

DETERMINANTS OF POOR UTILIZATION OF ORTHODOX HEALTH FACILITIES IN A NIGERIAN RURAL COMMUNITY

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ABSTRACT

Objective: To determine some factors limiting the utilization of orthodox health care facilities in Enugu State

Methods: Interview was conducted between September 2001 and November 2002 on 474 randomly selected pregnant women who received antenatal care in places other than the orthodox facilities in Nkanu. The interviewees were had experience with orthodox care

Results: Determinants of poor utilization of orthodox health facilities in Nkanu include some traditional and religious beliefs, extended family relationships, poor finances, long waiting hours and attitudes of the healthcare providers. About 96.5% of the respondents felt "omugwo" rite was not respected in the orthodox facilities. Religion influenced the choice of healthcare provider in 94.1% of respondents. Large volume of work was disliked by 93.2% and being addressed by first name was cherished by 89.8% of the respondents. Lack of guidance in moving round some of the facilities was highlighted by 58.9%, while financial difficulty was experienced by 50.6% of respondents

Conclusion: Development of community – defined model, in which health as well as acceptable traditional cultural practices, which have long been the key to individual and community health should be pursued. This may involve both the community and the care providers

Key words: Determinants, maternal health, rural community.

INTRODUCTION

In Nigeria, the maternal mortality rate is still high and in fact higher than a decade ago¹⁻³. Several health care facilities – maternity home, health centers – have been established in the rural communities in the recent past. This is aimed at making health care places where it is aimed that "staff can complete an incomplete abortion, administer blood transfusion, provide intravenous antibiotics, oxytocics, anticonvulsants and provide emergency caesarean section"⁴ provision of these centers notwithstanding this rise in maternal mortality rate may be attributable to the interplay of various inappropriate cultural and social factors which adversely affect women's lives⁵. This has rate to between 100- 2420 / 10-0, 00 live births^{1,6-9}.

It has been observed in 2003 that 37% of our

women receive no antenatal care. Of our women who receive antenatal care, 3% visit orthodox care centers only once, 11% 2 to 3 visits, only 47% four or more visits, and 66% of births occur at home. This leaves slightly more than one third of births attended to by doctors, nurses and midwives⁸. This exposes the larger proportion of our pregnant women patronized birth attendants⁹ Could this be because orthodox medicine which has a culture of its own, with its traditional codes of conducts that have been passed on from generation to generation, has superseded the individuals culture of the healthcare provided?¹⁰ Medicinal practice operates on the assumption that patients will arrive on time conform to the physician's expectations and will not ask many demanding questions¹¹ We therefore looked at some action, non-action and factor that can be considered counter to the acceptable norms of a community. This is because there are variable beliefs even within the same region that can alienate the people from non-use of these orthodox facilities.

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BACKGROUND

The population of Nigeria is predominantly rural, approximately one third live in the urban area. However some states are more urbanized than other. For example in Anambra 62% live in the urban area: 94% Lagos; and Oyo 69%⁸ Nkanu community in Enugu State of Nigerian is predominantly semi-urban. It consists of small pockets of urbanized areas within the local Government Headquarters, Agbani; and some communities such as Ozalla, Nara Akpugo, while the greater part of the rest are predominantly dotted with rural communities. The majority of the people are subsistent farmers, wine tapes traders. The predominantly Igbo and are widely known to be very resourceful, Hospitable and hardworking. They show a great respect for visitors and those who come to live and work with them. A pilot survey¹² on Model Primary Health Care in Nkanu Local Government Area, 1990 showed that "people in the area patronize different health care facilities including traditional healers, spiritual healers, chemist shops or patent medicine dealers and quacks for cheap health care delivery" Analysis of the female data also showed "poor responses to maternal and child health services in spite of the presence of a General Hospital, a comprehensive Health Centre, Four basic Health Center, Six Primary Health Centers and three Maternity Homes scattered within the Local Government". In addition there are ten privately owned orthodox health facilities.

MATERIAL AND METHODS

A two - day workshop was organized for the field workers (three girls with secondary school education). Between Sept 2001 and November 2002 they interviewed randomly selected 474 pregnant women attending antenatal care in non-orthodox facilities in Nkanu. Most of these women had experienced orthodox care previously. The idea was to determine the attractions to these non-orthodox facilities, and to have those interviewed as their own controls. Igbo (with a peculiar dialect) and English are the official languages in the area; but the local girls were chosen in order to capture the sensitive aspects of the language and meaning surrounding pregnancy, delivery, health, and family issues.

Question concerning the system of care; compliance and outcome of personal relationships; effects of the physical structures on the ground in the orthodox health institutions and the specific action and non-actions considered to be at odds with their culture were asked of each individual. Sample questions from

the questionnaire are included in Table 1. The information collected was analyzed using the Epi Info statistical package analysis.

RESULTS

The ages of those interviewed ranged from 17 to 38 year (mean 27.5) few 19.6% (93 of 474) had education; majority 62.2% (295 of 474) secondary, 14.8% (70) primary and 1.05% (5) had no formal education. Christians constituted 98.8% (460 of 474) of various denominations and Igbo constituted 97.6% (463 of 474). Only 62.4% were married 30.8% (146 of 474) (single, 5.7% (27) widowed, 0.8% (4) divorced and 0.2% (1) separated. Out of the 474 interviewed 448 had experienced care in some orthodox facility. Of these, religion and spiritual inclination influenced choice of the healthcare provider in 93.97% (421 of 448). The opinion of the family (nuclear and/or extended) members influenced choice of healthcare provider in 4.7% (21 of 448). Of the 448, 94.9% liked the detailed history taken by the care provider but 93.2% disliked the volume of paper work done because it was time consuming. Whereas 14.7% (66 of 448) were scared by professional jargon from physicians and nurses, 47.5% (213 of 448) were not, and 37.7% were indifferent. Visiting time was normal for 56.7% long for 31.5% and short for 11.8% who felt that birth is a happy event and should harbour no restrictions. Being addressed by first name was preferred by 89.7% (402 of 448), 10.2% (46 of 448) did not. In seeking treatment, the woman's family was responsible for finances in 38.8% the husband 31.4% and self 32.7%. If there was to be an emergency the decision to seek help during illness was by individual parents in 37.9% and husbands in 26.7%. In a planned surgery the husbands signed the consent in 31.8% and self signed in 30.3%. Some of the problems experienced by 58.9% included lack of guidance with regards to movement and procedures in the orthodox facilities. Other included long waiting hours 50.8% financial difficulties 50.63% missing appointments due to many referrals and lack of interpreters 27.5% about 60.3% would not discuss abortion and contraception freely. All indulged in male circumcision and 97.8% in "omugwo" rites. This "omugwo" is not respected in the orthodox hospitals as felt by 96.5% and it is 0.001 respectively). See Table II and III. There is statistically significant association between care determinants (spirituality, extended family and traditional beliefs) and use of contraception, $p=0.0000019$.

Table 1:

Sample of questions adapted for the interview:

- Which of the following has influence on your using health care system?
- (a) Extended family (b) Spiritual or Religious belief (c) Traditional remedies for cure and relief of symptoms
- Do you like to be called by your first name?
- Do you prefer to be addressed by your first name?
- What is the source of your financial help in seeking treatment?
- Does your financial capability influence your choice of care facility?
- Who signs the consent for operations performed on you?
- Who takes decisions for seeking hospital help for you?
- What problems do you encounter with hospital attendance?
- Do you think that the specimens taken for laboratory test are used properly?
- Do you have faith in the laboratory test performed on you?
- Do you use any form of contraception?
- Is your cultural beliefs respected in the hospital?
- Would you submit to abortion if you do not want this pregnancy?
- What influence will the birth of this baby have on you?
- What influences your utilization of health services?
- Is pregnancy and childbirth a time to indulge in cultural practices?

Table 2: The Practice Of ‘Omugwo’ Rite* According To Levels Education

Levels of education	Practised (n=300)	Not practised (n=7)	Total ⁺ (n=307)
None	3	0	3
Primary	57	0	57
Secondary	187	2	189
Tertiary	53	5	58

*A temporary Lavishing care provided for the parturient by the husband to compensate the past possible neglect.
+ There were missing data from some respondents.

Table 3: The Practice Of “Omugwo” Rite According To Religion

Religion	Practised (n=303)	Not practised (n=7)	Total ⁺ (n=310)
Christian	300	6	306
Moslem	2	1	3
Traditional	1	0	1

* Some missing data from some respondents

DISCUSSION

In developing countries the healthcare systems, the culture of the patient and the culture of the providers exert on the on the patterns of healthcare utilization, compliance with recommended therapy and consequently there outcome¹³⁻¹⁸. This is illustrated in this interview in which 93.9% of these pregnant women chose their healthcare providers on the basis of having common religion / spirituality with the providers. Appreciation of this especially in Igbo community can form a basis for reduction of the high maternal mortality and morbidity figures. With subvention to the mission Hospital and maintenance of adequate trained manpower, other contributory factors as mentioned by Ekempu can be targeted. The majority of the patients, though considered unethical in orthodox medical practice, appreciate being addressed by their first name. Cultural awareness of the can facilitate positive interactions with the healthcare delivery and consequently better outcomes.

Another setback to the utilization of orthodox facility and revealed in this interview are the norm deeply rooted in the customs, and tradition of various communities¹⁹. One obvious example is the issue of contraception and abortion. Abortion is considered taboo not only in this community but also in many others in Nigeria. It is no wonder that it contributes 13% of the maternal mortality figures^{9,20}. Customary and traditional beliefs disapprove f access to use of contraceptives by the children and youth¹². It is, therefore not surprising that only 13.08% accept the use of contraception n this community

Pregnancy and childbirth initiate’s another generation into the family affords a new opportunity for cultural traditions to solidify and strengthen bonds. The high maternal mortality figures that have not improved in the past years may result from the perception of the orthodox care centers as leaving little room for the inclusion of individual family traditions and values. The sensitivity and understanding with which a woman is treated in the orthodox care centers can have a long – term impact n the family’s healthcare utilization. In Nigeria only about 33% of deliveries take place in the orthodox facilities⁸ and as such even with the high figures, most maternal deaths are not reported. Perhaps the reverse will be the case if efforts are made accommodate those values and traditions as long as they fall within the guideline of safe obstetric practice. the aim will be develop an acceptable community define model, in which health as well as traditional cultural practices, which have long been the key to individual as

community health, are maintained. This was the case in the Mohawk community in the U.S.A.²² In Thailand, for example indigenous religion prohibits katang woman from giving births in the house²³. Traditionally they go into the forest for delivery. The "birthing hut (an innovation in one village), training of six birth attendants, the opening of a primary level clinic where normal births can take place and growing awareness of the new referral to higher levels of care in case in of complications all changes that are transforming woman's childbirth experience.

Added to the above is that education has had an impact in reversing detrimental trends. A study to determine the socioeconomic and cultural factors on the health and nutritional status of 300 women of childbearing age in two Nigerian communities showed that teachers had better knowledge and adhered less to detrimental cultural practices.¹³ Education in this instance should be for both the healthcare providers and consumers.

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