health care."*

The particular health conditions that community Health Extension Workers and Peer Educators (CHEWS) generally treat are –
Malaria, typhoid, immunize children against the six killer diseases as directed by the medical doctors.

Like in every vocation, the challenges faced by CHEWS is the operatives (this category of health personnel are not adequate to cover all nooks and crannies where their services are needed. Nurses and doctors need to be resident in the community to shorten the challenge of community members carrying their health needs to distant places. Door to door health campaigns by CHEWS is cumbersome especially when response rate are often slow or sometimes not forthcoming.

- **Knowledge, attitudes and practices towards prevention of childhood diseases**

The CHEWS/TBAs in focus reported that the communities have demonstrated good knowledge of especially the six killer diseases among children in the State. Generally, the factors that influence the occurrence and spread of these diseases are unclean environment, lack of portable water, lack of knowledge of human hygiene and non-use of treated mosquito nets. Besides, there was the admission of the fact that immunization has helped

them in their drive towards prevention. For instance, the CHEWS in Ikot Ekpene, Uyo, Ikot Abasi and Abak all agreed that polio has not been a health issue in recent years. As far as their knowledge base goes, traditional remedies do exist but are not as effective and dependable as immunization. Patronage to traditional herbal remedies has dropped remarkably compared to the position 20 to 30 years ago. It was stressed that the communities' faith in modern medical care was attributed to the information which health personnels in the mould of CHEWS provide. Their believe was reinforced by the fact that with specialist medical personnel, increase in HF across the State, laboratory and drugs made available, members of the various communities in the State could/would be the more encouraged to manage childhood diseases.

❖ **Immunization**

All over the State, discussants admitted that immunization is/was very good for the children as the exercise helped in preventing deaths among children. To this end, all was supportive of the idea of administering immunization on the children as a statewide phenomenon. As to the type of immunization that should be given to the children, the conscensus was BCG, OPV, DPT, Measles, Yellow Fever, VIt A. With available Peer education, CHEWS agreed that the ages at which children should be immunized are:

- at birth, 6, 10 and 14 weeks of age
- at 9 months and 15 months and – upto 5 years or 60 months of age.

In terms of the physical evidence, one can observe on a baby that has been exposed to immunization such signs identified as

- Upper left arm
- Mouth

- Outer part of thigh and
- Upper right arm.

In all, more women displayed knowledge of immunization/children diseases and pains than their male counterparts. As far as they were concerned, a healthy child that would not fall sick easily shows evidence of immunization.

c. Health Officials in State and LGA

- Availability and quality of service

This was one of those IDI sessions we had with these group of respondents. Respondents/Discussants said that RH Services were available within the HF (Health facilities) that were in their communities or those in nearby communities. Responding to the question dealing with the types of MNCH services offered in the LGAs and state, our KI stated categorically that:

> *"We offer immunization, FP (Family Planning), child welfare clinic, Antenatal, delivery and Post natal services. These services are available more or in greater proportions in our general hospitals and comprehensive Health Centres which are in urban centres than are in PHCs that sprawl our rural areas"*

All KII described the quality of MNCH services as either excellent or very good certifying that by the policy thrusts of the Ministry of Health and by extension the State Government, the services are affordable, most often free and the proximity or nearness of HF to the communities makes them reasonably good.

Health services such as caesarian section, blood transfusion and obstetrics services are provided mostly in the general hospitals and tertiary health institutions like the one at the University of Uyo Teaching Hospital (UUTH).

Both IDI (i.e. KII) sessions in the Local Government Areas within our focus and the State agreed that the care for the neonates are reasonably

good since the government provides the necessary working tools to enable health officials function effectively. Immunization, child welfare and FP services are available and provided on a State wide basis since health facilities and personnel are located and posted to mann and provide the services to the communities in the State.

> *"Infact, we are in all the wards meaning health services are available in all the political wards in the States."* (KII State).

Respondents at the State and Local Government Area levels regretted the losses often sustained and negative impressions they receive resulting from long periods of waiting to see health operatives like the doctors.

The experience of the State Co-ordinator (Qualitative) and Research assistants on this confirms the challenges of waiting time people go through to see officials. In booking our appointment for this IDI and securing one were very very heculian.

❖ **Demand and Supply for MNCH Services**

There was unanimity among the KIs in the six Local Government Areas and the State Official who submitted to interview that there is remarkable improvements in the level of patronage of MNCH services across the State in the areas of antenatal, delivery and post natal as well as other areas of health needs. From their vantage points of health information and based on the data at their disposal, health officials at the Local Government Areas and State conceded the fact that women with their children come more to the health facilities than they come with their husbands. As to the decision on who determines when they come, statistics available indicates that the patients take that decision. At other times, the family economy is a determinant factor. Payments for services provided can be made by either of the partners (wife or

husband or joint efforts) since it is done in love. Concerning care for the neonates, both parents show care but that of mother weighs greater and since the services rendered to neonates are most often free and where there is a charge, such is minimal, no particular preference is given to one service over the other and should tokens be necessary, the household heads do that (mostly husbands).

All officials under our IDI confirmed that their experience and exposure showed parents never had any preferential treatment for either male or female children when exposing them to health facilities and health services.

❖ **Post-delivery visits**

As officials in the State and Local Government Areas charged with matters pertaining health, all KII respondents affirmed that practice of post-delivery visits in the State health facilities were near excellent. This is reinforced by the presence of ambulance vehicles in our secondary and tertiary health institutions – namely in all the general-hospitals as well as the teaching hospital. (KII – State).

❖ **Waste disposal challenges**

The normal practice in the health facilities around the State is that waste materials are centrally collected, burned and buried. All officials under KII agreed that doing so were within prescribed health standards. Concerning the challenges associated with bio-medical waste disposal in the health facilities in the State, Rainy/Wet season was said to pose difficulty/challenges in the burning and burying of bio-medic wastes.

❖ **Contraceptives requisition and stockings**

Health officials in the Local Government Areas said they make requisitions for contraceptives from the State Ministry of Health.

> *"When they are supplied, we distribute them to the health facilities through the CHEWS, Peer educators and occasionally the nurses"*
> - (KII in Eket, Ikot Ekpene and Uyo) which corroborate claims from Ikot Abasi, Abak and Ibiono.

> *"When not in use or distributed, they are kept in our store where other drugs are kept"* (KI, Uyo).

On the whole, KII (IDI) revealed that contraceptives generally are issues for women. Their reason was that women were the ones who carry pregnancy and hence programmed by nature to exercise discretion. They revealed further that a number of women (especially the exposed and fairly well educated) agreed to using such contraceptive devices as IUD, Pills and injections with injection and IUD forming the majority. To such ladies, the comfort and convenience were determinant factors.

❖ **Reproductive health needs awareness creation**

All the Local Government Area and State health officials said they employed the regular methods/mechanisms which all government agencies use to get RH messages to the grassroots. This is done through use of home visits via CHEWS/Peer educators, disseminating information or creating awareness through respectable religious leaders, traditional rulers, opinion leaders and through the women themselves – in their group meetings, etc.

❖ **Co-ordination of Meetings**

Meetings on RH and related matters are held once a month at the level of the Local Government Areas. Reports reaching the State office indicates

that often times, poor attendance characterize meetings due to activities of fbos.

d. **Adolescent groups**

- **The Value of the 'Girl/Boy Child' in the Community**

Discussants under focus in the State in this category admitted that children newly born are celebrated equally without discrimination as to gender or position. The difference, they uphold, lay on if all previous births were similar gender (sex – i.e. either of male or female). With the birth of a different gender after a series of a particular gender, such will usher greater celebration because he/she had been long expected. In terms of the privileges enjoyed by boys that girls do not, discussants from Efoi (Eket) and Afaha Obong (Abak) said:

"the boys are free to go out and play more than the girls"

On the other hand, the privileges which girls enjoy in the communities more than the boys is that it was a general consensus that girls are loved and cared for better than boys by FATHERS. The girls enjoyed being girls for the extra attention parents provide them where the boys have average.

- **General Wellbeing of the 'girl child' in the Community**

Discussants in all FGDs were agreed that the basic needs of the girl child are met. This, parents do, to avoid the girl child being wayward or loose or being promiscuous.

Women and young people suffer most in most communities from lack of basic needs such as food, water, shelter, clothing and medicare. They will have to fend extra hard to meet these needs due to the high poverty index in

the State. As coping strategies, the categories of men and young adults will migrate to the cities in search of the non-existing job opportunities thus adding their own quota to urban social and economic problems. Those unable to migrate due to lack of cushions in the cities, resort to menial jobs or become pimps and easy tools in the hands of political elites.

It was a general agreement by all the discussants in focus that the fears of young girls in the community were those of unwanted pregnancy and contracting STDs. In almost all communities, it was revealed that all girls were relatively very safe except those who predispose themselves to sexual assaults by miscreants and deviants from poorly socialized homes, norms and community values.

- **Socio-cultural practices in the communities that do not support advancement of the girl child.**

All the FGDs in all the twelve communities in the six Local Government Areas in focus agreed that certain festivals like Ekpo masquerade, Obon, Ikpa Isong, Atat, etc do affect girls negatively and boys who are non-initiates in these cult groups. Effects however are minimized because of recent government intervention in banning these festivals.

Concerning the age at which girls/boys in the communities could get married, FGD groups averred that most adolescents in the State postpone gratification and rather pursue vocations that would sustain them during married life. Generally, recourse is made to the Nigerian constitution where 18 years is placed as start of responsibility to marry or not.

> *"The present practice of seeking the girl's hands in marriage under prevailing cultural arrangement is alright for us"* - (FGD) Adolescents from Anua, Mbak Obio Etoi (Uyo), Ikot Ada Idem (Ibiono), Ikot Ekpene urban and Efoi (Eket).

As to jobs done by both sexes, all goes well except where a girl chooses to be a palm wine tapper, cane chair maker/carpentry, etc are frowned at on a statewide basis. Both sexes help parents in house chores though performed under gender lines – for example the girls prepare the meals, fetch firewood and water, wash plates and clothes, sweep and scrub the floor while the boys break the wood, sweep the compound, replace the roof mats, and cut the grass. All these are done without recourse to any traditional taboos concerning division of labour.

Because Akwa Ibom State, like most states of the country is a partricentric society and the principle of primogeniture holds sway, inheritance rights are culturally determined in favour of the boy child. The girl child is expected to marry when grown and therefore would be contributing to the economy of the husband's family than those of orientation. That is why the girl is provided all household gift items when marital rites are performed to leave both doors and windows open for her brothers (The Boy Child) to inherit parents "wealth".

❖ Education

This is an issue at the heart of government of this State. There is no discrimination of gender in school enrolment nor of exposure of pupils/students to lectures/lessons by school authorities.

Currently, it is an offence not to allow the boy/girl child enroll in school. Indeed, education here (i.e. Akwa Ibom State) is not only free but COMPULSORY to all categories of children

❖ Health and Sexuality

Adolescents in discussion across the state had fairly good knowledge of rH and sexuality. Over 80% of the discussants in focus agreed to being educated on rh sexuality in the schools, in workshops and seminars. All agreed to awareness of STIs and HIV/AIDs and contraceptives used in preventing pregnancy. When distressed, they approach friends, women and at other times church leaders for counseling. Upon probing, they were found to resort to the hf where doctors would examine, advice and treat. At other times, our findings showed that some would go to traditional healers for herbal concoctions, lime, alcohols or use of pepper as enema to procure abortion. These are alternatives to modern practice where pills, condoms and IUD are used to prevent pregnancy. Sexual intercourse, sharing of sharp objects, sharing of unsterilized clippers and blood transfusion are some of the main means of contracting STIs, HIV/AIDs and other sexually related challenges adolescents face. These, they agreed, could be prevented where there is Abstinence and use of condoms, injectables and IUD for girls.

❖ Violence against Girls/Boys

All the FGDs groups reported of a very minimal, level of violence against girls/boys in the communities in focus. It was only in the urban centres that cases abound where girls are raped at odd hours of the day with seductive dressings.

The few cases in the rural communities are usually reported to either the family heads or village heads concerned – where cases are ultimately amicably settled with the culprits receiving sanctions. In the cities, cases are reported to the police where arrests are effected with the law taking its course.

❖ **The General Status of Women in the Community**

From the ancient of days till today, the status of women in all communities in the State is lower than those of men. While in those days women were to be seen and not heard, today there is a shift in the position of women. They are not only seen but heard as education and other forms of culture contacts with the Western world have opened a vista of privileges to women as some are now in opinion leadership positions.

Discussants agreed that eventhough they advocate that rights and privileges men have been extended to women, there are no specific rights assigned to women by the cultural demands, norms and values in Akwa Ibom State. This constitutes the challenge which women here face as they are excluded from major decision making mechanisms in the communities in focus and this is inferred on a statewide basis. This is not oblivious of the Beijing resolutions for which they are pushing for 35% affirmative acts.

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

The UNH_4 (Comprising UNFPA, UNICEF, WHO and World Bank) Qualitative Baseline and Gender Needs Assessment on Maternal, Child and Newborn health in Akwa Ibom State was geared/aimed towards or at providing the necessary data (information) that would guide intervention agencies now and in the future and in the process measure achievements attained.

Our survey was qualitatively designed to cover the State through the use of the clusters of communities where health facilities are located and which are spread in the 3 Senatorial Districts of the State. It was focused on the following thematic layout by instruments: Male and Female parents/opinion leaders' value of children, socio-cultural practices predisposing pregnant women to risks, knowledge of pregnancy care, knowledge, attitudes and practice towards MNCH services, Antenatal, Delivery, Postnatal and Neonatal cares, Immunization, Rights of Women/Children to MNCH services, Rights of Newborns, Use of Contraceptives, Long lasting insecticide treated nets as well as prevention of mother to child transmission of HIV/AIDs. These besides, such other thematic areas as CHEWS/TBAs, Health officials in the State and Local Government Areas and matters which touch the 'heart' of Adolescent groups (Girl/Boy) child in the communities which our study (investigations) covered were discussed.

Our own aspect of the investigation namely Qualitative was purposively designed by our sponsor – the UNH_4 – to complement the quantitative data generated from the cluster of health facilities that fell within the study locale. Indeed, as sociologists involved in the Qualitative aspects of the baseline study, it was designed to provide the cultural/traditional background to the

responses which the participants/respondents in focus provided to corroborate the findings of the quantitative group.

The findings were that very high premiums are placed on children in Akwa Ibom State more so male children. Children are not only 'seen' as pillars of the family. They are seen as security at old age, economic resource as are generally said that 'Eyen Edi Akot Adubok; family mirrors and those that perpetuate the name of the family by serving as carriers of the culture of the family and society from generation to generation. Only a very insignificant proportion of the discussants/participants saw children (irrespective of gender) as burdens. The study further found that reproductive health needs awareness are created at the State and Local Government levels thus sensitizing dwellers of the threshold - the villages and communities – to avail themselves with improved health techniques now in vogue.

A society or culture that onced abhorred or saw the birth of twins or multiple births as abomination now not only welcomes the idea, but celebrates women who give birth to twins. They now regret the 'folly' or is it ignorance? of their forebears and owe a lot of gratitude to the wisdom of Mary Mitchell Slessor – who prior to her transition in 1915 - saved the twins from the slaughter slabs of an unscientific "dark age" of Africa's past.

The Adolescents (Girl/Boy) child in focus had a fairly good knowledge and awareness about HIV/AIDs. This, our study, found was due to the sensitization made possible by the CHEWS at St. Luke's Hospital Anua, Uyo, General Hospital, Ikot Ekpene, Emmanuel Hospital, Eket as well as the Mercy Hospital in Abak. This sensitization goes beyond the hospitals to schools and churches. A study of this nature was not without challenges. Meeting with Health officials at the State level as scheduled were often truncated due to equally demanding State commitments. Also, some scheduled FGDs were

scuttled by partisan interests because this FGD came at a time the State was at its 'fever pitch' electoral campaigns/gerrymandering to elect chairmen and councilors into the 31 Local Government Areas of the State. It also coincided with the time my Research Assistants, who are lecturers, like myself, were involved in the 1st Semester Examination for the 2011/2012 Session.

Conclusion

Concluding, we cannot overemphasize the fact that there is a need for a comprehensive or complete RH, Gender Needs Assessment on Maternal, Child and Newborn Health services to be integrated into the existing HF (Health Facilities) and associated communities in Akwa Ibom State. In addition, following the spate of uncommon transformation going on in Akwa Ibom State, there is need to integrate the general status of women in the communities with the transformation agenda of the various levels of governance. This, perhaps, adds a knuckle to the advocacy of affirmative act of 35% for women in public service.

Recommendations

From the findings and conclusions drawn, it is recommended that:

- Communities in Akwa Ibom State should be sensitized to take initiatives toward RH, Maternal and child health issues.
- RH and HF status of the State should be improved.
- PHC system be re-vitalized and Doctors encouraged to be resident in rural communities for a more effective health care practice.
- An effective administration of health care services through an articulate monitoring system be put in place.

- The widening gap existing between the modern and traditional medicine be narrowed.
- The youth be part of the war against HIV/AIDs awareness creation programmes.
- Exclusive breast feeding for new born campaigns be intensified

In itself, the survey revealed a number of characteristics about health issues in Akwa Ibom State. Although adolescent are ignorant of many RH issues and the quality of services rendered/ provided at the RH to be sub-optimal, they are aware or educated on a number of health related matters that affect them. There is still gender imbalance/inequality and women are still confined to cultural norms, values that make them still unequal to the boy child.

APPENDIX 1

Names of people met (Key Gate Keeper)

- Chief Effiong Akpe (Eket)
- Mr. Amos Eshiet
- Mr. Uwana Williams (Abak)
- Chief Ufot Ndah (Ikot Abasi)
- Mr. Imo Nanna
- Mrs. Elizabeth O. A. Umoh
- Idorienyin Thompson (Uyo)
- Uyime Okon Etim (Ikot Ekpene)

Names of Team Members

-	Dr. Peter A. Essoh	-	State Co-ordinator (Qualitative)
-	Dr. Okon S. Udoh	-	Research Assistant (Ibiono)
-	Dr. Aniefiok S. Ukommi	-	Research Assistant (Ikot Abasi)
-	Dr. Victor E. Ben	-	Research Assistant (Uyo)
-	Akaninyene S. Archibong	-	Research Assistant (Ikot Ekpene)
-	David Samuel	-	Research Assistant (Eket)
-	Blessing F. Akpan	-	Research Assistant (Abak)

Documents

(a) Letter from OAU to Hon. Commissioner for Health, AKS

(b) Letters to the Chief of Communities under FGD

(c) UNH_4 Baseline form 1,2,3-10

(d) Language/concepts clarification

Appendix 1: Letter from OAU (National Co-ordinator of UNH4 to Hon. Commissioner in Health Akwa Ibom State).

Appendix 2: Letter to the Chiefs of Communities under FGD in Health Officials undr IDI (Forms 8,9 and 10).

Appendix 3: UNH4 Baseline FGD&IDI Forms 1,2,3-10

Appendix 4: Language/Concept Clarification

APPENDIX 2

LETTER TO THE CHIEFS OF COMMUNITIES UNDER FGD AND HEALTH OFFICIALS UNDER IDI

Department of Sociology Anthropology
University of Uyo
Uyo
18th May 2012

RE- UNH4 QUALITATIVE BASELINE AND GENDER NEEDS ASSESSMENT ON MATERNAL, CHILD AND NEWBORN HEALTH IN AKWA IBOM STATE, NIGERIA.

With due respect, we write to inform you that the UNH4 baseline and gender Needs assessment on maternal, child and newborn health in Akwa Ibom State will commence on Monday 5th June 2012.

We respectfully request that you please provide the enabling environment and co-operation for our logistics and research assistants to function in collecting the correct data from your community those under our FGD (Focus group discussion).

Thank you Sir.

Dr. U. S. Ekanem
State Co-ordinator (Quantitative)

Dr. P. A. Essoh
State Co-ordinator (Qualitative)

UNH$_4$ QUALITATIVE RESEARCH

LANGUAGE/CONCEPTS CLARIFICATION

English	Ibibio/Annang/Ekid
Mother/Motherhood	Eka
Father/Fatherhood	Ette
Childbearing age	Isua uman eyen
Newborn	Obufa eyen
Single birth	Aman kiet
Twins	Amaniba/aman mba
Value of children	Ufon ndito
Social status	Idaha ke obio/idung
Scio-culture practices	Edu edinam
Modern	Obufa
Norms	Ubuno mkpo/Ndutum
Health challenges	Mme mfine nson idem
Challenges/problems	Mme mfine
Pregnancy	Ndisana ye idip/ediyombo
Pregnancy care	Ndutim asanake ye uyombo idip
Symptoms	Mme idiongo
Prefer	Mbumek
Available	Mmodo
Accessible	Ufan ndinyene odu
Affordable	Ukeme odu
Antenatal	Edisanga nse idem anam idip
Neonatal	Ndibo usobo idem uman
Postnatal	Use Eyen Idem ke Ufok Ibok
Cord	Okop
Emergency	Idi waad
Immunization	Mkpi nsin

Prevention	Edikpan
Violence	Afai
Rights	Unen
Contraceptives	Usobo edikpan uyombo idip
Delivery	Uman
Ability	Ukeme
Skilled	Mbufiok
Render	Edidian ubok uwam
Risk	Mfina
Female circumcise	Mbobi eyenanwan
Modern practices	Mme obufa edinam
Grandmother	Eka-eka
Disposition/opinion	Ekikere
BCG	Editibe
OPV	Editibe
DPT	Editibe
Measles	Ayaya
Hepatitis	Idiok utuenyin
Yellow fever	Utuenyin ekpo
remedy	Ukok/uwam
Empowered	Edino ukeme/odudu
HIV/AIDS	Udongo itiaita
Familial taboos	Mme mkpo ibet
Mosquito Nets	Ufok obong