Problems and Progress of Obstetric Care in Nigeria: Home or Hospital Delivery? Views from a Rural Community.

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Abstract

Context: Maternal mortality remains a major health problem in Nigeria. Obstetric care services that are acceptable to the community and which they utilise is an essential component of programmes to reduce maternal mortality

Objective: To assess the pattern of utilisation of maternity and other reproductive health care facilities in the rural community of Ilora in Southwestern Nigeria.

Study Design, Setting and Subjects: A questionnaire survey of women of childbearing age during visits to households selected by a multistage sampling process

Results: More than 70% of the women were illiterate. Despite the fact that 87% of the women made use of antenatal care services, nearly half of the children were born either at home (40.2%) or in the farm (9.7%). Among women delivering at home, 45% were assisted by mothers-in-law, 38.7% by neighbours and 22% had no help at all. The reasons the women gave for delivering at home include lack of transportation, being unaware that labour was advanced until it was too late and the influence of their mothers and mothers-in-law who had delivered their own babies at home.

Conclusion: There are deep psychosocial and cultural barriers to the utilisation of obstetric care services by rural women in Southwestern Nigeria. In order to reduce maternal mortality, there is need for intensive health education not only for the pregnant women but also their mothers, mothers-in-law, siblings and husbands on the potential complications of labour and delivery that cannot be managed effectively either at home or on the farm.

Key Words: Obstetric Services, Maternal Mortality, Rural Women. [Trop J Obstet Gynaecol, 2002, 19: 82-85]

Introduction

Nigeria, like most developing countries, has one of the highest maternal mortality rates in the world - between 1000 and 1500 per 100,000 births[1]. Haemorrhage and obstructed labour have been found to be the principal causes, closely followed by anaemia and other serious infections. Many affected women do not book for antenatal care[2]. However, it has been observed that although antenatal care has led to a remarkable reduction in maternal and perinatal complications among pregnant women and their babies,[3] those benefits may not be maximal if the women do not receive good intrapartum care [4].

One is regarded as having had good antenatal care if the woman booked for such care and afterwards, came for a minimum of two antenatal visits, the last of which should be no more than 2 weeks before delivery[5]. The time of the last visit for antenatal care is as important as the number of visits and the interval between the last visit and delivery[6].

Undoubtedly, 80% of Nigeria's population live in rural communities[7]. In many of these communities health care facilities have been provided either by governmental agencies, non-governmental organisations and private individuals. Yet, a lot of children are still born at home or on the farm[8]. This study was designed to ascertain the reasons for non-utilisation of the maternal and child health care services provided by the comprehensive health centre of a rural community in South-western Nigeria; and to suggest ways by which the services could be better fashioned for the benefit of the people for whom it was primarily designed.

Materials and Methods

This study was conducted at Ilora, a rural community of about 60,000 people (1991/1992 estimated population)[7]. It has basic amenities such as electricity and pipe borne water. A health survey performed shortly before the establishment of its health centre in 1953 showed that malaria and schistosomiasis were the greatest medical problems in this area. The inhabitants are mostly farmers and artisans, while some engage in petty trading and other pursuits. Small hamlets and farms surround the village. Many go to their farms daily from their homes in Ilora, but over 20% only come home either on weekends or once in a month to attend family meetings, social functions, or other special occasions such as during festivals.

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The Ilora Health Centre

The Ilora Health Centre was set up under a special arrangement between the Ilora Local Government and the former Department of Preventive and Social Medicine, University College Hospital, Ibadan, Nigeria. While the department provides staff and gives primary health care, the local government provides money for the purchase of drugs and other consumables. Community Care Nurses hold clinics thrice a week and a doctor is also in attendance once a week. Activities at the centre include postnatal clinic, infant welfare and antenatal clinics, health education and food demonstration sessions, home visits and the collection of data. There is also a twelve-bed maternity home on site. The centre established a Motherless Babies Project in the village in 1958. This revolutionised the care of motherless babies in the community. A close relative (usually the grandmother) is encouraged and supported to care for the child. The social and psychological advantages of such a system have been studied and well documented [8].

Apart from the primary health care being provided, the centre also serves as a place for the training of student nurses and undergraduate medical students.

Sampling Techniques and Data Collection

A multistage (stratified and random) sampling technique was used to select 400 women of childbearing age for interview. These were conducted on a house-to-house basis. Information obtained include social and demographic characteristics of the people such as age, religion, occupation, marital status, place of residence, frequency of homecoming if living on the farm, and number of children, alive or dead. Questions on the health services were based on specific utilisation of maternal and child health services. An attempt was made to measure respondents' attitudes to these services.

Results

A high proportion (72.5%) of mothers interviewed were illiterate, and only 9.1% had post-primary formal education. Nearly 80% of the women interviewed were Christians, 15.7% were Moslems and 4.7% professed traditional religion (Table I). Although most of the women were married, about 40% of these married women had changed husbands at least once. Most of the women lived in Ilora and the adjoining farms.

The average number of pregnancies per woman in the study population was 3.5 but the average number of surviving children was just 2.4 per woman. The childhood mortality rate was 25.7% and the pregnancy wastage rate was 6.7%.

Table 1

Socio-Demographic Characteristics of the Respondents

	Number	*Percentage*
Religion		
Christianity	316	79.0
Moslem	63	15.7
Traditionalist	19	4.7
Others	3	0.6
Formal Education		
None	288	72.5
Primary	69	17.2
Post-Primary	38	9.1
Arabic	5	1.2
Marital Status		
Single	1	0.2
Married	391	97.7
Separated	6	1.7
Divorced	1	0.2
Widowed	1	0.2
Place of Residence		
Ilora	289	72.3
Farm	94	23.5
Oyo Town	11	2.7
Unknown	6	1.5
Total	**400**	**100**

Among the women interviewed, 348 (87%) had used or were using antenatal services, 25 (6.3%) had never used it, while 26 (6.5%) had never required such services before. One woman did not respond. The reasons adduced by those who had needed but never used the service before were inability to pay clinic fees and the long distance between their farms and the clinic. Those who chose to use the service tended to be regular in their attendance. A high proportion of pregnant women (67.3% of respondents) attended antenatal clinic for the first time during the second trimester of their pregnancy. Only 7.3% booked for antenatal care in the first trimester and 12.5% waited till the third trimester before reporting.

Among the 1031 births reported by the women, 40.2% of the babies were born at home, 9.7% on the farm, 19.7% at the maternity centre and 32.3% in hospital. Forty-five percent of those who had delivered their child at home were helped by mothers in-law, 38.7% by neighbours, and 22% stated that they had no help and that it was after expulsion of the baby that they called for help.

Majority of the people who boasted of delivering without help had no choice in the matter; their labour commenced when everybody in the house had gone to the farm.

Over 10% of the women interviewed who had experienced home delivery had one complication or the other such as excessive bleeding, fainting, convulsion and retained placenta. When we investigated why those who delivered at home did so, the reasons given were as follows:

- Lack of transport either from the farm or from the village to the clinic.
- A claim of ignorance about how advanced in labour they were until it was too late to walk the distance to the health centre in time.
- Inability to see the reason for going to the maternity centre to deliver when her mother and grandmother did not use such facilities and yet survived the fear, pain and dangers of child birth.
- Discouragement from using the maternity centre by her mother, mother-in-law or grandmother.

Many of the women of the women also felt that delivering at home provided a degree of privacy that they could not get in a maternity centre.

Concerning post-natal and infant welfare services, 79% of the women interviewed had at one time or another made use of postnatal and infant welfare services while 11.5% did not utilise the services. The others never had a reason to use the services. The reasons adduced for not using the services range from lack of money and time, to the belief that since the child was not born in hospital or maternity centre, there was no need to go there for postnatal services. Among the women who made use of the services, nearly 77% expressed satisfaction with the quality of care they received. The 1.5% of the women who were dissatisfied with the care received in the postnatal and infant welfare clinics proffered no reasons for their dissatisfaction.

In assessing the attitude of the women to delivery at home or in a health institution, they were asked four main questions. Their responses are summarised in Table 2.

On the questions pertaining to diet and healthy living, majority (60%) of the women emphasised the need for a good diet for the child and themselves, while only 14% emphasize the combination of good diet and good hygiene as essential for healthy living and good growth of the family.

Discussion

No doubt, Ilora rural Health Clinic is contributing to the development of the rural population in its own small way by bringing services nearer to them and this was confidently shown in the large proportion of women making use of the antenatal and postnatal services. However, the low utilisation of intrapartun care and delivery services, the high pregnancy wastage, and the high childhood mortality rate revealed medical and cultural problems that require urgent attention and solution.

Table 2

Attitude to Delivery in a Maternity Centre

	Attitude Scale			
	Agreed	**Indifferent**	**Disagreed**	**No Idea**
	N(%)	N(%)	N(%)	N(%)
To deliver a child at home is the best way because it is according to tradition	29(7.5)	87(21.7)	272(68.0)	12(3.0)
A woman is bound to suffer pain during delivery and there is no need to seek help	248(62.0)	16(4.0)	123(30.9)	13(3.3)
Only cowards delivered in Hospitals or Maternity Centres.	52(13.0)	23(5.7)	308(77.0)	17(4.3)
If a woman is not at the last stage of labour, she should not go to hospital or maternity home.	73(18.2)	23(5.7)	285(71.2)	19(4.9)

Although majority of the women have a favourable attitude toward hospital births and early reporting in labour, there is still a relatively low level of utilisation of the health facilities for delivery. About half of all births still take place outside proper health facilities in spite of the fact that nearly nine out of ten pregnant women attended the antenatal clinic of the health centre. The low utilisation of the delivery services could be partly attributed to the fact that suffering is accepted as part of labour and the women do not see a clear need to seek care to minimise the suffering. The pains associated with

child birth is expected and most African women had been trained right from youth that, to be a complete woman, labour pains are an unavoidable rite of passage, of short duration and endowed by nature. At the end of it, the child can be looked upon as the wonderful compensation for the pain. Majority of the women interviewed agreed with the view that the suffering was inevitable and the need to call for help was therefore not necessary.

The heavy influence of mothers-in-law in encouraging home deliveries is quite apparent in this community. They served as the attendants at the births of almost half of such births. Any programme that will encourage increased utilisation of health facilities for deliveries must therefore target these women for intervention by way of education and other activities that will encourage a change in their attitude towards institutional deliveries.

One concern of the women that health care providers should find ways of addressing is the issue of privacy during delivery. This is particularly important in a cultural environment where people are suspicious of the disposition of their neghbours toward them. This prompts some women to hide their health problems and even conceal the fact that they are in labour. However, during the process of covering up, a woman may reach the advanced stages of labour without being fully aware, which may explain why some women eventually delivered their babies at home. Such practices ought to be strongly discouraged because of the risk of complications such as obstetric haemorrhage, retained placenta and sepsis which lead to maternal mortality. In fact, most of the motherless babies being cared for at the centre lost their mothers in the process of childbirth [8].

Above all, lack of financial means has been identified as one of the key factors for non-utilisation of postnatal care services; it may also be a key factor for non-utilisation of intrapartum and delivery services. Several studies have shown a decline in utilisation of health services once user fees are introduced [9].

The findings from this study have demonstrated deep psychosocial and cultural barriers to the utilisation of obstetric care services by rural women in Ilora and its surrounding hamlets and farms. In order to reduce maternal mortality in the area and similar rural settings in Nigeria, there is need for intensive health education not only for the pregnant women but also their mothers, mothers-in-law, siblings and husbands on the potential complications of labour and delivery that cannot be managed effectively either at home or on the farm. Above all, provision of ambulance as a means of transporting women in danger to state or, tertiary hospitals is an important service, which is often overlooked in rural services. Definitely, provision of this essential service will go a long way to reduce the burden of maternal deaths in our society [10].

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