Urban Women's Use of Rural-Based Health Care Services: The Case of Igbo Women in Aba City, Nigeria

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ABSTRACT *This study addresses the quest for rural-based health care services among women in urban Nigeria relying on a large qualitative database obtained from 63 Igbo women living in Aba, Nigeria. Results indicate that urban Igbo women of different socioeconomic and demographic characteristics utilize the services of different rural-based health care providers—indigenous healers, traditional birth attendants (TBAs), faith/spiritual, western-trained doctors and nurses as well as chemist shopkeepers—for conditions ranging from infertility, through child birthing and abortions, to swollen body, epilepsy, bone setting, and stubborn skin diseases. Major attractions to rural-based therapists were the failure of urban-based health services to provide cure, perceived mystical nature of conditions, need to conceal information on therapeutic progress and/or the nature of specific disease conditions, belief in rural-based therapists' ability to cure condition, and affordability of the services of rural-based health care providers. Findings underscore the critical implications of service characteristics, cultural beliefs, and the symbolic content of place(s) for care seekers' patterns of resort. We suggest that need exists for policies and programs aimed at making health care services in urban Nigeria more responsive to care seekers' socioeconomic and cultural sensitivities, integrating informal health care providers into Nigeria's health care system, and strengthening public health education in Nigeria.*

KEYWORDS *Igbo, Nigeria, Rural-based health care services, Urban women.*

INTRODUCTION

Rural people's use of urban-based health services in Nigeria is relatively well documented.¹⁻⁶ But we know little about the use of rural-based health services by urban Nigerians. This study explores patterns of use of rural-based health services among urban-based Nigerian women. Data for this study emerged from a qualitative survey of sources of health care utilized by ethnic Igbo women in the city of Aba, in southeastern Nigeria. The original purpose of this study was to provide scientific information for promoting the use of safe- and quality-health care services among women in urban Nigeria. However, during the course of the survey we found evidence that some of the healing services used by urban women were rural-based. As we are not aware of any study investigating the use of rural-based health services by urban dwellers in Nigeria, we decided to explore the evidence.

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We hope not only to provide information on a relatively poorly documented phenomenon but to also sharpen current understanding of the issues affecting the health status of southern women in the transition towards global health sustainability as expressed, for instance, in the 1995 Beijing Plan of Action. The key questions explored in this study were Who are these urban Igbo women seeking rural-based health services? What specific rural-based healing services do they seek? What are the health conditions for which they sought rural-based health care services? What issues motivate their quest for specific rural-based health service providers? Answers are expected to enlarge scientific understanding of urban people's health-seeking practices and enrich health policy and action especially for women.

Methods

Study Site The specific site of this study is Aba, a commercial city in Abia State, southeastern Nigeria. Aba lies between latitudes 5°04' and 5°08' north and longitudes 7°18' and 7°24' east and has an estimated population size of 1 million. Aba has an area of roughly 40,000 km². About 92% of persons who live in Aba town belong to the Igbo ethnic group. Igbo women comprise about 38% of residents in Aba. Fifty-one percent of persons living in Aba were classified as severely poor in 2001 and women form the bulk of these people.⁷ Although described as one of the fastest growing towns in Nigeria and as the commercial hub of the entire southeastern Nigeria, Aba is characterized by poverty and poor public-services delivery. The history, geography, demography, and political organization of the city are well documented,^{8,9} with some of these studies offering insights into residents' life. Records show that there are eight government-owned health facilities in Aba (one teaching hospital, one general hospital, and six community health clinics) and 83 privately owned hospitals and clinics.

A host of other informal health care providers operates freely in Aba. These include traditional medical practitioners, spiritual healers, itinerant and patent medicine sellers, and injectionists.^{10,11}

Participants This study, conducted between April and August, 2003, was part of citywide survey of patterns of health care-services utilization among female Igbo persons residing in Aba. The main purpose of the survey was to profile the varieties of therapeutic systems, which female Igbo persons in the city of Aba utilized—between the year 2000 and the study period—to manage their ill-health conditions. This study focused on Igbo women ages 15 and above. To recruit the study participants, we identified and clustered all households in Aba into 42 zones. Seven of these zones were subsequently selected by using the systematic sampling technique.¹² With the help of local informants, all the households in these seven zones with ethnic Igbo female heads were carefully identified and listed. For the purposes of this study, we defined a household as a group of people living in the same house, answerable to the same head and sharing a common source of food and income. The fishbowl sampling technique¹² was then used to select 41 households in each of sampled zones. Altogether 287 households with ethnic Igbo female heads were selected. The women heads of each of these households were targeted for interviewing but where they were not seen, any other Igbo female, ages 15 and above, in the household was interviewed. Of the 287 Igbo women interviewed, 63 (22%) confirmed having utilized rural-based health resources or services for some of their illness episodes during the period covered by this study.

Interview Procedures Data for this study were elicited from the 63 urban women who reported utilizing rural-based health care facilities for some of their illnesses. The instrument for data collection was an open-ended, in-depth, face-to-face individual interviewing schedule. The qualitative approach was adopted as it supports the generation of a rich pool of descriptive information and data that affords multiple thematization and analysis. The interviews sought, *inter alia*, information on the ill-health conditions for which participants had sought rural-based health care, the socioeconomic and demographic characteristics of the women, the particular forms of rural-based health services, which they had utilized, why they chose to uptake particular therapeutic systems, and so forth. Four methodologists—from sociology, anthropology, communication arts, and community health—independently vetted the interview schedules used in this study. The interviews were administered in local language by 11 trained female Igbo field assistants recruited from the Abia State Polytechnic in Aba. Participants verbally consented to the audio recording of their responses and were guaranteed confidentiality and anonymity of their responses. Audio-taped responses were later transcribed into English with the help of the field assistants and a few Igbo-speaking persons studying English language and linguistics at the University of Uyo. Samples of transcribed responses were also independently discussed with sociologists and anthropologists in the Faculty of Social Sciences, University of Uyo, Nigeria. They made useful suggestions that helped to refine, validate, and establish themes in the data. Analysis of data was thematic, seeking to identify and discuss the key issues that the interviews threw up. Narratives are quoted verbatim to illustrate participants' responses on key issues.

Findings

The Respondents The ages of the respondents ranged between 17 and 61 with the highest proportion of the respondents (41%) in the 35–45 age bracket. Altogether, the average age of all the participants stood roughly at 43. Interview data indicate that most women were married. There were, however, eight single women, seven widows, two divorced, and one separated participant in the sample.

Most of the women were either Catholics or Protestants. A handful of the respondents identified themselves as traditional worshippers. Recent estimates show that most of the persons living in Aba are Catholics and Protestants. Although gradually losing its grips, traditional religion is practised both in urban and in rural Igboland.¹³

The bulk of the respondents had little or no formal education (67%). Only a few of the respondents had tertiary-level education. Altogether, completed years of formal schooling among the participants averaged nine. Most of the participants were housewives (81%), petty traders (79%), students (9%), and unemployed (41%). There were also civil servants and private sector employees in the sample.

Many respondents confirmed having sought rural-based health care services for more than one condition during the period surveyed. Respondents did not only uptake health services in their own (rural) villages but also in rural Igbo villages other than theirs. Five respondents also sought rural-based health care outside Igboland. It was observed that it is not all people who seek rural-based health services that get healed. "Some get well, some do not, some even die," noted one middle-aged woman.

Depending on the nature and severity of their conditions, care seekers utilizing rural health services may stay in the facility of the rural care provider until the cessation of their treatment. Or they could be going to meet the healers on appointed days.

Many of the participants knew city dwellers that had undertaken similar trips to rural areas. "It is not uncommon for people here (i.e. in Aba town) to go to rural areas to seek treatments for some diseases . . . several people who live in Aba do it; sometimes women even go to the village to deliver babies. Even young children are sometimes taken to rural areas to be treated," remarked one of the women.

When asked the sources of funds with which they were able to undertake their therapeutic quests, the women mentioned husbands, boyfriends, personal savings, their children, relatives, and well-wishers. Some of the care seekers also reported that they had to borrow and sell some of their properties to finance the trips. In some instances, care seekers had to be accompanied by relatives, such as sons, daughters, husbands, brothers, sisters, and mothers or by persons taking them to the therapists. Those whose conditions were such that they needed to stay back with the therapists or healers had to take extra money for their feeding and other contingencies. Care seekers who had to stay awhile with rural-based care providers sometimes also went with relatives who run their errands and acted as caregivers. One woman told us;

I stayed there . . . with one of my daughters. She used to fetch water, prepare my food, and wash my things. She also used to go to the town to get more money and to tell the family how I was doing.

Sixty-three percent of the women claimed they were successfully treated in the rural-health facility they had utilized. Few said their conditions failed to improve or even worsened. Nineteen percent confirmed that their treatments were ongoing; they were still keeping appointments with their rural-based therapists. Many of these people were, however, positive about the likely outcome of the treatments.

Health Conditions and Types of Rural Providers Utilized

Urban Igbo women sought both western and nonwestern health services and cures in rural areas. The women confirmed seeking such health providers as traditional birth assistants (TBAs) and traditional healers (priestess/priests, bone-setters, diviners, indigenous psychiatrists, and herbalists). The services of rural-based prayer homes, chemists, and western-trained nurses and doctors were also utilized by the participants.

Urban women sought the services of rural-based healers for conditions ranging from bone setting through infertility to sexually transmitted infections (STIs) and fibroid. Abortion services and cures for chronic cough, skin diseases, and eye disorders were also frequently sought from rural-based health service providers. Most of the conditions for which rural-based health services were sought related to reproductive health-related conditions—abortion, childbearing, infertility, STIs (particularly gonorrhoea and sores/discharging pus from the vagina), fibroid, menstrual problems, breast disorders, and family planning.

Most of the women (80%) sought treatment in the city within 7 days of appearance of symptoms. The duration of illness episodes before sufferers began uptaking rural-based health care services ranged between 4 days (for STIs) and 21 years (for sleepwalking). The period was longest for sufferers of epilepsy, sleepwalking, fibroid, diabetes, menstrual problems, stubborn skin diseases, eye disorders, and cough.

Delays in uptaking rural-based health care services were largely consequent upon the initial use of urban-based healing services. Major places of initial presentation with symptoms were pharmacies, chemists, clinics, and hospitals in the city. Upon first presentation to a hospital or clinic and in few instances pharmacies and chemist stores, many of the women had their conditions diagnosed. In the hospitals and clinics, most of the women were admitted after a diagnosis and were informed of their specific disease conditions. Participants with a history of initial hospital admission for their conditions were more precise in naming their conditions to us (e.g., fibroid, stroke, diabetes). Faith and spiritual healers, itinerant medicine sellers, traditional healers in the town were also frequently mentioned providers of initial presentation. There were also reports of self-medication involving over-the-counter medicines and popular herbal remedies.

Choosing and Using Particular Forms of Rural-Based Health Services

From the interview accounts, urban Igbo women use rural-based health services for several reasons. A major reason is the perceived failure of initial treatments in the urban area to improve sufferers' conditions. Many of the women reported seeking rural-based health services when it became obvious that the symptoms or conditions were persisting despite initial treatments in the town.

In some instances, respondents believed their initial treatments in the city were unsuccessful because mystical forces (i.e., witchcraft, spells, infraction of taboos) caused their conditions. One of the respondents says:

I tried many cures in the city. I went to the hospital where many tests were conducted, nothing was ever found out, my church also prayed and I also visited many pastors and Christian faith healers. I also attended several crusades . . . Yet, the condition persisted. Witchcraft was responsible for my condition . . . that is why all the treatments I sought couldn't work. I traveled to my village where I consulted a traditional healer/seer who confirmed it . . . and he destroyed the witchcraft . . .

Some respondents also believed that their conditions persisted because the initial treatments they used in the urban areas were either unsuitable or not strong enough for their conditions. They noted that besides diseases with supernatural aetiology, there were some disease conditions that respond faster to traditional medicine than to western cures. Conditions such as fractures, stroke, diabetes, and infertility were widely believed to defy western cures and are best treated by good traditional healers presumably found mainly in rural areas. For instance, one woman who revealed being cured of strange crawling/movement by a rural-based herbalist observes;

The diseases that hospitals cure are different from the ones traditional healers cure . . . I began experiencing strange movements in my body about two years ago . . . like a thousand millipedes were crawling all over me . . . some very uncomfortably, strange, frightening movements. Immediately it started, I knew that this was not the type of disease you take to a hospital or chemist. I told my husband what I thought . . . and we went back to our village . . . to meet one herbalist who is popular for his anti-witch herbs. The man cured me completely in two months. He even divined that I had stepped on *nsi*, poison, kept for someone else. Hospitals would not have done much in that instance, traditional healers in the city are

not also usually as good as the ones in the villages . . . If you want good herbalists, you just have to go the rural areas – that’s where you will find them.

Interview data also reveal that very rarely did care seekers alone take the decision to seek rural-based therapeutic services. There was only one care seeker who confirmed uptaking a rural-based health provider without seeking anybody’s advice. Her case was unique; she sought abortion services from her own aunt who runs a patent medicine store in the village, and who had earlier told her that she should see her first if she ever has need for an abortion. In some instances, friends and relations visiting the patients were the first to express the need to try rural-based treatments while in other cases, the families of the sufferers felt a need for it. Cases of previous healers (including both traditional and western healers) openly advising care seekers to return to their villages for solutions to their health problem were also reported. Patients and their families also did seek information from colleagues, relations, peers, neighbours, and healers about potential healers when it became obvious that initial treatments were not working. In one case, the husband of a respondent travelled back to the village to inform village-based family members about the wife’s condition and to seek their opinion. The family decided that she be brought back to the village to be treated by a popular traditional healer in a nearby village.

In all cases, specific rural therapeutic destinations were selected after the potentials of available and similar options in the rural place had been extensively considered. Respondents noted that in selecting specific rural therapeutic destinations, premium was often placed on the service characteristics such as affordability, service providers’ reputation and popularity, and responsiveness of destination to patients’ sociocultural sensitivities. One of the women noted;

I went to that particular native healer because he does not perform sacrifices as part of his treatment. I am a Christian and I don’t support animal sacrifices. We heard of other good healers too but from our inquiries, we discovered that most of them told patients to perform sacrifices as part of their treatment.

Many participants also sought health services in rural places primarily because they needed secrecy and privacy over the nature of their conditions, which they felt could not be guaranteed if they used health care services in the urban place. Need for privacy and secrecy often arose when sufferers did not want people in their places of origin (i.e., the urban place) to know the type of health problems they had, their progress with treatment, and/or the particular forms of healing systems they were utilizing. One of such persons informed us that there were native healers in Aba town she could have consulted, but she feared being discovered by her church members. Her church, she said frowns against the use of the services of indigenous healers. Another young woman who suffered from an STI and sought treatment for it in a rural area told us she did not feel comfortable seeking cure for the STI in Aba town where according to her, she had lived for 26 years. “People know me quite well here”; she said “they may find out and begin to see me as wayward”.

The need for privacy/secrecy also motivated urban women to seek rural-based health care when they suspected people (such as their neighbours in towns) to be responsible for their condition. In such situations, care seekers leave the urban place so that people suspected to be responsible will not know where they were seeking treatment or what progress they were making. It was feared that such people may work towards rendering ongoing therapies ineffective. We were told;

I suffered three years from a very terrible skin disease . . . It was caused by our neighbour's witchcraft and we didn't know. I went to several health providers in town and when my condition tries to improve, he will make the situation worse . . . we later discovered and I left for the village . . . we had to leave the city and we kept the destination secret. He was always asking my husband about where I was receiving treatments. Nobody told him. . . . I came back cured and the herbalist who cured me told us that if the man tries to bewitch me again, he would die.

Another also says;

Well . . . we did not want people in the city to know how and where I was being treated. You have to be careful about such things. You do not know who has caused your problem. If the person knows you are responding positively to treatment . . . he may worsen the situation . . .

Low cost of rural-based health care services was also a major attraction of rural-based health services for care seekers in this study. Many of the respondents noted they had utilized the services of rural-based care providers because treatments for their conditions were cheaper in the rural areas than in the city. This was attributed to the high cost of living in urban centres and people in urban areas were more materialistic than rural dwellers. Respondents also noted that health services of all types cost higher in the city than in the rural areas. Many of the respondents sought rural-based health care services because they could not afford the same type of health care in the city. One of the abortion seekers told us;

I sought abortion service from a rural-based clinic because . . . the cost was quite low. I visited many hospitals in Aba town and the prices they gave me were too high ranging between ₦4,500.00 – ₦8,000.00. I am only a student. I didn't have that kind of money. My friend directed me to a rural clinic which charged far less . . . They charged me ₦1,500 only.

Other important reasons why urban women sought rural-based health care include awareness of particular therapist's ability to manage the condition, desire to be treated by experienced and/or trusted therapists, and need for quick attention, and so forth. Five persons confirmed seeking particular rural-based healers on the basis of kinship relations. One of them utilized a rural-based maternity clinic owned by her husband's brother's wife. She said

My husband's brother's wife owns the clinic . . . she is a trained nurse; she has always helped me to deliver my babies and does not collect money from us.

Nonhealth Costs and Benefits of Urban–Rural Therapeutic Itineraries

The quest for therapy in rural areas by urban dwellers reportedly led to loss of household incomes and savings. Care seekers, especially those who took up residence with rural-healers areas during their therapeutic sojourns also noted that their other social activities and engagements suffered. Some of them could not attend weddings, naming ceremonies, parties, and other important wedding ceremonies. Others missed church activities and community programmes. Care seekers also confirmed that some of their children who stayed with them in the villages as caregivers missed school for the period and some even had to repeat classes. There were also care seekers

who reported that the therapeutic sojourns afforded them the opportunity to know some rural villages, meet and make friends elsewhere. "I sought cure in a rural Okigwe village . . . I am not from Okigwe anyway, . . ." said one middle-aged mother, "during the period I made friends among the people . . . I even began to learn Okigwe-Igbo dialect . . . I have gone back to visit them once . . ."

Discussion

This study focused only on the health-seeking behaviours of Igbo women in the city of Aba, Nigeria. Much of the data were qualitative in nature and may have led to a certain lack of clarity. For instance, when participants reported suffering from skin diseases, swollen body, and so forth, they may have been reporting signs and symptoms rather than actual ill-health conditions. But on the whole, respondents answered without being prompted and the views that emerged were theirs rather than the interviewers'. At a very close look, the emerging responses are critical and raise some potentially critical issues of note.

Urban Igbo women of different socioeconomic and demographic characteristics do uptake rural-based health services for conditions ranging from abortions to sleepwalking. The commonest conditions for which rural-based health services were utilized among women in urban Nigeria relate to reproductive health conditions. It has been noted that many urban women in the global south have unmet needs for quality abortion, family planning services, and skilled reproductive and obstetric care and often resort to various source of health care to address these needs.^{14,15} Emerging from this study is evidence that the sources of reproductive care among urban Igbo women in Nigeria include hospital, clinics, prayer houses, TBAs, chemists, medicine vendors, and indigenous healers in rural areas. However, while some of these providers may do a better job than those in the city because they have more experience and pay more attention than the urban providers, most of them appear to be poor substitutes for advanced medical care with potentials to expose women to risks of complications, fatalities, and further infections.¹⁶⁻¹⁸

Informal health services, especially indigenous medicine, were the most frequently sought form of rural health care services among urban women. This particular form of therapeutic service was utilized for conditions ranging from child birthing to infertility. Recent studies show that informal health services, especially traditional cures, are widely used in sub-Saharan Africa. Some authorities have shown that people in several parts of sub-Saharan Africa have great confidence in traditional medicine.¹⁹ Scholars^{3,20,21} contend that in sub-Saharan Africa, herbal medicine is viewed to be an effective therapeutic system for several ill-health conditions. It thus continues to be relevant and useful to the lives of many women in the developing world who, as can be seen from this study, can go at great length to get the best of it. A major attraction of traditional medicine may be that it always has some kind of treatment available in contrast to the allopathic practitioners who might prescribe medications not easily attainable.¹⁹

The main reasons care seekers gave for seeking rural-based health services relate to service characteristics such as affordability need for secrecy and privacy over conditions, reliability, trustworthiness, therapeutic popularity, and efficiency. Research has shown that health seekers tend to uptake the services of those providers that are seen as being responsive to their values, needs, and sensitivities.^{17,18} For instances, it has been noted in Nigeria that differences in lay and formal notions of diseases and therapy interfere with people's (especially the less educated) readiness to seek care in formal health settings.^{5,20-23} A mismatch between the values, needs,

and sensitivities of Igbo women may thus be a major push factor in their quest for rural-based therapists. Health care services in urban Nigeria are often exorbitant and outside the reach of many care seekers.^{24,25} High cost of urban-based health care services can be a disincentive to many people especially where poverty is widespread. Currently, formal health services in urban Nigeria are on a “cash and carry” basis. Poor care seekers who have need for such services are often at risk of being denied attention and good care.^{11,26–28}

In leaving the urban place to uptake health care services in rural places on grounds that certain diseases are best treated in rural areas and/or that urban-based health service providers may not meet their needs for secrecy and privacy over their conditions, care seekers also draw attention to how constructions of place may mediate care-seeking practices. Many respondents in this study confirmed seeking rural-based health services because they do not feel at home treating certain conditions in the city where they live. Or because they viewed the rural place as a potentially “better” place of the type and quality of care they need. Landscapes and places are often symbolically imbued with cultural identity and meaning. Places may, as Eyles²⁹ notes have symbolic content either in their own rights or because of the sentiments they represent. Consequently, respondents constructed urban and rural areas in given terms vis-à-vis their diseases. Ethnographic studies of health and place show that individuals often perceive a relationship between characteristics of a geographic location, their health, recovery, well-being, and self-identity. Illness and poor health can therefore hold intrinsic negative social value, which can be escaped by moving place. Places can also hold important social values for people seeking cures and treatment and can influence care seekers’ willingness to utilize health care resources. Leaving one place to uptake health services in another may thus be a mechanism through which care seekers negotiate the manifold context and nature of health and diseases and the dynamics of flows between places.¹¹ In this study, rural areas were imbued with and held forth certain intrinsic social values, part of which was the promise of protecting care seekers from certain unfavourable and negative social consequences in the urban place. This suggests a link between the symbolic content of places (i.e., sentiments places represent, the reputations they have, and peoples’ activities in or a memories of places) and care seekers’ willingness and readiness to uptake health services located in such places.

Concluding Observations

Evidence from this study suggests that urban Igbo women of different socio-economic characteristics utilize rural-based health care services for several health conditions. Their motivations in doing this vary. This study has its limitations. It relies only on data obtained from a small number of women. Including women and men from other ethnic groups and cities in Nigeria would have given us a broader picture of these itineraries and better equip us to generalize about their dynamics in Nigeria. Certainly, this is an area for further research and investigation. In the meantime, however, this study reveals the need for policies and programmes, which aim at

1. making health services in urban areas responsive to the socioeconomic and cultural sensitivities of urban dwellers, especially women,
2. mainstreaming informal health service providers into Nigeria’s health care system and working to reduce the risks faced by care seekers who utilize them,

3. improving the quality of public health education available to Nigerian peoples with the aim of promoting their understanding of the nature of health, diseases, and health services in society, and
4. reducing the high levels of poverty and illiteracy in Nigeria.

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