



# Using Drama and Participatory Methods to Investigate the Influence of Poverty and Traditional Practices on Health Seeking Behaviour of Tiv Women

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## ABSTRACT

Using participatory research methods to engage ordinary people in critical reflection and discussion of their problems has become a widely accepted practice among

scholars and stakeholders of development communication in a bid to foster social change. This article reports on the use of drama and Participatory Learning and Action tools (PLA) to investigate the influence of poverty and traditional practices on health seeking behaviour of Tiv women in Ikyaan and Amua communities of Benue State, Nigeria. The purpose was to provide an interactive session among discussants and researchers towards understanding factors that hinder access to prompt medical attention especially as regards pregnant women in the selected communities. Findings show that, women in the communities prior to the drama intervention preferred certain traditional practices because they were cheaper. The study concludes, among others that, if we are to succeed in the task of improving the health status of people in the rural areas, we must include, involve and listen to poor people and their representatives. The poor have long recognized the link between good health and development. But until recently, this link has been neglected in mainstream development thinking. Improving the health of the poor must become a priority, not only for public health but also for other sectors of development — economic, environmental and social.

**Keywords:** Drama, Development communication, Poverty, PLA, Health Behaviour, Tiv women.

## 1. Introduction

A combination of drama and other participatory tools goes a long way in helping to identify issues, and proffering lasting solutions to the identified problems. This explicitly describes the nexus between the drama approach and participatory learning and action (PLA) approaches, what Abah cited in Mbachaga describes as ‘methodological conversations’. To him,

There is a commonality of agenda, because the defining characteristic of both is the ethics of participation. PLA is a cavalcade of tools designed to be learned and used by ordinary villagers in the analysis of their problems ... TfD on its own part is a performative means of concretizing community issues as the body, words and objects (props) in space define, analyze and strategize for action ... ( 2011, p. 112 ).

The core issue here is that, a combination of drama and PLA tools breeds a situation of learning that debunks the top down approach of just handing information to participants and encourages participatory learning and sharing of experiences that enhances understanding of the problems and finding ways of solving them collectively.

Suffice to mention that the conversation mix allows for participatory engagement that engenders inclusiveness of participants in the development process where they are prodded to not only think but take actual steps to change their situation. Here, dialogue, participation, empowerment and sustenance become watch words because transformation occurs when people are able to interrogatively debate and negotiate for change in their own terms.

In this study, one of the prominent tools utilized in the 'methodological conversation mix' was theatre, what is commonly referred to as Theatre for Development TfD as well as key informant interviews, Focus Group Discussions (FGDs), community meetings as well as games and exercises were utilized.

## 2. Understanding the Situation

Three important quotes, to open this segment;

The extremes of rural poverty in the third world are an outrage. Faced with the facts, few would disagree with that statement. The outrage is not just that avoidable deprivation, suffering and death are intolerable; it is also that these coexist with affluence. ... hundreds of millions of poorer rural people, living in the same world, who have to struggle to find enough to eat, who are defenseless against disease, who expect some of their children to die ... appalling, and present efforts to eliminate that misery are so inadequate, that numbers are almost irrelevant in seeing what to do next. So much needs to be done, so much more radically, that estimates, however optimistic, could undermine the case for trying to do much more, much better, and faster. (Robert Chambers, 2008, p. 2)

Successfully impacting on the disease burden of the poorest and most marginalized people of Africa requires economic recovery pursued in a manner where real benefits reach those in greatest need... Health Services must reach the poor for their health to improve. In many countries, the cost of health care to poor families is catastrophic. (NEPAD, 2003, p. 25)

Poverty is perhaps one of the greatest obstacles to healthy living in the Benue Valley... this connects to issues such as access to land, lack of mobility, culture, illiteracy, etc. (James Alachi, 2008, p. 10)

Poverty is pivotal to safe motherhood because lack of resources and appropriate healthcare services often make pregnancy and child delivery life threatening. It is worth noting here that poverty is a strong factor that undermines access to good and appropriate healthcare especially among the rural poor. This covers physical access as well as economic access. High costs of delivery services as well as transportation costs and unavailability affects access to quality health care services by mother and child.

The World Bank paper on maternal health (2001, p.1) captures this succinctly when it submits that:

Globally, there is a stark relationship between poverty and poor health: in the Least Developed Countries, life expectancy is just 49 years, and one in ten children do not reach their first birthday. In high-income countries, by contrast, the average life span is 77 years and the infant mortality rate is six per 1000 live births. Poverty creates ill-health because it forces people to live in environments that make them sick, without decent shelter, clean water or adequate sanitation. Poverty creates hunger, which in turn leaves people vulnerable to disease. Poverty denies people access to reliable health services and affordable medicines, and causes children to miss out on routine vaccinations. Poverty creates illiteracy, leaving people poorly informed about health risks and forced into dangerous jobs that harm their health.

This means that, a fit, strong body is an asset that allows poor adults to work and poor children to learn. A sick, weak body is a liability, both to the individual and those who must support them. In particular, poor families are concerned about the health of their breadwinner

– when he or she dies, or needs expensive medical treatment, the costs can be devastating. The family may be thrown into a cycle of poverty from which it cannot escape.

Chambers (1983, pp. 109 - 111) aptly describes this circle of disadvantage as he identifies five clusters of disadvantages, namely,

1. The household is poor. It has few assets. Its hut, house or shelter is small, made of wood, bamboo, mud, grass, reeds, palm fronds or hides, and has little furniture: mats or hides for sleeping, perhaps a bed, cooking pots, a few tools. The household borrows from neighbors, kin, and traders and is in short or long term debt. The household's stocks and flow of food and cash are low, unreliable, seasonal and inadequate. Food or cash obtained meet immediate needs and are soon used up.

2. The household is physically weak. There is high ratio of dependants to able bodied adults. The dependants may be young children, old people, sick, or handicapped. The ratio of dependants to able – bodied adults is high for one of several reasons: because there is no man and the household head is a woman with responsibilities for child care, food processing, cooking, drawing water, collecting fire wood, marketing and domestic chores, besides earning a livelihood for the family. As a result, sickness and malnutrition prevail as household members are weakened by interactions of parasites, sickness and malnutrition. Pregnancy, birth and death are common. Birth weights are low. All have small bodies, stunted compared with their genetic potential.

3. The household is isolated. The household is isolated from the outside world. Its location is peripheral, either in an area remote from the town and communications, or removed within the village from the centres of trading, discussion and information. Often illiterate and without a radio, its members are not well informed about events beyond the neighborhood. Its children do not go to school, or go and drop out early. Its members either do not go to public meetings, or go and do not speak. They do not receive advice from extension workers in agriculture or health. They travel only to seek work or to beg from relatives. They are tied to their neighborhood by obligations to patrons, by debts, by immediate needs that must be satisfied, or by lack of means to travel.

4. The household is vulnerable. The household has few buffers against contingencies. Small needs are met by drawing on slender reserves of cash, by reduced consumption, by barter, or by loans from friends, relatives and traders. Disasters and social demands

– crop failure, famine, a hut burning down, an accident, sickness, a funeral, a dowry, bride-price, wedding expenses, costs of litigation or of a fine – have to be met by becoming poorer. This often means selling or mortgaging assets – land, livestock, trees, cooking pots, tools and equipment, ration books, jewellery, a standing crop, or future labour, often on distress sale or usurious terms.

5. The household is powerless. Ignorant of the law, without legal advice, competing for employment and services with others in a similar condition, the household is an easy victim of predation by the powerful. It has inherited or descended to low social status. Its position is weak in negotiating terms for the use of its labour or the sale of its produce or assets. It is easily exploited by money lenders, merchants, landlords, petty officials and police. Aware of the power of the richer rural and urban people and of their alliances, the household avoids political activity which might endanger future employment, tenancy, loans, favours or protection. It knows that in the short term, accepting powerlessness pays.

This quotation shows that, a vicious circle exists between poverty and ill health. Suffice to mention that, ill health contributes to poverty and is a strong reason why individuals and communities are sometimes unable to escape the poverty trap. Child spacing is another important factor in safe motherhood. This is because if a woman does not space children the tendency of becoming anaemic and weakened is high. As such, she puts her health at risk as well as that of the baby. Recent studies reveal that,

women who gave birth at 27 to 32 month intervals rather than at 9 to 14 months intervals, are 1.3 times more likely to avoid anaemia; 1.7 times more likely to avoid third trimester bleeding; and 2.5 times more likely to survive child birth (MSI, p. 3).

Lack of skilled birth attendants in rural communities is another factor in the quest for making pregnancy safer. According to the 2003 National Demographic Health Survey (NDHS) only 36% of mothers receive delivery care from professional health care providers... (UNFPA, 2006, p. 3). Traditional birth attendants (TBAs) lack the training that will enable them to recognize emergency situations and high risk pregnancies. Consequently, maternal deaths occur where they could have been avoided if the TBAs had ample training in life saving skills (LSS). To ensure safe child birth, skilled professional care needs to be made available.

### 3. Theoretical Underpinnings

#### Health Belief Model

The health belief model is a health behavior change and psychological model developed by Irwin M. Rosenstock in 1966 for studying and promoting the uptake of health services. The original model included these four constructs:

- Perceived susceptibility (an individual's assessment of their risk of getting the condition)
- Perceived severity (an individual's assessment of the seriousness of the condition, and its potential consequences)
- Perceived barriers (an individual's assessment of the influences that facilitate or discourage adoption of the promoted behaviour)
- Perceived benefits (an individual's assessment of the positive consequences of adopting the behaviour).

According to Alachi (2001, p. 8), the Health Belief Model (HBM) operates on the premise that: human behaviour is determined by an objective, logical thought process... that the likely hood that a person will initiate action related to his health condition is predicated on the person's preparedness to take action and also by the perceived benefits of the action contrasted by the perceived costs or barriers. This invariably means that an individual changes his attitude when he weighs the benefits of such change and its implications to health. Individuals' thoughts about himself form the bedrock for his subsequent attitudes and influences how he reacts to issues affecting him especially when he knows that he is exposed to risk.

This goes to say that, there are two vulnerability variables that are paramount before an individual decides on a decision regarding his health. The first is the perceived susceptibility which could include how 'susceptible' they feel they are to contracting an illness for instance ulcer and how 'severe' the consequences of having ulcer are then he or she may decide on a particular behaviour. Nova Corcoran (2007, p. 12) writing on this submits that; The HBM includes four factors that need to take place for a behaviour change to occur:

1. The person needs to have an 'incentive' to change their behavior. For example: An 'incentive' for a person to stop smoking could be the desire not to smoke around a new baby.

2. The person must feel there is a 'risk' of continuing the current behavior. For example:

By not taking preventive measures, such as compliance with anti-malarial drugs in a high malaria risk area, a person would feel that they would be putting themselves at 'risk' of contracting malaria.

3. The person must believe change will have 'benefits', and these need to outweigh the 'barriers' For example: A person may believe that the benefits of using a bicycle helmet means they are less likely to have a serious head injury if they fall off their bicycle. They also identify that the barriers to wearing one; they are cumbersome to carry throughout the day. The 'benefits' must outweigh the 'barriers' in order for a change to be made.

4. The person must have the 'confidence' (self-efficacy) to make the change to their

behavior For example: A person must believe they have the ability to cut down their fatty food intake to help them lose weight and are 'confident' about their abilities to do this.

In order to break beliefs, dramatic scenes to help people understand and see their situations in a new light were performed and participants interacted through performance activities and interrogated issues raised in the performances. This went a long way to help them break unhealthy cultural beliefs that affect their health.

The Theory of Reasoned Action

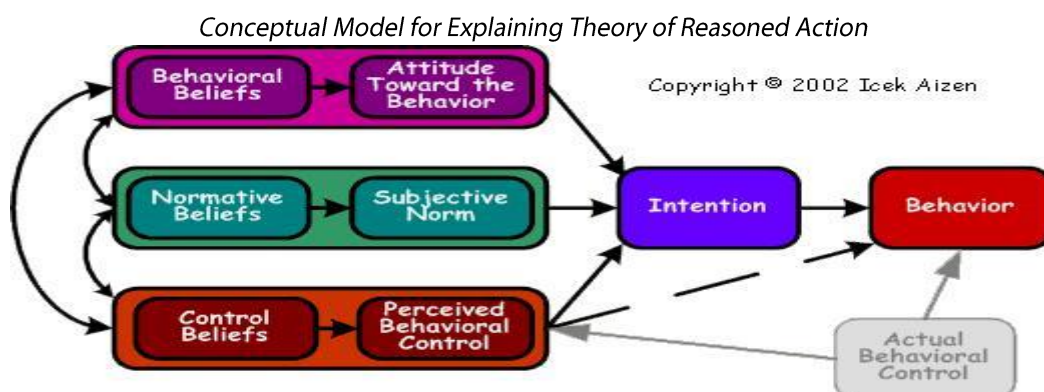
People often reason out their behavioural intentions before embarking on such behaviour. Thus, the theory of reasoned action is drawn from a series of hypothesis that link beliefs and attitudes to behaviour. According to Salazar as quoted by Alachi (2001, p.10), behavioural change ultimately is the outcome of changes in beliefs, and that people will exhibit behaviour if they think they should perform it... belief is central to an individuals attitude.

The theory of reasoned action to Ashiekpe (2010, p. 1) "estimates the relative strength of intention to perform behaviour in relation to beliefs about the consequences multiplied by valuation of the consequences". Ajzen (2002, p. 667) writing on this submits that; "a person's behaviour is determined by his/her intention to perform the behavior and that this intention is, in turn, a function of his/her attitude towards the behaviour and his/her subjective norm. The best predictor of behavior as observed by this theory is intention. Intention is the cognitive representation of a person's readiness to perform a given behaviour, and it is considered to be the immediate antecedent of behavior.

It is important to mention that, several attitudes bring pressure to bear on an individual who has the choice to perform or not to perform such given behaviour. The control of behaviour can be linked directly to individuals' belief especially when an individual is faced with dominant standards of culture such as day to day rules at our jobs, instructions by law officers and they respect such rules.

It is a result of their belief in the norms of the society because each of us believe that society has character stereotypes that we are expected to conform to and if we fail to do or conform to the right behaviour pattern expected of us, which will not put us in trouble with people or authorities of institutions or with colleagues at work. In essence, if you can Change an individuals belief towards something or somebody, then you can comfortably change his behaviour towards such a thing.

Ajzen (2002, p.671) explicitly presents the theory of reasoned action using a diagrammatic model to explain the theory and captures the theory's three general constructs thus: Behavioural Intention (BI), Attitude (A), and Subjective Norm (SN). This suggests that a person's behavioural intention depends on the person's attitude about the behaviour and subjective norms ( $BI = A + SN$ ).



Source: Ajzen, I. (2002). Perceived Behavioral Control, Self-Efficacy, Locus of Control, and the Theory of Planned Behavior. *Journal of Applied Social Psychology*, 32, 665-683.



This model strongly connects with Participatory drama because, drama influences behavior change as it presents issues with the aim of persuading acceptance and change. Here communities and people share in an experience that breeds dialogue aimed at collective decisions as a result of critical consciousness created. Collective reasoning and reflection on issues presented go a long way in influencing change in behavior and attitudes of participants.

#### 4. Methodological Consideration

Theatre for Development (TfD) based development projects require the use of drama techniques that involve using people to develop and act out a situation. The approach combines qualitative and quantitative research methods that utilize drama and other Participatory Learning and Action (PLA) tools to enhance understanding and raise awareness so as to help people gain a better understanding of issues around them; in this instance, the issue of Making Pregnancy Safer (MPS).

Data for this study was mainly assembled from plenary and group discussions after the performance of an improvised drama skit. Focus group discussion (FGDs), semi structured interviews (SSIs), games/exercises, participant observation, photographs, records, and official documents were used to cross check and fill information gaps and triangulate data. Drama skits were developed with the people in the research communities and performed. Critical analyses and discussions were held with the aid of a facilitator at the end of the episodes.

Basically, information was sought through interactive processes commonly referred to as Participatory Learning and Action (PLA). To bring about ownership, participants (men and women) in the research communities played lead roles with “catalyst” actors playing the supporting roles. A team consisting of 3 facilitators, 4 actors, and 3 ‘note takers’ worked on the field. The facilitators were supported by the note takers to ensure that information and certain details were not lost as the facilitators could miss certain details in the process of facilitating.

Discussions of the data were done at a plenary session after the performance of the drama. It is worth noting that since the data generated was qualitative and quantitative, as such, reports have been presented using the qualitative descriptive method; what is called “thick description” and tables where necessary. The validity of the approach cannot be overemphasized since it affords the target groups the opportunity to fully participate in the process rather than being passive recipients. Also, it involves face to face interaction which allows the drama catalysts and interviewers to gather information through observation of non-verbal codes that are hidden if questionnaires are used. Further, it creates an opportunity for issues to be collectively clarified and for more understanding to be generated over shady areas that confuse people through the post-performance discussions. The study also utilized library materials, the internet, seminar papers, journals and health manuals.

#### 5. Findings and Discussion

The need to understand the community problems gave vent to the research team conducting an advocacy visit to the community which provided us with a basic report on the area and allowed for traditional courtesies to be paid to the traditional authorities. More so, this allowed the visiting team to build rapport. Interviews held with the village elders, health workers and women in the area revealed that, women in the community preferred home based delivery of their babies – a practice that is encouraged by some men. The reason for this is not farfetched since home deliveries taken by Traditional birth attendants (TBA’s) is far cheaper than the costs incurred when women deliver in government hospitals. It is imperative to mention here that prior to the drama intervention on maternal health, the researcher, in discussions and review of clinic records in the two communities, discovered the following in regard to maternal deaths and clinic based deliveries. A summary is presented in Table 1 below.

**Table 1: Pre - Intervention**  
*Antenatal Attendance, Maternal Deaths and Clinic Based Deliveries in Project Sites.*

	Ikyaan Community	Amua Community
Number of Women Attending Antenatal	3	7
Number of Maternal Deaths	6	2
Number of Clinic Based Deliveries	2	5

Clinic records in the two communities at the pre intervention stage also revealed that in the last 3 years, only six women registered for antenatal clinic at Ikyaan health centre. During discussions with the clinic staff, it was gathered that of the six, only one completed the sessions and even delivered at one of the clinics. The rest never came back.

The statistics in table 1 clearly show that prior to the drama intervention in the two communities, antenatal clinic attendance was very poor due to such factors as poverty and belief in traditional practices and witch craft which perpetuate the issue of home based deliveries in the two communities.

During the pre-test at Ikyaan, 12 out of the 135 representing 11.1 percent female participants were aware of the mother to child transmission of HIV (MTCT) while at Amua community, out of the 108 participants, only one

person knew of HIV transmission from mothers to unborn children. Mrs. Hanmo Beeka, aged 46, had heard of it through her sister who is a health care provider at Tse-Agberagba at Konshisha Local Government Headquarters. This was incorporated in the drama skits and discussed as a health issue affecting women, especially pregnant women.

At Amua, two of the clinics had no records for the last three years relating to births and deaths or delivery though verbal results were claimed. This means that record keeping needs to be made a priority in these areas. The problem was discussed with the local government representative for further action.

Another crucial issue affecting access to quality health care and delivery in these areas was the lack of trained personnel. Our interaction with community members revealed that, Ikyaan had just 2 health providers who were trained nurses while Amua had 5 nurses scattered among the three communities. This establishes the fact that in the two communities, health providers are lacking because one health provider who is a nurse is serving a population of close to 2,700 persons, which is quite enormous. Further probing during plenary as to the reason for lack of personnel at the facilities revealed that, most nurses reject postings to the rural areas on account of poor accessibility where the roads to the communities are not accessible by car. Other reasons are lack of electricity, no water and sleeping quarters for the workers.

In trying to identify factors that militate against the practice of safe motherhood, several cultural practices that cause delay in seeking prompt medical care were identified. Discussions at this point focused on handling pregnancy complications and the following were identified in the communities:

*Akombo Dam* is used as a measure when it is perceived that the child is not growing well.

Further probing revealed that another treatment or practice is the *Igbe*.

A traditional healer in Amua community, Agbile Vaakaa, put it this way:

*Alu kwase ka nan haan awambe yo, Shie gen ka I too ipusugh ki ijikyegh i ese sha.*

Agbile vaakaa Aged 59 yrs, Amua community).

**Translation:**

*Sometimes if a woman is bleeding, a piece of eggs shell is used to clean the bleeding and it stops.*

When probed on how they handle complications, a TBA at Amua had this to say:

*Yange wankwase u gen maa, wan due angahar hir hir nahan m tough "ikya inombu" m chigh sha we nahan m tugh*

**Translation:**

*One woman had a complication, the baby came with legs first and I used leaves and pushed the legs to help her deliver. (Mama Zuai Afegha, 65 yrs old)*

Further discussions revealed that out of the five TBAs in Amua community, none was trained in life saving skills. Also, at Ikyaan, none of the three TBAs were trained in life saving skills. This underscores the need for training of TBAs alongside midwives.

Other cultural practices that cause delay in seeking prompt medical care include:

**M shough** – This is the process of turning the woman and shaking her. Further probing revealed that if the baby or the mother dies in the process, the source of death is given as witchcraft either by the woman's enemies or husband's relatives or her own relatives.

**Iche ikyl** – This is the administration of herbs to alleviate the pains of labour or reduce bleeding.

**Ikura Akombo (Igbe)** – it is used especially during delayed labour to enhance dilation of the cervix.

**Ver kombo** – This is an ailment that affects Pregnant women and characterized by symptoms such as swollen legs, very soft hair, change of skin color which often becomes yellowish and soft, and loss of appetite. It is a disorder associated with family lineage and treated through a ritual using a cock and the meat eaten by the affected person as well as other initiates in the family for cleansing.

**Swende soron** – It is common belief among the Tiv that *swende* occurs if a dog is killed or dies and a woman witnesses it or accidentally or unconsciously steps over it. Such a woman would continue having pregnancy problems until this problem is treated by a healer. One of such pregnancy problems is 'still birth' which is referred to as *swende* or *wakombu*. The woman has to be traditionally cleansed of the 'Swende' or else, she continues to lose all her children at birth or through miscarriage. This can even lead to death during labour.

**Itondo Atar** – Here, sand is poured on the navel, then water is sprinkled with incantations against the disease. After the process, the woman leaves the venue without looking back. This is a general ritual for any ailment practiced among the Tiv people.

These practices often are barriers to seeking proper medical attention, especially as it connects to safe pregnancy and health of women and/or children. Participants were aware of the dangers of some of these practices

and their role in serving as a form of delay in health seeking behavior of rural folk. As Buter Torwua an elder in Amua, describes it thus:

lor mba gen ka ve vihi shie kpishi u man chigh ke ya shi shie gen yo I lu u zan a sol nahan angev mbula mbu mase va hemban ve man I gema I na ke mbatsav" (Buter Torwua, 48 years, Amua community).

**Translation:**

Some people spend time on drinking traditionally prepared herbs and some spend time consulting soothsayers and when the victim dies they will blame it on witch craft

Most people, during discussions on where they accessed information on safe motherhood, said that traditional birth attendants, personal experience and information handed down from husbands or wife's parents were the principal sources of information regarding safe pregnancy, especially danger signs.

Regarding beliefs, it was discovered at Amua that most women did not attend antenatal clinic because they believed that the drugs given to women there led to their children having convulsions. Further probing revealed that the few women who attended antenatal clinic never took the drugs given to them by the health provider. This impression was corrected by the health specialists after the drama performance, who explained that the drugs given during antenatal clinic do not cause convulsions; rather, they are given so as to protect the mother and child from diseases. At Ikyaan, the people simply preferred herbal cures to western or orthodox medicine because they are cheaper and easy to access. This collaborates with the Health Belief Model discussed earlier and clearly explicates how people's beliefs influence their health behaviour.

Cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in rural communities (Omoera, Awosola, Okhakhu, & Eregare 2011). Advice from elderly women in the house is also very instrumental and cannot be ignored. These factors result in delay in treatment seeking and are more common amongst women, not only for their own health but also when their children are ill. Family size and parity, educational status and occupation of the head of the family are also associated with health seeking behaviour besides age, gender and marital status.

Discussions with community members also revealed that many men believe it is better to allow women deliver at home for fear of the cost of transportation to the clinic and the delivery charges which range from one two thousand five hundred naira to as much as five thousand naira. It was apparent that poverty plays a prominent role in depriving the people access to quality health care.

The inability to pay for health services, prepare properly for pregnancy related emergencies and properly feed a pregnant woman to enable her have a healthy baby under the supervision of a well-trained nurse is truncated by the 'deprivation trap' that affects the health seeking behavior of rural peasants. The above circle also affects awareness and recognition of severity of illness, availability of services and acceptability of services.

The issue of 'home based deliveries' was recurrent in the discussions with health providers and community groups. The discussions focused on what the men and women in the research communities need to do, to ensure healthy and safe pregnancies with emphasis on receiving care from qualified nurses and having regular monthly check - ups as soon as a woman discovers she is pregnant.

In all the communities, there was low knowledge regarding the issue of mother to child transmission (MTCT) of HIV/AIDS prior to the drama performance. The communities had not heard of it before this time. Drawing an inference from the drama skit performance aimed at mobilizing the communities towards safe motherhood, this issue was discussed during the post-performance discussion. The activist aided by the local health providers, enlightened the people on the risks and suggested where to get help. This led to a more detailed discussion of HIV/AIDS. We discussed safe sex practice as well as avoiding risky behaviour. This included discussions on using condoms and other contraceptives with a practical demonstration on how to use a condom.

**Table 2: Local Names of HIV/AIDS in the Research Communities**

<b>Local Names for HIV/AIDS</b>	Lace, Agbeda, Anakande, Danzaria, Horityo,
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The above names for HIV/AIDS were discovered during post - performance discussions at stage 3 of the study. This is because HIV/AIDS related infections are among the factors that lead to maternal deaths. Due to this, a lot of people readily asked, if they could be tested since they desired to know their status. This was no problem as the researcher had since arranged with an NGO (Eva Youth World) to conduct the HIV counseling and testing for women, men and teenagers during the 'follow up visits'. This also served the purpose of evaluating the impact of the workshops in the various communities.

## 6. Conclusion and Implication for Drama

Reducing child and maternal mortality among rural communities in Nigeria is an enormous task that requires all hands to be on deck. It entails creating access to information by people regarding what makes them healthy and unhealthy. Babar T. Shaikh and Juanita Hatcher (2004, p.49), commenting on this, submit that;

Strategic policy formation in all health care systems should be based on information relating to health promoting, seeking and utilization behaviour and the factors determining these behaviours. All such behaviours occur within some institutional structure such as family, community or the health care services. The factors determining the health behaviours may be seen in various contexts: physical, socio-economic, cultural and political.

Theatre for Development in the words of Mbachaga (2011, pp. 121 – 122) provides policy makers and planners with the much needed alternative approach to providing people with information that will enable them improve their knowledge base regarding the causative factors of diseases that affect them. In line with this, healthcare programmes to improve maternal health must be supported by strong policies, adequate training of health care providers and logistical services that facilitate the provision of those programmes.

Suffice to mention that, if we are to succeed in the task of improving the health status of people in the rural areas, we must include, involve and listen to poor people and their representatives. The poor have long recognized the link between good health and development. But until recently, this link has been neglected in mainstream development thinking. As good health is crucial to protect the family from poverty, so, better health is central to poverty reduction. Improving the health of the poor must become a priority, not only for public health but also for other sectors of development — economic, environmental and social. Traditional Birth Attendants are crucial in the struggle to bring health care to the grassroots. As such, training and retraining of TBAs in basic lifesaving skills and delivery techniques will go a long way in helping to reduce maternal deaths in rural areas.

Government needs to ensure that functioning mechanisms for quality improvement that ensure and evaluate the effectiveness of the system, including practitioners' as well as women's and community satisfaction with the care provided are put in place. Empowering individuals, families and communities to act to improve their health, achieve health literacy and integrate effective health interventions into existing community structures is a strong requirement if the target of improving maternal health of women is to be met as envisioned in the sustainable development goals (SDGs) programme. Also, there is need to develop new models for drugs supply to rural clinics and hospitals to be able to overcome supply system problems.

The utility of participatory drama within theatre for development praxis as tool of mass education in promoting health and engaging participants, beginning with individuals and the generality of the public must continually be engaged as we pursue 'conversations' towards reducing maternal deaths and improving the quality of health among rural folk. This is because, this approach to creating awareness on maternal health issues which uses peoples cultural forms blended with songs and dances creates room for acceptance of discussions and quick internalization of key issues as participation is guaranteed through the process of play creation and performance. The atmosphere in this process is that of co - learning where drama animators and audiences in this context become teachers and learners at the same time. As such, the debate on public health with focus on women's health in this instance, happened through the dramatic approach that provides a gate way through which issues presented in performance were deliberated, negotiated in an informal democratic space that gave voice to the voiceless and marginalized. Also, more concerted effort is required for designing health behaviour promotion campaigns through inter-sectoral collaboration focusing more on disadvantaged segments of the population.

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