

Community Perception of the Causes of Maternal Mortality Among the Annang of Nigeria's South-East Coast

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Abstract

Context: Nigeria still has one of the highest maternal mortality rates in the world despite several intervention programmes aimed at its reduction. In Akwa Ibom state, Nigeria, maternal mortality has been found to be highest among the Annang speaking people of the state.

Objective: The aim of this study was to ascertain the perception of the causes of maternal mortality among the Annang speaking people of Akwa Ibom State, Nigeria.

Method: Focus group discussions were carried out in 2 local government areas of Akwa Ibom State, Nigeria between 1st February 2002 and 30th April 2002.

Results: Majority of the participants (60%) were between 26 and 35 years. Most of the participants felt hospitals generally connote sickness and were places reserved for only sick people. The most common causes of maternal death highlighted by the participants were spiritual attack from enemies and punishment by the Gods for infidelity. Suggestions made by the participants to reduce maternal death included, education of women on the need to be faithful to their husbands, acceptance of Christianity by all women and total surrender to God during pregnancy.

Conclusion: There must be intensive grassroots enlightenment and health education in our communities on the causes and prevention of maternal mortality. The advantages of antenatal care and hospital delivery should be included as part of the health education curriculum in our primary and secondary schools. There is need for provision of accessible comprehensive health centres with facilities for emergency obstetric care in our communities by the government.

Key Words: Community Perception, Maternal Mortality, Annang, Nigeria

Introduction

Obstetric problems are the leading causes of death among women of childbearing age¹. World wide, approximately 600,000 women die each year of pregnancy related causes thus equalling one woman every minute². Unfortunately, 98% of these deaths occur in the developing countries^{2,3}. Currently, Nigeria has one of the highest maternal mortality rates in the world⁴. At 1,500 per 100,000 live births; its maternal mortality rate is higher than the maternal mortality rates found in Europe in the early twentieth century^{2,5,6}. Thus maternal mortality statistics currently provide one of the worst differentials in health indices between the developed and developing countries⁷. Various factors ranging from poverty, unregulated fertility, illiteracy, unhealthy customs and beliefs, worsening reproductive health and lack of appropriate organisation of health services have been largely responsible for this gloomy situation in Nigeria⁸.

Following two independent initiatives, which drew attention to the continuing high levels of maternal mortality in developing countries in 1987⁹, several intervention programmes have been initiated in several countries including Nigeria^{8,10}. In Akwa-Ibom state South-South Nigeria for example, there has been a tremendous increase in the number of health facilities and general improvement in facilities in all government health institutions. Also, a 60 million Naira revolving

fund was introduced to ensure a steady supply of drugs in all government facilities. In spite of these, the maternal mortality rate in the state has remained high and is even higher in its rural areas¹¹. This has been largely attributed to lack of antenatal care and delivery under sub-optimal conditions¹¹. Recent reports indicate that majority of our women do not have formal antenatal care and they are attended to during delivery by evangelistic spiritualists who own spiritual churches^{11,12}. Others deliver in the homes of untrained traditional birth attendants (TBAs)^{13,14}.

At a maternal mortality seminar sponsored by the Ford foundation Nigeria, and organised by the reproductive research group of St Luke's hospital Anua, Uyo (unpublished data), it was discovered that maternal mortality was highest amongst the Annang speaking people of Akwa-Ibom State, South-South Nigeria. These were mostly from unbooked cases and cases referred late from spiritual churches and TBAs. This formed the background and prompted this study. Thus, if maternal mortality among our people is to be reduced effectively, it will invariably involve the peoples' willingness to accept interventions designed for this. Hence, their perception of the causes of this calamity is

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important if positive achievements are to be realized. Thus, this study was carried out to ascertain the perception of the causes of maternal mortality among the Annang people of South-South Nigeria. It is hoped that the results of this study will help highlight possible ways of improving acceptance of formal antenatal care and hospital delivery by our women.

Materials and Method

This study was carried out among the Annang speaking people of Akwa Ibom State in South-South, Nigeria. The Annang people are the second major ethnic group in the state and occupy 8 of the 31 local government areas (LGAs). They are predominantly of the Christian faith, although a negligible minority practice some form of traditional African religion. They have a warlike attitude and are noted for their craftsmanship in woodcarving and raffia works, though they also engage in farming, trading and palm wine tapping. This study was carried out in Obot Akara and Ikot Ekpene, 2 of the 8 LGAs where the Annang speaking people are found between 1st February 2002 and 30th April 2002 using convenient sampling technique. There are 177 villages and 12 wards in these 2 LGAs. Collectively, they have a population of 156,304 (1991 provisional census figures). There are three functioning government secondary health facilities and nine primary health facilities in the 2 LGAs.

Twenty-five focus group discussions were carried out in 5 communities and 10 churches. Focus group participants were selected geographically from the two LGAs based on their current residence. This method was adopted in order to reach the people at their traditional place of residence. Advance notice was given to the people whose places were to be visited either through the village health workers, the community health extension workers, the village heads or pastors. To make the attendance broad based, the most appropriate and convenient days were selected after discussion with residents of a particular area, such arrangement avoided market days. The interviews/discussions took place in village halls, churches and in some cases homes of some of the participants.

The focus group discussions and in-depth interviews were conducted by trained personnel selected from Youth Corp doctors, students from the state college of health technology on community health postings and industrial attachment, student midwives and community health extension workers led by the first author. In all 25 focus group discussions (FGDs) were held. A total of 550 women attended and the groups ranged in size from 15-20 participants per session. Each discussion lasted between 60-90 minutes. After introductions, the participants were asked their ages, marital status and educational level. They were then encouraged to express their views as to what they disliked about hospital

delivery, the role hospitals play in the reduction of maternal deaths, and factors responsible for maternal death. Possible ways to prevent maternal death were also discussed. The FGDs were conducted in pigin English and vernacular for better understanding by the participants and the discussions were recorded on tape with their permission. In addition, notes were taken during the discussions and these were subsequently employed when the tapes were reviewed and transcribed.

Table 1:
Socio Demographic Characteristics of Participants

Variable	Number N = 550	(%)
Age (Years)		
20-25	39	(7.1)
26-30	157	(28.5)
31-35	178	(32.4)
36-40	104	(18.9)
41-45	44	(8.0)
46-50	22	(4.0)
>50	6	(1.1)
Educational Level		
No Formal Education	24	(4.4)
Primary Education	219	(39.8)
Secondary Education	263	(47.8)
Post Secondary Education	44	(8.0)
Marital Status		
Single	47	(8.5)
Married	428	(77.8)
Separated	8	(1.5)
Divorced	17	(3.1)
Widowed	50	(9.1)

Results

Socio-Demographic Characteristics

All the participants willingly expressed their views about pregnancy and delivery. The participants were between 20 and 75 years. Majority, 335 (60.9%) were between 26 35 years. Four hundred and twenty-eight (77.8%) of the women were married. Two hundred and sixty three (55.8%) had secondary level education, while 24 (4.4%) had no formal education (Table 1).

Views About Hospital Delivery

Majority of the participants agreed that deliveries could effectively be carried out in hospitals and other orthodox health facilities as most of them were parents and had attended a hospital at some point in their lives. Moreover, extension health workers from neighbouring health centres came regularly to educate them on health promoting activities. Some of them held the view that delivery in hospitals could help prevent maternal death while some also felt hospital workers were well trained

to conduct deliveries. Most of the participants believed hospitals were well equipped to manage complications arising in labour.

Dislikes About Hospital Delivery

Most of the participants were of the view that hospitals generally connote sickness and as such were places reserved for only sick people. Some, feel there is lack of privacy during delivery in hospital as midwives and student midwives, porters, cleaners, and other health workers could stay around to watch deliveries as one of them put “*I no like hospital-O Plenty people go come stand round de look you as you de born*”. Fear of Caesarean Section was expressed by many of the participants. They believed they could die during the operation. Undue interference in labour was expressed by some of them. Intravenous infusions, pitocin induction or augmentation of labour, artificial rupture of membranes and vaginal examinations done in hospital were regarded as unnecessary interference, which were not done in church or by TBAs “*small time dey go just de put their hand inside your body talk say dem wan commot water. After, dem go come put that drip to pain you*”. The possibility of having an episiotomy in hospital was expressed by some of the participants as this was said to result in severe postpartum perineal pain. Few of the participants preferred to deliver in the squatting or kneeling position instead of the dorsal position that attendants in hospitals insist on “*If my mama swat born me, why I no go swat born my pikin ?*”. Some of them also felt attendants in hospitals gave little or no assistance during delivery “*For hospital dem go say madam, labour never start you don begin make noise. After dem go abandon you.*”. They pointed out that in churches or TBAs the attendants usually give fundal pressure and sit behind them to rub their backs during labour. Few of them felt there was a strong possibility of blood transfusion when delivering in hospital. Closer inquiry revealed the association of blood transfusion with the transfer of obnoxious traits like theft, witchcraft and mental illness.

Causes of Maternal Mortality

Most of the participants believed that pregnancy, and delivery were physiological processes and therefore interference was generally unnecessary. Majority also felt complications during pregnancy and labour were primarily as a result of spiritual attacks from enemies and witches. Even the educated participants, believed that demons and other spiritual beings used various means to cause death during pregnancy “*You no say na de time wey you get belle and when you wan born wey your enemies go begin their attack*”. The other major cause of maternal death highlighted by the participants was punishment by the Gods for infidelity (“*ekpo-nka-owo*” the spirit that punishes adulterers). They believed punishment for infidelity could take the

form of fits, obstetric haemorrhage and obstructed labour. The only solution in this instance was for the woman to confess and subsequently provide materials for offering appropriate sacrifices. Other causes of maternal death highlighted by the participants were ones destiny to die during pregnancy and delivery, and infections from germs.

Suggestions Made to Reduce Maternal Death

The various suggestions made by the participants to reduce complications arising during pregnancy including maternal death were education of women on the need to be faithful to their husbands and avoid adultery, acceptance of Christianity by all women and total surrender to God especially during pregnancy.

Discussion

The study has provided an insight into the community perception of reasons for the high maternal mortality among the Annang speaking people in our state. The people believe that demons and other spiritual beings use various means to cause death during pregnancy and delivery. Most deaths in pregnancy and labour are the results of spiritual attacks from enemies or witches and punishment from God for infidelity and these are not amenable to hospital treatment. Though the Annang people have good knowledge of the positive roles that hospitals and other Orthodox health facilities play in the reduction of maternal mortality including the availability of personnel trained to manage appropriately complications arising during pregnancy and labour, they do not utilize these facilities as they believe that hospitals are for sick people only and that pregnancy is purely a physiological event. Thus, women with complications during pregnancy and labour are told they would die if they go to hospital since there is no spiritual protection there. They also dislike hospital delivery because of lack of privacy, the possibility of episiotomy, blood transfusion and the attitude of hospital workers.

The results of this study are in direct contrast to what obtains in other parts of the country where difficulties with transportation, cost of care, lack of motivation, poor communication and family influence have been cited as reasons for non utilization of orthodox health facilities for maternity care^{15,16}. This is not surprising since recently, it has been discovered that most of our women now attend antenatal care and deliver in spiritual churches^{11,12,13,17}. There, they are brainwashed that faith in God is all they need to overcome all obstetric complications, prophecies and visions are used to instil fear into them and they are strongly discouraged from utilizing orthodox health facilities¹¹. Lack of privacy, fear of episiotomy and blood

transfusions as well as attitude of health workers revealed by this study, have also been reported by other workers as contributing to antenatal clinic default in their centers¹⁷.

Trado-cultural and religious beliefs of our people play a major role in the high maternal morbidity and mortality in our community. Efforts to reduce maternal morbidity and mortality must take these into consideration. There is therefore need for intensive community grassroot enlightenment and health education. This should encompass the causes of maternal mortality and the importance of antenatal care and hospital delivery. The advantages of emergency obstetric care (EOC) services available in hospitals should be specifically emphasized. Community extension and public health workers and community midwives should be encouraged to hold enlightenment sessions in the community explaining the events that occur in pregnancy and labour and the indications of simple obstetric procedures. The need for our government to provide accessible comprehensive health centres with

facilities for EOC cannot be overemphasized. The causes of maternal mortality and the important role antenatal care and hospital delivery play in its reduction should be included as part of the health education curriculum in all primary and secondary schools in our state in order to lay an early foundation in the minds of our young girls.

There is need to assess the perception of maternal mortality of the leaders of spiritual churches in our environment in order to recommend appropriate measures to prevent them from continuing in their present practice. There is also need for quantitative research on a larger scale assessing the quality of health talk given in the antenatal clinics and the women's perception of them. In conclusion, deeply rooted trado-cultural and religious beliefs highly contribute to the high maternal mortality among the Annang speaking people of South-South Nigeria. Extensive health education and grassroot enlightenment may be the only tool effective to counter these beliefs and encourage our women to have antenatal care and deliver in hospitals.

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