SOCIO DEMOGRAPHIC DETERMINANTS OF HERBAL USE AMONG PREGNANT WOMEN IN EKITI STATE OYE AND ADO AS A CASE STUDY

BY

OLALEYE OMORINSOLA R.

SOC/14/2086

A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF SOCIOLOGY, FACULTY OF THE SOCIAL SCIENCES, FEDERAL UNIVERSITY OYE-EKITI, EKITI STATE.

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF BACHELOR OF SCIENCE IN SOCIOLOGY, FEDERAL UNIVERSITY OYE-EKITI, EKITI STATE, NIGERIA.
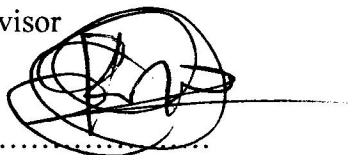
NOVEMBER 2018

CERTIFICATION

I heréby certify that OLALEYE OMORINSOLA RUTH with Matric Number: SOC/14/2086 carried out this project in the Department of Sociology. Faculty of the Social Sciences. Federal University Oye Ekiti, Ekiti. In partial fulfillment of the requirements for the award of Bachelor of Science in Sociology (B. sc Sociology)

....

DR. ABIMBOLA O.H
Supervisor

23/02/2019
Date

....

DR. KOLAWOLE TAIWO
Head, Department of Sociology
Federal University Oye Ekiti.

5/03/2019
Date

....

External Examiner

....

Date

DEDICATION

I dedicate this work to the glory of God. I also dedicate it to my lovely, understanding and ever-supportive parent **MR AND MRS ADEBAYO OLALEYE** for their priceless effort and encouragement towards my education I really appreciate it, I pray you will reap the fruit of your labour in good health and wealth, I love you so much and God bless you both amen.

ACKNOWLEDGEMENT

TABLE OF CONTENT

ABSTRACT

This study examined the socio-demographic determinant of herbal use among pregnant women in Ekiti state. The project set to investigate factors that spurred the use of herbs among pregnant women, to see the relationship in the perception pattern of pregnant women residing in urban and rural area. It also attempt, to understand the interaction between modern and indigenous medicines. The sampling technique used was the convenient sampling technique. For the analysis, such parameters such as frequency table and percentage distributions were employed while for the inferential data such parameters such as means, standard deviation and other inferential analysis . The quantitative data was analysed using the Statistical Package for the Social Sciences (SPSS) version 17.The analysis revealed the distribution of respondence according to their place of residence is almost even as 50.5 percent of the total sample resides in Oye-Ekiti while 49.5 percent are from Ado. Majority of whom are between the ages 20 to 30, 29 percent between the ages 31-40 and the least populous of the categories which are the people between the ages 41-50 consisting of just 3% of the total sample. Comparing on the basis of ethnicity, majority of them are Yoruba consisting of 79% of the total sample size. Nearly 13% Igbo and 6% Hausa, and other ethnic groups made less than 3% of the total sample. Observing the religion of respondents, nearly 80% of them are Christian, and less than 16% Muslims, other religions are just 5% of the total population. Using the chi-square analysis, it was revealed that at 5% level of significance, it can be ascertained that only three of the tested socio-demographic variables had a significant relationship with the use of herbal medicine. These variables are age, ethnicity and level of income. The study concluded that not all socio-demographic and economic factors put to test had an effect in the use of herbal medicine, as some factors had significant influences some do not. This research suggest that government and non-governmental agencies concerned with health care should invest immensely to improve and promote herbal medicines as it is preferred by most people for different reasons. Thereby decreasing the inherent risk of exposing people to over dose and other health risk that may be associated with the use of herbal medicine. Also there should be an approach towards making herbal medicines scientific and understandable through researches as to what the constituents of those mixtures are and how they work.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Herbal medicines are defined as plant derived materials or preparations with therapeutic benefits, and contains raw or processed ingredients from one or more plants (W.H.O, 2000). Herbal medicines refer to the use of plants for the promotion of healing and maintenance of health. It is said that the use of herbal medicines originated in Egypt back in 1550 BC, yea many of their pharmacological effects remain poorly understood (Abas, 2001).

The use of herbal medicine has been on the increase in many developing and industrialized countries [Ernst, 2003; Tiran, 2003,]. Herbal medicines have been used to treat many illness, disease and ailments, such as asthma, eczema, premenstrual syndrome, rheumatoid arthritis, migraine, menopausal symptoms, and chronic fatigue, among others. The use of herbal medicine during pregnancy is common, ranging from 7.0% to 55.0% [Frawley et. al, 2013]. However, there are variations in the prevalence of herbal use among pregnant women across geographical locations depending on certain international factors some reviewed studies show that in developing countries in Africa, especially Nigeria the same pattern still exist ranging from 12.08% to 66.7% among reviewed works [Fakeye et al,2009; Tamuno et al,2010;Orief YI et al,2014].

In the western world prevalence estimates of herbal medicine use in pregnancy varies considerably across countries, ranging from 52-58% in Australia and the United Kingdom [Hoist L et al,2011; Nordeng H et al,2011]to 40-48% in Norway and Italy [Lapi F.et al, 2010; Mousally K, et al, 2009] and 6-9% in Canada and US [Louik C,et al,2010; Gharoro EP,2000].

In Nigeria, the use of herbal medicine has been the dominant method of health care system in all cultural and traditional societies. In urban and rural areas today, there is a high patronage of herbal medicine. A lot of individuals make use of herbal medicine basically for therapeutic purpose with the sole aim of treatment of diseases or disorders as well as restoring health to normalcy. In Nigeria, the Female population is no stranger to the use of herbal care as a bulk of the women population makes use of herbs often times, most especially when they are pregnant. In Nigeria, it's no exception the Nigerian people and even the government equally are aware of the role and need for an alternative means of health care for the people. This awareness gave birth to the establishment of the "Nigerian Natural Medicine Development Agency" (NNMDA). Herbal medicine/traditional medicine practice in Nigeria permeates every tribe.Thus the aim of this study was to assess the socio-demographic factors influencing herbal medicine use among pregnant women attending clinics in Ekiti-state.

1.2 Statement Of The Problem

The high use of herbal medicines may be due to accessibility, affordability, availability and acceptability of traditional medicines by majority of the populace in developing countries. The Increasing cost and distrust of modern western medical care in recent years has given rise to the promotion of the use of traditional therapies. Many of these herbal remedies include some form of herbal or homoeopathic remedy that is not medically regulated for safety or efficacy (Ernst and White, 2000). In several contexts, women preferred to deliver at home and call in a missionary midwife where they were in a familiar and convenient setting. During a homebirth, a woman would not need to arrange for child care or transportation, could rest in her own bed after delivery and be catered for by her family and friends (Garces et al.,2012). The perception that

2

birth is a natural life event rather than a medical procedure emerged as a common belief amongst many women therefore they saw no rationale for delivering at a facility and paying to do so is considered illogical and superfluous. Giving birth in a religion's environment played an important role as first-line providers for many women. (Chinwe 2012),

In most developed countries herbal medicines are gaining popularity. Herbal medicine and Therapy have in time past been seen as a fetish way of curing diseases. It was widely believed that only poor and illiterate individuals were patronisers of traditional medicine. This thought is further buttressed by the fact that most of its practioners were regarded as witch doctors who took care of their patient with occultic powers. Practioners of traditional medicine were not in any way seen as doctors; even the western trained doctors saw them as a threat to the well being of their patient.

According to World Health Organization, 60% of the world's population depends on traditional medicine and 80% of the population in developing countries depends almost entirely on traditional medicine practices and herbal medicines for their primary health care needs. As a result of increasing demand for herbal medicines, there are increasing concerns about the safety, standardization, efficacy, quality, availability and preservation of herbal products by policy-makers, health professionals as well as the general public. Among the Female population in the country, there are various factors that accounts for the use of herbal medicine and these factors could be social or could be as a result of the environment these women find themselves. Social factors such as education, age, income, and employment determine the use of herbal medicine among women. Also, Urban as well as rural settings affect herbal use among women. Those in the rural areas are thought to patronize herbal care givers due to the locality of the area and the absence of standard western modern medical facilities compared to what is obtainable in urban

3

centers. The weak performance of the health system has been attributed to the country's long-standing problems with governance. Corruption in the political system is endemic while social development, including the promotion of the health of Nigerian citizens has been more rhetorical than a real aim of the state (Lindroos 2010).

The problem of poor organization and access to maternal health services has always been a major challenge in Nigeria despite the fact that the health care is organized around three tiers: primary, secondary and tertiary care levels. Primary health centres are located in all the local government councils in the country where pregnant women are to receive antenatal care, delivery and postnatal care in the one nearest to them. In case of complications they are referred to secondary care centres managed by states or tertiary centres, managed by the federal government. Unfortunately, the primary health care centers designed for pregnancy related issue are mostly poorly funded and filled with incompetent staff. (Aghoja et al, 2008).

These pertinent issues amongst others have become fresh and burning in sociological research and public concern due to the adverse effect herbal medicines have. This study is therefore concerned with socio-demographic determinant of herbal medicine use among pregnant women in Oye local government and Ado local government.

1.3 Significance Of The Study

Health is the most precious of all things and it is the foundation of all happiness. The use of Herbal medicine has developed in various communities in Nigeria, and among the female folks as well in response to the health needs of the people. Many communities have, therefore, since creation, developed various traditional systems using locally-available resources for the alleviation of their health problems. This research is aimed at investigating the socio demographic determinant of herbal medicine use among Nigerian women. In view of this, the

4

study will as well be significant in identifying the various societal level factors responsible for increased herbal intake, this study will also help to find out other factors that promote herbal intake and also more importantly this research will add to the existing knowledge about herbal use as everyone will have valuable information about herbal medicine use. Furthermore, Findings in this study will also help other researchers interested in any of the variables mentioned in this work to source for information and insights. This research work will also be a major scientific landmark as it is one of the major projects in Nigeria focusing on Socio demographic determinants of herbal medicine use among Nigerian women. I believe this is a contribution to the body of Knowledge

1.4 Purpose Of The Study

This study proposes to investigate Socio-Demographic determinant of herbal medicine use among pregnant women in Oye local government and Ado local government.

1.5 Research Questions

1. What is the prevalence of herbal medicine use among pregnant women?

2. What are the social factors that influence the intake of herbal medicine among pregnant women?

3. What are the demographic factors that influence the intake of herbal medicine among pregnant women?

1.6 Research Objective

The main objective of this study is to examine the Socio-demographic determinant of herbal use among pregnant women and the specific objectives are to:

1. Identify the various socio-demographic factors that is responsible for increased herbal intake among pregnant women.

2. Establish if there are other factors affecting herbal use among pregnant women

3. Identify other factors that promotes the use of herbal medicine

4. Add to existing knowledge about herbal use.

1.7 Research Hypothesis

In pursuit of the research problems and to realize the objectives of this study, the following hypotheses have been raised and·will be tested:

Hypothesis 1

H0 Socio-demographic factors have no significant effect on the use of herbal medicine

H1 Socio-demographic factors have a significant effect on the use of herbal medicine

Hypothesis 2

H0 Socio-economic factors have no significant effect on the use of herbal medicine

H1 Socio-economic factors have a significant effect on the use of herbal medicine

1.8 Scope Of The Study

This research work focuses on Socio-Demographic determinant of herbal medicine use among Nigerian women. This study is limited to Ekiti state from where data will be gathered from Oye local government and Ado Local government.

1.9. Operational Definition Of Terms

For the purpose of clarification .Certain terms need to be defined. These terms are: health, medicine, herbal medicine, pregnant women, social factors and demographic factors.

Health

W.H.O. defined health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. Health is a process of adaptation the result is not of instinct but of an autonomous yet culturally shaped reaction that is socially created. According to this research health refers to the physical, spiritual, moral and social aspects functioning together harmoniously which is the traditional definition of health.

Traditional health

The W.H.O. define traditionalmedicine as the sum of all knowledgeand practices (whether explicable or not) usedin the diagnosis, prevention and elimination ofthe physical, mental, and social imbalance and relying exclusively on the practical experience and observations handed down from generation to generation whether verbally or orally or in writing

Modern or scientific health

Scientific medicine -sometimes referred to as 'orthodox medicine' -can be termed as a system of care that is based on the knowledge attained from a scientific process (i.e., through observation and research. Although scientific medicine emphasizes on the physical and mental health of a person, the spiritual aspect of the person is not taken into consideration

Medicine

Medicine can be defined as a profession which is predominantly manned or controlled by doctors who give their service to patients. It is a science of healing, the practice of diagnoses, treatment and prevention of disease.

Herbal Medicine

Herbal medicines are defined as plant derived materials or preparations with therapeutic benefits and contains raw or processed ingredients from one or more plants [WHO, 2000]. Herbal medicine, also called botanical medicine or phytomedicine, was defined as herb, herbal material, herbal preparation, and finished herbal product that contains parts of plants or other plant materials as active ingredients. The plant materials include seeds, berries, roots, leaves, bark or flowers (WHO,2008). In this research herbal medicines are basically those medicines or mixtures used for cure of ailment that were casually prepared by not necessarily a trained medical practitioner and with no chemical or laboratory employment involved. Again, the questions centered on herbal products that were used solely for medicinal purposes and excluded those consumed as nutrients.

Pregnant women

A pregnant woman is a woman having a baby developing inside her (oxford advanced learner dictionary 7th edition). However, the pregnant women that will be considered in this research are all categories of women that their physical appearance makes it obvious that they are pregnant, that is, such person is aware that she is pregnant.

Social Factors

Social factors are every situation or circumstances that surrounds and depends on the people and interaction one engage in. such social factors include cultural beliefs, religious beliefs etc.

Demographic Factors

Demographic factors include personal details of an individual such as age, marital status, educational status, occupation, geographical settlement etc.

1.10 Ethical Issues

Data will be collected from both primary and secondary with proper consideration of ethical values such as:

i. Anonymity: the invisibility and deliberate cover up of respondent to ensure confidentiality. Anonymity includes no name or any personal or traceable information about respondent.

ii. Participant will not be forced to be part of the research rather participant will become part of research only by voluntary acceptance.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

This chapter is concerned with the review of prior and existing literature and theoretical framework on the Socio-demographic Determinant of Herbal Use among pregnant women. The literature review is thematised as follow:

iii. Herbal medicines

iv. The history of herbal medicine

v. Herbal medicine in Nigeria

vi. African perspective of herbal medicine in healing and curing

vii. Interaction between indigenous and modern medicine

viii. Prevalence of herbal medicines

ix. Factors that influence the use of herbal medicine by pregnant women

x. Theoretical framework

2.1 Herbal Medicines

Herbal medicines are defined as plant derived materials or preparations with therapeutic benefits, and contains raw or processed ingredients from one or more plants [WHO, 2000]. Herbal medicine, also called botanical medicine or phytomedicine, was defined as herb, herbal material, herbal preparation, and finished herbal product that contains parts of plants or other plant materials as active ingredients.The plant materials include seeds, berries, roots, leaves, bark or flowers(WHO,2008). In this research herbal medicines are basically those medicines or mixtures used for cure of ailment that were casually prepared by not necessarily a trained medical practitioner and with no chemical or laboratory employment involved. Again, the questions

centered on herbal products that were used solely for medicinal purposes and excluded those consumed as nutrients.

2.2 History of Herbal Medicine

Herbal medicine is the oldest form of healthcare known to mankind. Herbs had beenused by all cultures throughout history. It therefore means that every culture has explored and used plants for medicinal purposes. The presence of several plants withmedicinal properties in a Neanderthal tomb in Iraq suggests that herbs may have been used therapeutically for more than 60 000 years (Solecki, 1975). The first records come from China, where the Emperor ShenNung compiled Pen Tsao (The Great Herbal, or Chinese MateriaMedica) in about 3000 BC. This book had many subsequent editions, and many of the thousand or more drugs described are still used in China (Guthrie, 1945). Ancient Egyptian medicine of 1000 B.C. are known to haveused garlic, opium, castor oil, coriander, mint,indigo, and other herbs for medicine and theOld Testament also mentions herb use andcultivation, including mandrake, vetch, caraway, wheat, barley, and rye. It is also on recordthat the Ebers Papyrus discovered in atomb in Egypt in 1862, dates from 1550 BCand is the oldest medical text to survive. Itcontains hundreds of herbal remedies, includingcastor seeds and senna for constipation, and a decoction of cumin, goose fat and milk for various stomach complaints. Mesopotamianpractice is recorded on a thousand clay tabletsdating from the 7th Century BC: over 200 plant-derived medicines again included castor oil and senna as laxatives (Porter, 1977). In the written record, the study of herbs dates back over

11

5,000 years to the Sumerians, who described well-established medicinal uses for such plants as laurel, caraway, and thyme. Through the middle Ages, herbalism was preserved in the monasteries of Britain and mainland Europe. Before the establishment of universities in the eleventh and twelfth centuries, monasteries served as medical schools. Monks copied and translated many of the works of Hippocrates, Dioscorides, and Galen. Their "physick" gardens, well-stocked with the most common and useful medicinal herbs, served as basic training grounds for the next generation of physicians - monks and laymen alike.

Meanwhile, as a result of the Islamic conquest of North Africa in the seventh and eighth centuries, Arabic scholars acquired many Greek and Roman medical texts. Iranian physician IbnSina, also known as Avicenna (980-1037 A.D.), combined the herbal traditions of Dioscorides and Galen with the ancient practices of his own people in The Canon of Medicine (al-Qanunfi at-tibb). One of the most influential medical texts ever written, Avicenna's Canon spread through Europe during the eleventh and twelfth centuries. With the invention of the printing press in the mid-fifteenth century, the herbals of Dioscorides, Galen, and Avicenna were mass-produced and made accessible to people outside the palace, the monastery, and the university. Use of the herbals required no specialized skills: readers simply gathered the herbs and applied them in the prescribed manner and dosage

2.3 African Perspective in Herbal Medicine and Curing

As there is an African way of understanding God ... in the same way, there is an African way of understanding the world, the visible world around us – the cattle, trees, people and cities as well

as the unseen world, the supernatural world of spirits, powers, and diseases' (Oduro*et al.* 2008:9). In spite of the introduction of Western medicine and health care systems in Africa, many African communities still rely on traditional health care (World Health Organisation [WHO] 2001). Kofi-Tsekpo (2004:i–ii) notes that the phrase 'traditional medicine' has become a catchword among the peoples in all countries in Africa. This is partly because the use of herbal remedies has gained popularity worldwide and the exploitation of these remedies has become a multimillion industry. He further argues that the term 'African traditional medicine' is not synonymous with 'alternative and complementary medicine'. African traditional medicine is the African indigenous system of health care and, therefore, cannot be an alternative. In Africa, there is an important reason why African traditional medicine has become increasingly popular. The high cost of allopathic medical health care and the expensive pharmaceutical products have become unavailable to a majority of people. Also based on the definition in the South African traditional medicine act which defines Traditional Medicine in the light of the African context Traditional African Medicine, Traditional African Medicine is the system of traditional medicine which has its origin and root embedded in the culture and beliefs of the African continent. Reports from the WHO state that less than 50 per cent of the populations in Africa especially sub-Saharan Africa have regular access to pharmaceuticals. Ninety percent of Traditional African Medicine is based on herbal therapy. Herbal therapy or medicine include herbs, herbal materials, herbal preparations and finished herbal products, which contain as active ingredients parts of plants, or other plant materials, or combinations thereof. Africa is blessed with a rich biodiversity estimated to over forty thousand plant species about 6,377 plant species are used in tropical Africa, four thousand of which have medicinal value.

2.4 Herbal Medicine in Nigeria

In Nigeria, it's no exception the Nigerian people and even the government equally are aware of the role and need for an alternative means of health care for the people. This awareness gave birth to the establishment of the "Nigerian Natural Medicine Development Agency" (NNMDA). Herbal medicine practice in Nigeria permeates every tribe. In a research involving Eighty nine species, plants belonging to forty six families were identified from fifty respondents, with herbal recipes recorded for thirty five ailments or therapeutic uses Nigeria, Herbal medicine practice in Nigeria permeates every tribe. In a research involving Eighty nine species, plants belonging to forty six families were identified from fifty respondents, with herbal recipes recorded for thirty five ailments or therapeutic uses. It should be however be noted that before now, quacks bedeviled the Nigerian traditionalmedicine practice. This was largely due tolack of necessary legislations to control andregulate the practice. But regulation of herbalmedicines was introduced in Nigeria in 1993in Decree No.15 and was revised in 1999. Underthis decree herbal medicines are regulatedas dietary supplements, health foods, functionalfoods and as an independent regulatory category.As reported in the WHO global surveyon National, policy on traditional medicine andregulation of herbal medicines, May 2005,Nigeria, the expert committee on Traditional Medicine was created in 1978. The work of this committeeled to the creation of two national researchinstitutes on Traditional Medicine and herbalmedicines, founded in 1988 and 1992. Theyare the Nigeria Natural Medicines DevelopmentAgency in Lagos, Nigeria and the

National Institute for Pharmaceutical Research and Development. In recent years, the treatments

and remedies used in traditional African medicine vis- a-vis Nigeria have gained more

appreciation from researchers in Western science. Developing countries have begun to realize

the high costs of modern health care systems and the technologies that are required, thus proving

Africa's dependence to it (Helwig, 2010). The various societies that make up the Nigerian State

have for long relied on the indigenous health system which was developed as a response to their

environment and it involves the use of locally available resources to prevent and cure diseases. It

is a natural health care system which many generations of Nigerians have used. The practice

transcends the maintenance of good health of the people as it also protects them from the menace

of wild animals, evil spirits, accidents, provide bountiful harvest, good luck and other human

activities [S. Roan, 1999,O. Osborne, 2007.]. Nigerians therefore, have a deep belief and reliance

on traditional medicine, hence about 80 per cent of the population uses it almost exclusively

while about 95 per cent use it concurrently with western medicine. This is because, to the

Nigerian, traditional medicine treats the entire individual rather than one aspect of him or just his

disease. According to the World Health Organization, traditional medicine is: The total

combination of knowledge and practices, whether explicable or not, used in diagnosing,

preventing or eliminating physical, mental or social diseases and which may rely exclusively on

past experience and observation handed down from generation to generation, verbally or

inwriting [WHO, (2008).].At the centre of this practice are health professionals variously called

Babalawo (Yoruba), Dibia (Igbo), Boka(Hausa), and among whom different expertise in healing has emerged. These include herbalists, bone-setters, traditional birth attendants, and psychiatrists among several others. They usually rely on vegetables, mineral substances, animal parts and certain other methods such as prayers, divinations, and incantations [J. S. Mbiti, (1976)., B.E. Owumi et al 2008].Traditional medicine exists in four major categories viz: Nature healing (bone setting ,hydrotherapy, use of air, fire and hypnotism etc.), Natural healing (telepathy prayers, incantations, hypnotism etc.),Herbal healing (use of leaves, branches, fruits, stem back, roots, whole plants); Spiritual healing (involving spirit as demons, witchcraft, water mermaid etc.) [Nigerian Tribune, September, 8, 2010].

2.5 Interaction between Indigenous and Modern Medicine

According to Asante and Awornyo (2013), integrating these two medical systems involves "the introduction of traditional medicines, techniques and knowledge into the country's mainstream health care delivery system and the exposure of the practitioners of both systems to the philosophies and theories of the systems in order to provide an effective preventive and curative treatment for all people". This is to say that the integration should be institutional, consumer-engendered, adaptation and cognitive. The integration of biomedicine, traditional healing, western medicine (integrative approach) can yield extensive results in healing the physical body and psychological illnesses if applied in a knowledgeable manner. In any part of the world, the functioning condition of the general state of the body and the degree to which it is free from both

16

physical and psychological illness has always been a source of concern to the medical experts (Abiodun, 2005).

2.5.1 Prevalence of Herbal Medicines

Herbal medicines are defined as plant derived materials or preparations with therapeutic benefits, and contains raw or processed ingredients from one or more plants [World Health Organization (WHO). 2000;].The use of herbal medicine has been on the increase in many developing and industrialized countries [Ernst, 2003;Trian, 2003]. The use of herbal medicine during pregnancy is common, ranging from 7.0% to 55.0% [Frawley,2013]. Reviewed studies across the world show wide variations in prevalence of herbal medicine use. In the western world prevalence estimates of herbal medicine use in pregnancy varies considerably across countries, ranging from 52-58% in Australia and the United Kingdom [Hoist et al,2011; Nordened et al,2011] to 40-48% in Norway and Italy [Lapi,2010] and 6-9% in Canada and US [Louik, 2010]. In developing countries in Africa, especially Nigeria the same pattern still exist ranging from 12.08% to 66.7% among reviewed works [Fakeye et al,2009; Tamuno et al,2010;Orief YI et al,2014].This high use of herbal medicines may be due to accessibility, affordability, availability and acceptability of traditional medicines by majority of the populace in developing countries [Elvin-Lewis, 2000]. Some of the herbs could cause adverse effects due to adulteration, inappropriate formulations, plant and drug interactions, effects that are sometimes life threatening or lethal [Drew AK 1997]. Patients who are likely to be at risk from adverse effects of herbal medicines

include those who are already prone to difficulties from orthodox medications including fetuses, infants, pregnant and lactating mothers [Conover E.A. 2003; Becaw J et al 2010]. Herbal medicine use among pregnant women raises particular concerns of safety. Exposure of pregnant women to chemicals such as herbs and supplements during pregnancy period could affect their fetuses [Wilkinson JM. 2000] and could contribute to maternal and fetal morbidity and mortality for instance as common as the use of ginger is, a study in rats found an association between prenatal exposure to ginger in high quantities with increased fetal loss, increased fetal weight and bone maturation [Hepner DI.2002].

Herbal medicine use in pregnancy has been reported to be recommended by health providers [Broussard CS et al,2009;Hollyer T et al, 2002], natural and alternative medicine providers [Broussard CS et al,2009; Hollyer T et al 2002; Maats F. et al2002], pharmacists [Broussard CS et al,2009; Maats F. et al2002], friends and family [Broussard CS et al,2009;
Nordeng H et al, 2004; Tsui B, et al 2001], based on information from media sources [Broussard C et.al 2010] or based on woman's own information and knowledge [Broussard CS et al,2009; 29]. In addition to these concerns, poor regulatory framework for importation, manufacturing and distribution of herbal medicines in Africa keeps herbal medicine poorly researched, where even the registered products exist, it does not adhere to good manufacturing practices, principles of safety and efficacy as is required for conventional medicines [Hemminki E. et al 1991; Hoist L. et al2009].

The prevalence of pregnant women taking herbal medicinesin the Offinso North District was 6.5%. This isrelatively low compared with other similar studies inSub-saharan Africa- 12% in

Kenya in a district hospital14;50.4% in Ethiopia15 and 50.0% in Harere.16 Forthis study in Offinso North district; pregnant womenwere asked open-ended questions to assess whetherthey used any herbal medicines during pregnancy.

2.5.2 Factors that Influence the Use of Herbal Medicine by Pregnant Women

A greater understanding of the factors influencing women's health from a biological perspective has been paralleled by a greater understanding of the psychosocial and social factors that affect women's health status. Differences in employment patterns also result in fewer women being medically insured than men, strongly affecting access to health care and health status.

Though the pattern of herbs used varied greatly from one location to another due to their type of vegetation and culture, ginger and garlic have been consistently reported as some of the common herbs used in pregnancy from most of the works reviewed [Lapi F et al2010; Louik C et al2010; Tamuno I et al2010; Orief YI et al2014; Mbura JS et al1985;Tsui B et al2001; Nordeng H etal2005;Kennedy DA et al2013].

Characteristics of women likely to take herbal supplements in pregnancy as reported in various studies include; being older i.e. women over the age of 35 [Hoist L et al, 2008; Foster DA. et al,2006; Nordeng H.et al 2005], married [Broussard CS et al 2009; Hoist L et al 2009; Nordeng H et al2005], primiparous [Nordeng H et al2011; Fakeye T.O et al2009; Broussard CS et al2009; Nordeng H et al2004;Nordeng H et al2005], having tertiary education [Broussard CS et al2009; Hoist L et al2008; Foster DA et al2006; Rashmi S et al2006;Moussalhy K et al2008; Gibson P et al2001] being less educated [Fakeye T.O et al2009;Orief YI et al 2014; Hoist L et al2009; Henry A, 2000], low socioeconomic status [Orief YI et al 2014], high socioeconomic status [Rashmi S et al2006; Gibson P et al2001], trimester of pregnancy at herbal use [Orief YI

19

et al2014; Hollyer et al2002; Nordeng H, et al2004], having higher gravidity and parity [Mbura JS, et al1985], higher body mass index [Mbura JS, et al1985], previous history of herbal use [Henry A ett al2000], prior pregnancy[Hoist L et al 2008;Foster DA et al2006], and severity of nausea and vomiting [Broussard CS et al2009; Henry A et al 2000; Kennedy DA et al 2013]. Women with "basic" and "no formal education" with a median age of 25 years used herbal medicine more than women with senior high and tertiary education. Bodeker and Kronenberg obtained similar results where women with no formal or only primary education used herbal medicines more.(Bodeker G et al 2002) Other sources have indicated contrary results, that women who use herbal medicines are characterized as having higher education and incomelevels.(Frawley J et al2013;Holst L et al2009) Therefore, it must be pointed out thatseveral of the factors associated with herbal medicineusers vary from one study to another and appears to reflect whether it is a community study or simply, pregnant women attending ANC in a health facility.(Frawley J et al2013)

Majority, of pregnant women indicated that the source of acquisition of the herbal medicines was through ancestral practice. This goes to buttress the point that some of the more complex reasons for preference of herbal medicines are associated with cultural and personal beliefs, philosophical views on life and health (Frawley J et al2013;Hall HGet al2011). Several authors have also suggested that this may well reflect a woman's desire to have a natural approach to pregnancy Ernst et.al 2009) or perhaps these women feel a desire to use less conventional medication. This could represent a concern, as studies have found that women will often not communicate the use of herbal medicines to their health care providers.(Frawley J et al2013;Holst L et al2009)

20

Some reasons given for the use of herbal medicines by pregnant women in Offinso North were for well-being of the fetus (to improve on fetal outcome) and to aid in easy labour and delivery. Also the indiscriminate sale of herbal drugs in vehicles with loud speakers both in rural and urban centers in Nigeria, with little or no restriction is worrisome, as this aids the mass sale of these drugs to the unsuspecting masses with little or no information about the safety of these herbs.

2.5.3 Socio-Demographic Factors That Influence Herbal Use

Income And Herbal Use

Direct costs associated with maternal health care services are very high for many Nigerian women, considering the poverty level in the country many cannot afford to pay their medical bills as such they prefer to stay at home and look for the services of traditional birth attendants who charge less or in some cases free of charge (Ajaebu, 2013).

Education And Herbal Use

A strong body of evidence indicates that educational level is one of the measures for assessing socioeconomic status and also an important predictor of health status. Low education levels are linked with poor health, more stress and lower self-confidence whereas, higher education predicts good health. (Aminu 2011). Attainment of better education can' increase income and empower individuals to effectively promote their own health. Education is one of the factors for early childhood development that has a determining influence on subsequent life and the decision an individual makes in life.

Religion And Herbal Use

In several contexts, women preferred to deliver at home and call in a missionary midwife where they were in a familiar and convenient setting. During a homebirth, a woman would not need to

arrange for child care or transportation, could rest in her own bed after delivery and be catered for by her family and friends (Garces et al., 2012). The perception that birth is a natural life event rather than a medical procedure emerged as a common belief amongst many women therefore they saw no rationale for delivering at a facility and paying to do so is considered illogical and superfluous. Giving birth in a religion's environment played an important role as first-line providers for many women. (Chinwe 2012), women emphasized the close bond that they felt with the missionary midwives, due to their status in the community and the trust they developed over years of experience. This relationship often prompted women to desire home-based births attended to by a missionary midwives rather than a facility. Women perceived these missionary midwives as providing high quality delivery care, often emphasizing the supportive and emotional role that they play. A lot of women believed that these missionary midwives have innate skills giving to them by God and are more dependable providers than facility-based health workers. (Chinwe, 2012).

Rural And Urban Differences In Herbal Use

Access to healthcare services which includes prenatal care, childbirth and postnatal care, is largely determined by geographical location, cost, proximity of the health facility, affordability of healthcare services, quality of service, level of education and gender (Filipi et al. 2016). Research have shown that approximately 71 percent of Nigerian rural settlement have a primary healthcare facility within a 5km radius to their homes but many of these facilities are not functional due to lack of equipment and essential supplies, inaccessible due to distance and bad roads and unqualified staff (Federal Ministry of Health 2011). Rural areas in developing countries such as Nigeria tend to receive less healthcare attention compared to the urban areas.

The few healthcare facilities located in rural areas are often poorly equipped and poorly-staffed and inaccessible due to distance, bad roads, and high cost of transportation.

2.6 Review Of Relevant Theories

The relevant theories reviewed on this study will be anchored on the Health Belief Model Theory the Political Economy of Health Theory and the Human Ecology Model.

2.6.1 Health Belief Model

The health belief model is a psychological health behavior change model developed to explain and predict health-related behaviours, particularly in regard to the uptake of health services. The health belief model was developed in the 1950s by social psychologists at the U.S. Public Health Service and remains one of the best known and most widely used theories in health behavior *research. The health belief model suggests that people's beliefs about health problems, perceived* benefits of action, barriers to action, and self-efficacy explain engagement (or lack of engagement) in health-promoting behavior. A stimulus, or cue to action, must also be present in order to trigger the health-promoting behavior.

Assumptions

The assumptions of this theory is that human being are very rational in their thoughts and action and will take a health related action if they

- Feel that a negative health condition can be avoided

- Have a positive expectation that when they take recommended action, it will be possible to address a negative health condition.

- Believe they can successfully take the recommended action to address their health condition

Based on the above assumptions of the health belief model, we can assume that the use of herbal medicines among pregnant women in Nigeria may not be steered towards the positive direction due to the fact that women in Nigeria are unduly marginalized e.g.in education, employment, politics etc, the interest of women are not considered including pregnant women, women are subdued by cultural roles, expectation without necessary attention given to their own personal upgrading how then can they possibly avoid a negative health condition in such an environment? The condition of most pregnant women is such that it will be very difficult to take health related actions to address health issues except if the government intervenes .

The health belief model is based on six concepts which are:

1. Perceived susceptibility: one's belief of the chances of developing a health problem. The health belief model is of the idea that individuals who believe that they are likely to develop a particular health problem will engage in behaviors that will reduce their chances of developing the health problem while those who do not feel that they are likely to develop the health problem are more likely to engage in unhealthy, risky behavior.

2. Perceived severity: one's belief about how serious a health problem is and its potential consequences. The health belief model predicts that individuals who perceive a particular health problem are more likely to develop behavior that prevents the health problem from occurring. It is based on individual's opinion of the disease itself

3. Perceived benefit: this refers to one's perception about the efficacy of actions available to reduce the risk or seriousness of an illness or disease. This course of action one takes is

24

based on one's evaluation of perceived susceptibility and perceived benefit of taking the action. An individual is likely to accept a recommended action· if it is perceived as beneficial and would have a positive result

4. Perceived barriers: this refers to the person's belief about the obstacles to undertaking the recommended health action. This includes both physical and psychological barriers. The person weighs the effectiveness of the actions against the perceptions that it may be expensive, dangerous, unpleasant, time consuming or inconvenient

5. Cues to action: this refers to what prompts or triggers an individual to accept a recommended health action. The cues can be internal such as pain, or external such as advice from others or illness of a relative

6. Self efficacy: this refers to one's level of confidence and ability to successfully perform the health action. If an individual thinks he/she can't do it, they may avoid taking the action. This can be helped by encouragement and support from other persons.

2.6.2 Political Economics of Health Theory

The political economy theory is a broad theoretical framework which can enhance better understanding of the many economic, political and socio-historical forces which determines contemporary health issues and how we handle those issues. (Minkler, Walace and McDonald 1994). The political economy of health refers to a body of analysis and a perspective on health policy which seeks to understand the conditions which shape population health and health service development within the wider macro economics and political context. (IPHU, 2013)

2.6.3 Human Ecology Model

Human ecological theory was first associated with Ernest Haeckel (1969), a German zoologist who explain how human interaction provide a way of making sense of events that have happened in the past thereby, allowing us to make predictions about what may happen in the future. Human ecology theory is a way of looking at the interactions of humans with their environments and considering this relationship as a system where biological, social, and physical aspects of the organism are considered within the context of their environments. This theory focus on how the natural and human environments influence our behavior and how individual and families in turn, influence these environments, individual and the environment are viewed as being interconnected in an active process of mutual influence and change The theorists outline an ecosystem, most particularly a human ecosystem or a family ecosystem, as being composed of three organizing concepts: humans, their environment, and the interactions between them. The humans can be any group of individuals dependent on the environment for·their subsistence. The environment includes the natural environment, which is made up of the atmosphere, climate, plants, and microorganisms that support life (Filipi et al. 2006).. Another environment is the natural and human-built environments which include roads, machines, shelter, material goods and the social- cultural environment.Also human beings; cultural constructs such as language, law, values; also social and economic institutions such as our market economy and regulatory systems.

The ecosystem interacts at the boundaries of these systems as they interface, but also can occur within any part of an ecosystem that causes a change in or acts upon any other part of the system. Change in any part of the system affects the system as a whole and, its other subparts, creating the need for adaptation of the entire system, rather than minor attention to only one aspect of it.

Below are the importance and relevance of human ecology theory as outlined by Bubolz and Sontag (1993);

- It helps to understand the processes by which families function and adapt and how they ensure survival, improve their quality of life, and sustain their natural resources

- It helps to determine ways by which families allocate and manage resources to meet needs and goals of individuals and families as a group and how their decisions affect the quality of life and the quality of the.

- It gives us insight into how various kinds and levels of environments affect human development and how family system adapt when one or more of its members make transitions into other environmental settings, such as day care, schools and hospitals.

- It provides understanding on how to create, manage, or enhance environments to improve both the quality of life for humans, and to conserve the environment and resources necessary for life.

- It helps to show changes that are necessary to improve human lives and how can families and family professionals contribute to the process of change.

The human ecology model provides a framework for understanding maternal mortality and its spatial patterns in Nigeria. Used by geographers, social and behavioral scientists to explain the patterns of human interaction with their physical and social environment. It suggests that human health variations over the surface of the earth are due to habitat, population and behavior differences (Meade and Emch 2010. The absence or presence of health facilities differs across space and therefore affects us differently. Human behavior

stems from cultural beliefs, values and perceptions which ultimately affect the decisions we make.

2.7 Theoretical framework

2.7.1 Health belief model and Herbal Use among Pregnant Women

In the case of pregnant women, the major factors that contribute to the use of herbal medicines is their socio-economic status and external factors (social factors) this can be linked under health belief model to perceived barriers and cues to action, which considers the person's perception about the obstacles to taking recommended action and what prompts individual to accept a recommended health action. There are lots of barriers that can hinder pregnant women from avoiding herbal medicines; they include financial ability, environment, lack of adequate infrastructure like hospitals, good roads and so on. And there are cues which could be internal or external that can trigger the use of herbal medicines among pregnant women it could be pressure from families, friends and even the community as a whole or it could be internal in form of pain.

2.7.2 Political Economy of Health Theory and Herbal Use among Pregnant Women

Most researchers often studies issues concerning health with regard to biological factors but the fact remains that factors which affects health goes beyond the biological factor. It is strongly connected to society and its cultural and economic environment. Herbal medicine use among pregnant women can be challenged by various factors such as the affordability of health care services, supply of medical practitioners, government policies and availability of health facilities. For someone to have good health, two conditions must be met; first, one's living conditions

should not induce diseases, and secondly, one should have access to health care services (John, 2015). Unfortunately, these two conditions are not met in Nigeria access to health care services are limited and overstretched due to overcrowding in the available hospitals

The political economy theory is mainly based on the assumption that those that are rich are more likely to live in good conditions and practice healthy lifestyle than those that are poor. Many of the diseases which endanger the lives of most pregnant woman in Nigeria could have been easily cured or eliminated if resources were made available and affordable to them.

Political economy theory posits that people make use of herbal medicine as a result of their status in the society, and the status is affected by some demographic factors such as age, educational background, occupation, location. For instance, people living at Ado Ekiti are kind of obviously richer than those in Oye Ekiti, a trader would have access to the use of herbal medicines than a banker.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter provides the description of the methods used in collecting and analyzing the data for this research. It makes clear certain part of the work such as research design, population of study, sampling procedure, sample size, sampling technique, method of analysis and presentation.

3.1 Study Area

Historical Profile Of Ekiti State

Located in the south western part of Nigeria, Ekiti state was created on October 1st 1996 by the late Former Head of state and Commander-in-Chief of Armed Forces of the Federal Republic of Nigeria, General Sani Abacha, in a nation-wide broadcast to mark the 36th Independence anniversary of Nigeria. The people of Ekiti state are mostly Muslims and Christians while some are traditionalists. The State has sixteen local Councils which include Edo-Ekiti-East, Ekiti Southwest, Ekiti West, Ikere, Irepodun, Ijero, Oye, Ikole, Efon, Moba etc. And its major towns include Ado-Ekiti, Efon Alaaye, Aramoko-Ekiti, Ikole Ekiti, Iyin-Ekiti. John Kayode Fayemi serves as the current governor of Ekiti State in Nigeria.

Historical Profile Of Oye Ekiti

Oye is a town and Local Government capital in Ekiti. Oye is bounded by Ilejemeje to the North, Ifelodun to the South and Ikole. Oye hosts a growing student community hosted by the Federal

University Oye . Oye Local Government Area was carved out from the defunct Ekiti North Local Government on 17th May, 1989. Majority of its inhabitants speak Yoruba with only a few dialectical variations.

3.2 Population Of The Study

This refers to the unit or universe from which samples were selected for the study. The population for this study will be all the categories of pregnant women, few selected herbalist and western medical practioners in Ekiti state particularly Oye and Ado.

3.3 Research design

The research design that will be employed for this study will be the descriptive research design. This research design becomes imperative due to the descriptive nature of the phenomenon under investigation.

3.4 Sampling procedure and technique

The sampling technique for this study will be the convenient sampling technique. The convenient sampling will be 200 pregnant women in the selected communities, 100 in each community.

3.5 Data collection instrument

The research instrument for the study will basically consist of questionnaire survey. Both primary and secondary data will be generated. For the primary data, the questionnaire will be employed. While the secondary data will be generated through textbooks, internet, journals to mention but a few.

3.6 Method of Data analysis

Using quantitative method, the data generated for this study will be analysed using both the descriptive and the inferential statistic analysis. For the analysis, such parameters such as frequency table and percentage distributions will be employed while for the inferential data such parameters such as means, standard deviation and other inferential analysis e.g ANOVA. The quantitative data will be analysed using the Statistical Package for the Social Sciences (SPSS) version 17.

3.7 Ethical considerations

Data will be collected from both primary and secondary with proper consideration of ethical values such as:

i.   Anonymity: the invisibility and deliberate cover up of respondent to ensure confidentiality. Anonymity includes no name or any personal or traceable information about respondent.

ii.   Participant will not be forced to be part of the research rather participant will become part of research only by voluntary acceptance.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter focuses on data presentation and statistical analysis on socio-demographic determinants of herb use among pregnant women in Nigeria.However, the statistical analysis is going to be done in two in levels, which are the univariate and the bivariate level.

The univariate level explains the characteristics of the respondents using tables of frequencies and percentages. The second level which is the bivariate mainly compares two variables, usually a dependent and independent variable, statistical technique such as chj-square, one-way ANOVA and Sidak's test would be employed in doing this.

4.1 Univariate Analysis

Univariate analysis refers to the description of variables to be considered in this research work. The variable to be considered are tabulated below.

TABLE 4.1.1: Socio-demographic and economic characteristics.

	Frequency	Percentage
Place of residence		
Ado	99	49.5
Oye	101	50.5
Age group		
20-30	136	68.0
31-40	58	29.0

41-50	6	3.0

Ethnicity

Yoruba	158	79.0
Igbo	25	12.5
Hausa	12	6.0
Others	5	2.5

Level of education

no formal education	3	1.5
Primary	43	21.5
Secondary	17	8.5
Graduate	118	59.0
post graduate	19	9.5

Monthly income

no income	55	28.6
below 18,000	24	12.5
18,000-35,000	44	22.9
35,000-52,000	25	13.0
52,000-75,000	10	5.2
75,000+	34	17.7

Religion

Christianity	159	79.5
Islam	31	15.5
Traditional	10	5.0

Occupation

Unemployed	20	10.0
civil servant	58	29.0
self-employed	39	19.5
Student	83	41.5

Have you heard of herbal medicine

Yes	200	100
No	0	0

Source of knowledge

Internet	12	6.0
family and friends	141	70.5
health talks	30	15.0
Media	10	5.0
Others	7	3.5

Ever used herbs

Yes	163	84.5
No	30	15.5

Where do you seek health care while pregnant

Church	4	2.0
Mosque	4	2.0
Hospital	172	87.8
Herbalist homes	16	8.2

how effective is herbs is during pregnancy?

Not effective	36	19.9

Effective		68	37.6
Indifferent		60	33.1
I don't know		17	9.4
***No response		19	
TOTAL		200	100

Source: Field survey

Table 4.1.2.   **Reasons for using herbal medicines**

	strongly disagree (%)	Disagree (%)	Undecided (%)	Agree (%)	strongly agree (%)	**TOTAL**
Affordability	28.0	14.5	24.4	16.1	17.1	100
experience with traditional healing	19.2	18.7	20.2	25.4	16.6	100
my parents are herbalist/ native doctor	76.2	15.5	4.1	2.1	2.1	100
hospitals have too many protocols	11.4	14.0	13.5	38.9	22.3	100
prefer herbs to pharmaceutical drugs	19.2	19.2	22.3	19.7	24.2	100

hospital personnel are rude and unapproachable	9.3	18.7	36.3	25.4	10.4	100
pharmaceutical drugs are expensive compared to herbs	3.6	4.7	5.7	40.4	45.6	100
herbs are effective during pregnancy	0.0	19.9	9.4	33.1	37.6	100

Source: Field survey

Interpretation

The tables above describe the socio-demographic and economic characteristics of the respondents and their reasons for using herbs.

From the table 4.1.1. above, the distribution of respondence according to their place of residence is almost even as 50.5 percent of the total sample reside in Òye-Ekiti while 49.5 percent are from Ado. Majority of whom are between the ages 20 to 30, 29 percent between the ages 31-40 and the least populous of the categories which are the people between the ages 41-50 consisting of just 3% of the total sample.

Comparing on the basis of ethnicity, majority of them are Yoruba consisting of 79% of the total sample size. Nearly 13% Igbo and 6% Hausa, and other ethnic groups made less than 3% of the total sample. Less than 2% of the total respondents had no formal education. Less than 22% had their education till prmary school, almost 9% had secondary level education. The chunk

of the sample consisting exactly 59% of the population where able to have a tertiary level of education and nearly 10% of them claim to have a post graduate level of education.

Observing the religion of respondents, nearly 80% of them are Christian, and less than 16% Muslims, other religions hare just 5% of the total population.

In terms of economic characteristics, majority of the respondents do not have a stable source of income, the least categories consisting less than six percent of the respondents earns 52,000-75,000. 10% are unemployed, nearly 42% are still students likely to be economically inactive, and others are either self employed or civil servant.

All the respondents claimed to have heard of herbal medicine from one source or the other. Of which nearly 85% make use of herb during pregnancy, and less than 16% of the respondents claimed never to have used herbal medicine at on time or the other.

4.2. Bivariate

The table below shows the relationship and the statistical extent to which women's socio-economic characteristics influence their use of herbal medicine. It also showing the characteristics of currently pregnant women by Income, place of residence, occupational status, and educational level.

It will include crosstabulation and other statistical techniques such as chi square, eta test. etc.

Table 4.2.1

		ever used herbs		Total
		Yes	No	
place of residence	Ado	80	16	96
		83.3%	16.7%	100.0%
	Oye	83	14	97
		85.6%	14.4%	100.0%
	20-30	116	20	136
		85.3%	14.7%	100.0%
Age of respondent	31-40	46	8	54
		85.2%	14.8%	100.0%
	41-50	1	2	3
		33.3%	66.7%	100.0%
	Yoruba	133	21	154
		86.4%	13.6%	100.0%
	Igbo	16	9	25
Ethnicity		64.0%	36.0%	100.0%
	Hausa	9	0	9
		100.0%	0.0%	100.0%
	Others	5	0	5
		100.0%	0.0%	100.0%
	no formal education	3	0	3
		100.0%	0.0%	100.0%
	Primary	40	3	43

		93.0%	7.0%	100.0%
Education	Secondary	10	4	14
		71.4%	28.6%	100.0%
	Graduate	93	21	114
		81.6%	18.4%	100.0%
	post graduate	17	2	19
		89.5%	10.5%	100.0%
	no income	52	3	55
		94.5%	5.5%	100.0%
	below 18,000	16	4	20
		80.0%	20.0%	100.0%
Monthly income	18,000-35,000	36	5	41
		87.8%	12.2%	100.0%
	35,000-52,000	19	6	25
		76.0%	24.0%	100.0%
	52,000-75,000	10	0	10
		100.0%	0.0%	100.0%
	75,000+	22	12	34
		64.7%	35.3%	100.0%
	Christianity	129	26	155
		83.2%	16.8%	100.0%
	Islam	27	4	31
		87.1%	12.9%	100.0%
Religion	Traditional	7	0	7

		100.0%	0.0%	100.0%
	Unemployed	17	3	20
		85.0%	15.0%	100.0%
	Civil servant	46	12	58
		79.3%	20.7%	100.0%
	Self-employed	28	8	36
Occupation		77.8%	22.2%	100.0%
	Student	72	7	79
		91.1%	8.9%	100.0%

Source: Field survey

Table 4.2.2.: Chi-square (X^2) Analysis for use herb against other variables

Variables	Coefficient	P-Value	Interpretation
Place of residence	0.183	0.668	Not significant
Age-group	6.067	0.048	Significant
Ethnic group	10.972	0.012	Significant
Education	5.849	0.211	Not significant
Income	17.545	0.004	Significant
Religion	2.512	0.473	Not Significant
Occupation	5.085	0.166	Nqt Significant

Source: Field survey

Interpretation

From table 4.2.1 above, it can be deduced that 83% of the respondents residing in Ado Ekiti claimed to have ever used herb, and 17% said they do not use herbal medicines, also among those living in Oye-Ekiti, the trend seems similar, with nearly 86% using herbs during pregnancy and 14% non-users of herbal medicine. Across age categories, number of users are extremely higher than non-users, 86% to 14% respectively, except for the eldest age group 41-50 which had more than 66% non-users and 33% users.

The odds also differs across educational attainment, as the level of educational attainment increases the use of herbal medicines decreases. Also, while assessing the level of income against the use of herbal medicine, the cross tabulation revealed that income also seem to be inversely proportional to the use of herbs, in other word the higher the income of respondents, the less likely they are to make use of herbal medicine.

Considering the religious affiliation of respondents, there is no much discrepancy in the use of herb between the two most populous religions, viz: Christianity and Islam as each of the group had over 80% of its respondents using herbal medicine. As a matter of fact, those who adhere to other religions other than the two aforementioned groups had all their adherents using herbal medicine.

Occupation is also an economic factor to be considered, as it also determines the use of herbal medicines. The categories of occupation with the highest proportion of herb users are students and unemployed pregnant women having 91% and 85% users respectively. Other two categories viz: civil servants and self-employed women had 79% and 78% herb users respectively.

However, after the chi-square analysis, it was revealed that at 5% level of significance, it can be ascertained that only three of the tested socio-demographic variables had a significant relationship with the use of herbal medicine. These variables are age, ethnicity and level of income. As the p values calculated from this variables are less than 0.05, in essence we reject the null hypothesis (H_0) and accept the alternative hypothesis (H_1) meaning there is discrepancy across ethnic group, age groups, and level of income with respect to respondent's use of herbal medicine.

On the other hand, place of residence, level of education, religion and occupation were found to have no statistically significant influence on the use of herbal medicine as the as the P-values calculated from those variables are greater than 0.05, depicting a level of statistical insignificance.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

The main aim of this study is to investigate the socio-demographic determinant of herbal use among pregnant women in Ekiti State. This project thesis has however been classified into five (5) chapters. Chapter one of the project thesis talks about the introduction of the research topic. Chapter two of this research deals with the literature review, theoretical and empirical framework. The third chapter deals with the research methodology, sampling technique, method of data collection, and most importantly how the results were analyzed. Chapter four shows the presentation and interpretation of results pertaining the analysis of primary data gathered through the administering of the questionnaire. The result and interpretation of the research hypothesis were also presented. Finally, the fifth chapter presents the summary of the study, discussion of findings, conclusions, and recommendation. Also this chapter also deals with the discussion of research findings as they relate to the objectives of the study and providing answers to the research questions formulated in this study.

5.2 Discussion Of Findings

The major objective of this research is to ascertain if the socio-demographic characteristics of women most especially their place of residence affect their use of herbal medicines. The more reasons why the sample was collected from two different locations Ado-Ekiti and Oye-Ekiti both of which serve as models for urban and rural residence respectively. At the end if the research, it was discovered that place of residence as to whether living in Ado an

44

urban area or living in Oye a rural area as no statistically significant relationship with the use herbal medicine, that is place of residence had nothing to do with the use of herbal medicine.

Also, other socio-demographic variables such as level of education, religion and type of occupation also proved a neutral role in the determination of the use of herbal medicine.

However, factors such as level of income ethnicity and ages had significant things to say in determining the use of herbal medicine.

5.3 Conclusion

Conclusively, it can be deduced that not all socio-demographic and economic factors put to test had an effect in the use of herbal medicine, as some factors had significant influences some do not.

5.4 Recommendation

After going through literatures and commencement of this research, it is apparent that a large proportion people do prefer herbal medicine to pharmaceutical medicine for various reasons. Even from this research nearly 85% of the respondents are users of herbal medicines even during pregnancy.

Hence, my recommendation will be that government and non-governmental agencies concerned with health care should invest immensely to improve and promote herbal medicines as it is preffered by most people for different reasons. Thereby decreasing the inherent risk of exposing people to over dose and other health risk that may be associated with the use of herbal medicine. Also they there should be an approach towards making herbal medicines scientific and

understandable through researches as to what the constituents of those mixtures are and how they work.

5.5 Suggested Area For Further Studies

Herbal use among pregnant women is usually affected not only by socio demographic factors, am suggesting that further research should do findings on the following

1. Gender and health seeking behavior

2. Relationship between income and health management of people

3. Socio-cultural beliefs and health seeking behavior; a study of child and maternal health

4, The use of traditional medicine in treatment of malaria among pregnant women

REFERENCE

Asante, E. & Avornyo, R.,(2013). "Enhancing Healthcare System in Ghana through Integration of traditional Medicine". *Journal of Sociological Research*, Vol. 4, No. 2: 256-257.

B.E. Owumi, & P.A. Jerome, (2008) "Traditional Medicine and National Healthcare Reforms in Nigeria: Which Way?".

Becker, M.H.,Haefner,D.P.; Kasl;S.V.et al. (1977). *'Selected Psychological Models and Correlates of Individual Health-related Behaviours'* (Vol. 15).

Ernst E, White A. The BBC survey of complementarymedicine use in the UK. *Compl Ther Med*2000, 8:32-6.

Fakeye T.O, Adisa R, Musa I.E (2009). Attitude and use of herbal medicines among pregnant women in Nigeria. BMC Complementary and Alternative Medicine.

Frawley J, Adams J, Sibbrit D, Steel A, Broom A, Gallois C (2013). Prevalence and determinants of complementary and alternative medicine use during pregnancy: results from a nationally representative sample of Australian women. Aust. NZ. Obstet. Gynaceol., 53(4): 347-352. *from Antiquity to the Present.* Harpers Collins, London.

Guthrie, D.A. (1945). *History of Medicine.*Thomas Nelson and Sons Ltd., London.
Helwig, D. (2010). Traditional African medicine.Encyclopedia of Alternative Medicine.
Hoist L, Wright D, Haavik S, Nordeng H. Safety and efficacy of herbal remedies in obstetrics-review and clinical implications. Midwifery, 2011:27(1): 80-86.

International Journal of African Society, Cultures and Traditions Vol.3, No.5, pp.22-36, November 2015 Published by European Centre for Research Training and Development UK

International People's Health University (IPHU). The political economy of health, 2013. www. Iphu.org/en/polecon

J. S. Mbiti, (1976). African Religions and Philosophy. London. Heinemann.

Kofi-Tsekpo, M., 2004, 'Institutionalization of African traditional medicine in health care systems in Africa', *African Journal of Health Sciences* 11(1/2

Lapi F. Vannacci A, Moschiri M, Cipollini F, Morsuillo M, Gallo E, Banchelli G, Ceechi E, DiPirro M, Giovannini MG, Cariglia MT, Gori L, Firenzuoli F, Mugelli A (2015). Use, attitude and knowledge of complementary and alternative drugs (CADs) among pregnant women.

Minkler M, Walace S.P and Mc Donald M. (1994). The political economy of health: a useful theoretical tool for health education practices. University of California, Berkeley.

Olenja J. Feb,(2013). East African Medical Journal, Department of community health, College of Health Sciences, University of Nairobi, Kenya, Health Seeking Behaviour in Context

Mousallý K, Orachi D, Berard A (2009). Herbal products use during pregnancy: prevalence and predictors. PharmaCoepidemiol Drug Saf., 18(6): 454-461.

Nordeng H, Bayne K, Haven GC, Paulsen BS (2011). Use of herbal drugs during pregnancy among 600 Norwegian women in relation to concurrent use of conventional drugs and pregnancy outcome. Complement Ther. Clin. Pract.17(3): 147-151.

O. Osborne, (2007). Health Care System in Post-colonial Africa. Microsoft Student Dvd.

Oduro, T., Hennie P., Nussbaum S. & Brain B., (2008). *Mission in an African way: A practical introduction to African instituted churches and their sense of mission,* Christian Literature Fund and Bible Media, Wellington

Orief YI, Farghaly NF, Ibtahim MIA (2014). Use of herbal medicines among pregnant women attending family health centers in Alexandria Middle East Fertility Society, 19:42-50.

Porter, R. (1997). *The Greatest Benefit to Mankind. A Medical History of Humanity*
Proceedings of National Conference on Social Dimensions of Reforms and Development.
NASA, Sokoto. August 20-22.Pp 149-160.Retrieved 2010.

Rosenstock, Irwin (1974). '' Historical Origins of the Health Belief Model". Health Education Behaviour 2 (4) : 328-335.

S. Roan, (1999). Alternative Medicine. Encarta Yearbook, November.The Nation, August, 28, 2008. P. 44.

Sarieh Poortaghi, Afsaneh Raisifar, Parisa Bozorgad, Samad E.J, Sorror Parvizy and Forough Rafil. Evolutionary concept analysis of Health Seeking Behaviour in nursing: a systemic review.

Solecki, R.S. (1975). Shanidar IV, A Neanderthal Tower burial in Northern Iraq. *Science* **190:** 880-7.

Tamuno I, Omole-Ohonsi A, Fadare J. Use of Herbal Medicine among pregnant women attending a tertiary Hospital in Northern Nigeria. The Internet Journal of Gynecology and Obstetrics, 2010; 15(2).

Tipping, G., & Segall, M. (1995). Health Care Seeking Behaviour in Developing Countries: An Annotated Bibliography and Literature Review. Development Bibliography, 12. Brighton, UK: Institute of Development Studies, University of Sussex

Tiran D. The use of herbs by pregnant and child bearing women: a risk benefit assessment complement Ther. Nurs. Midwifery, 2003; 9:176-181

Toyin Adefolaju. Traditional and Orthodox Medical Systems in Nigeria: The Imperative of a Synthesis. *American Journal of Health Research.* Vol. 2, No. 4, 2014, pp. 118-124. doi: 10.11648/j.ajhr.20140204.13

University of Twente, 2012, Health Communication> Health Belief Model.
von Reis Altschul S. Exploring the herbarium. SciAm 1977; 236: 96-114

W.H.O, (2008). Traditional Medicine. Fact Sheet 134.

World Health Organization (W.H.O). General guidelines for methodology on research and evaluation of traditional medicine document. Geneva: World Health Organization, 2000

World Health Organization (W.H.O). General guidelines for methodology on research and evaluation of traditional medicine document. Geneva: World Health Organization, 2000

FEDERAL UNIVERSITY, OYE EKITI

QUESTIONNAIRE

SOCIO-DEMOGRAPHIC DETERMINANT OF HERBAL USE AMONG PREGNANT WOMEN

INTRODUCTION: I am a final year student of the Department of Sociology, Federal University Oye Ekiti, Ekiti state. This is a part of my B.sc research thesis and this is a questionnaire designed to obtain information from you for the prime purpose of conducting a research aimed at investigating the socio-demographic determinant of herbal use. You are kindly requested to answer the questions below by selecting the appropriate answer in your own humble opinion. Be rest assured that all the information required are for research purpose only and will be kept absolutely confidential. Thanks for your co-operation.

Yours faithfully,

Olaleye Omorinsola

SECTION A: QUESTION ON THE SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS.

Location

(1) Age group   (a) 20-30 ( )   (b) 31-40 ( )   (c) 41-50 ( )   (d) 51 and above ( )

(2) Ethnic group   (a) Yoruba ( )   (b) Igbo ( )   (c) Hausa ( )   (d) others Specify...........

(3) What is your highest level of education?

(a) No formal education ( )   (b) Primary ( )   (c) Secondary ( )   (d) Graduate ( ) (e) Post graduate ( )

(4) What is your estimated monthly salary?   (a) No income ( )   (b) below ₦18,000 ( )   (c) ₦18,000 - ₦35,000 ( )   (d) ₦35,001 - ₦52,000 ( )   (e) ₦52,001 - ₦75,000 ( ) (f) above ₦75,000 ( )

(5) Religion?   (a) Christianity ( )   (b) Islam ( )   (c) traditional ( )   (d) others Specify...............

(6) What is your occupation? (a) Unemployed ( )　(b) Civil servant ( )　(c) Self-employed ( )
(d) Student ( )　(d) others specify..............

SECTION B: QUESTIONS ON THE GENERAL KNOWLEDGE OF PEOPLE ABOUT HERBAL MEDICINES IN EKITI STATE

(7) Have you heard of herbal medicine before? (a) Yes ( ) (b) No ( )

(8) If Yes, How? (a) Through the internet ( ) (b) Through family and friends ( ) (c) Through health talks or medical practitioners ( ) (d) Through the media ( ) (e) Others specify..........

(9) Have you used herbal medicine before? (a) Yes ( ) (b) No ( )

(10) What do women prefer to use during pregnancy? (a) Prayer water ( ) (b) Herbs ( ) (c) pharmaceutical drugs ( )　(d) Others specify..........

(11) Why do women prefer your answer in number 10 above? ....

(12) Where do women seek health care while pregnant? (a) Church (b) mosque (c) hospital (d) herbalist home (e) Others specify..........

(13) Where do you seek health care while pregnant? (a) Church (b) mosque (c) hospital (d) herbalist home (e) Others specify..........

(14) How often do you seek health care? (a) daily (b) weekly (c) monthly (d) twice monthly

(e) Others specify..........

(15) In your language, what is the local name for herbs? ....

(16) What is your opinion about herbal use? ....

SECTION C: QUESTIONS ON THE SOCIO-DEMOGRAPHIC FACTORS THAT INFLUENCES HERBAL USE IN EKITI STATE

(17) What social class do you think use herbal medicines the most? (a) The rich (b) The poor (c) Both the rich and the poor (d) None of the above ( )

(18) What do you think is the rate of herbal use among pregnant women who are rich in Ekiti State? (a) Very low ( ) (b) Low ( ) (c) Moderate ( ) (d) High ( ) (e) Very High ( )

(19) What do you think is the rate of herbal use among pregnant women who are poor in Ekiti State? (a) Very low ( ) (b) Low ( ) (c) Moderate ( ) (d) High ( ) (e) Very high ( )

(20) Do you think income influence herbal use? (a) Yes ( ) (b) No ( )

(21) If yes/No how? ....

(22) Do you think residence affects herbal use? (a) Yes ( ) (b) No ( )

(23) If yes/No how? ………………………………………….

(24) Do you think education influence herbal use? (a) Yes ( ) (b) No ( )

(25) If yes/No how? ………………………………………….

(26) Does your religion permits the use of herbs? (a) Yes ( ) (b) No ( )

INSTRUCTION: SD = STRONGLY DISAGREE **D** = DISAGREE **UD** = UNDECIDED **A** = AGREE **SA** = STRONGLY AGREE

	QUESTION	SD	D	UD	A	SA
27	I use herbal medicines because it is cheaper					
28	I trust herbal medicines because of my previous experience with traditional healing					
29	I make use of herbal medicines because my parents are/is herbalist / native doctor					
30	I prefer herbs to pharmaceutical drugs					
31	Hospitals have too many protocol					
32	Herbal use is common among rural dwellers					
33	Educated people use herbs					
34	Hospital personnel are rude and unapproachable					
35	Pharmaceutical drugs are expensive compared to herbs					

36	Urban women use herbal medicines the most					
37	Rural women use herbal medicines the most					
38	Younger pregnant women use herbs the most					

(39)How effective do you think herb is during pregnancy?

....

(40)State some reasons why you feel herbal medicines are better?

....
....
....

(41) What is your general view on herbal use in Ekiti State and Nigeria at large?

....