

Obstetric Outcome in Grandmultipara in Bida, North Central Nigeria.

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Abstract

Objective: To highlight the striking differences in obstetric parameters between booked and unbooked grandmultiparous patients in a tertiary hospital in North Central Nigeria.

Methods: A total of 160 booked grandmultiparous patients who attended at least 6 sessions of antenatal clinic were compared with 160 unbooked grandmultiparous patients. Variables such as diagnosis made on admission, mode of delivery and complications, use of blood products, number of days spent in the hospital, maternal and perinatal deaths were compared for the two groups.

Results: Over 80% of the unbooked patients came from home. Diagnosis of active phase (normal) labour was made on admission in 81% of the booked and 43% of the unbooked patients. All other complications of labour noted on admission were at least twice as more in unbooked than booked patients. Operative deliveries occurred at least three (3) times, and other complications of delivery at least one and half times more in unbooked patients. The unbooked patients used more blood, spent more days (increased morbidity) in the hospital and had more maternal and three (3) times more perinatal deaths.

Conclusion: Delivery at home is very common in this community. The untrained attendants who take these deliveries at home do not appreciate and recognize obstetric problems when they arise and they refer the patients at very late stages.

Key Words: Grandmultipara, Childbirth, Outcome, Traditional Birth attendants

Introduction

Reproductive morbidity and mortality is known to be very high and rising in sub-saharan Africa¹. Obstetrics complication is a major contributor to this catastrophe mainly because less than 10 percent of pregnant women receive antenatal care from trained providers in health institutions¹.

The situation at Federal Medical Centre Bida since its inception as the only referral (tertiary) center in 1997 for Niger State of Nigeria and the Nupe's is similar. The Nupe's (an ethnic group) are in Niger, Kwara and parts of Kogi States (about 3 million people), and Bida in Niger State is their headquarters. Women who came for maternal services were not selected (open-door policy) to improve accessibility to maternal health services and obviate the prevalent home cultural and traditional practices. In this cohort study, the obstetric outcome in booked and unbooked grandmultiparous patients are compared and studied.

Patients and Methods

Over a 2-year period 1st April 2001 March 31st 2003, 160 (one hundred and sixty) grandmultiparous patients (parity = 5) who booked and attended our antenatal clinic at least 6 (six) times were selected and followed through till delivery in our labour ward. Most of our patients book at 17-20 weeks of pregnancy. Booked primigravida patients usually very young, were mostly under-attenders and didn't meet this criterion and were not used. Booked lower risk multiparous patients were also not used in this study.

One hundred and sixty (160) unbooked grandmultiparous patients (parity = 5) that arrived at the labour ward after each booked patient were selected. These unbooked patients never attended our antenatal clinic and were referred to us for problems in labour and delivery. Variables such as diagnosis made on admission, mode of delivery and complications, use of blood products, number of days spent in the hospital, maternal and perinatal deaths were compared for the two groups. The results were subjected to SPSS (Software Package for Statistical Solutions) statistical analysis.

Results

Over 80% of unbooked patients came from home (were in labour at home). Table I shows that all complications of labour (diagnosis made on admission) are at least twice as more in unbooked than booked patients. Booked patients had two times more normal active phase labour diagnosis. The X^2 show significant difference in normal and complicated labour $P < 0.05$. Table II shows spontaneous vaginal delivery occurred one and half times more in booked compared to unbooked patients. There were more operative deliveries in unbooked patients. This occurred three times more while other complications of delivery occurred at least one and half times more. The X^2 show significant difference in the mode of delivery $P < 0.05$. Table III shows that the unbooked patients spent more

Results

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days in the hospital and therefore more money. The χ^2 show significant difference $P < 0.05$. More maternal deaths and three (3) times more perinatal deaths occurred in unbooked patients. Unbooked patients also used more blood products.

Discussion

The principal findings of this study are:

1. Prevalence of home delivery. This is true for most semi-urban/rural areas of this country and this continent^{1,2}. Many of our patients still deliver at home

Table 1:
Diagnosis Made On Admission

	Booked	Percentage %	Un-booked	Percentage %
Normal Labour (Active Phase)	130	81.3	68	42.5
Antepartum Haemorrhage	3	1.9	13	8.1
Abnormal lie (Trasverse, oblique, unstable)	2	1.3	6	3.8
Malpresentation (Beech, brow, face, compound, shoulder).	6	3.8	15	9.4
Hypertensive Disorders of pregnancy	8	5.0	16	10.0
Postpartum Haemorrhage, (PPH) (uterine atony)	2	1.3	5	3.1
Twin Pregnancy (Normal	3	1.9	7	4.4
Retained placenta + other causes of PPH	-	-	5	3.1
Intra uterine death	3	1.9	8	5.0
Retained 2 nd Twin	-	-	5	3.1
Foetal Distress	3	1.9	3	1.9
Prolapse cord	-	-	3	1.9
Ruptured Uterus	-	-	6	3.8

$\chi^2 = 48.2$ (Tabulated 32.7) $P < 0.05$

Table 2:
Mode of Delivery and Associated Complications

	Booked	Percentage %	Un-booked	Percentage %
Spontaneous Vaginal delivery	110	68.8	64	40.0
Laparotomy	12	7.5	45	28.1
Breech delivery (Assisted/breech extraction)	6	3.8	5	3.1
Exploration of uterus and manual removal of placenta	2	1.3	5	3.1
Cervical, vaginal and perineal tear and repair	12	7.5	16	10.0
Oxytocic use for post partum haemorrhage	14	8.8	20	12.5
Vacuum extraction	-	-	-	-
Forceps delivery	4	2.5	5	3.1

$\chi^2 = 34.6$ (Tabulated 22.4) $P < 0.05$

Table 3:
Number of Days Spent in the Hospital

	Booked	Percentage %	Un-booked	Percentage %
< 48 hours	136	85.0	71	44.4
> 48 hours < 7 days	11	6.9	39	24.4
> 7 days	13	8.1	50	31.3

$\chi^2 = 57.8$ (Tabulated 11.1) $P < 0.05$

even after booking with us because of very strong cultural and traditional practices. Untrained traditional birth attendants take such deliveries under unsafe conditions.

2. Statistically significant more complications of labour and deliveries/surgeries in unbooked patients. The untrained attendants at home don't appreciate and recognize obstetric problems when they arise and refer the patients at very late stages.

These findings of complicated labour and deliveries are the major reasons for the high maternal morbidity (prolonged hospital stay) and mortality rates in this community. This is comparable to the findings in most rural/semi-urban communities of Nigeria^{3,4,5,6}. As shown in Tables I, II and III in this study antenatal care will reduce the problems of labour and improves maternal and fetal outcome. This also agrees with other similar reports^{5,6,7}.

This is a cohort study and the selection of patients simple. Primigravida, a major high-risk group of pregnant women, are notably excluded in this study. Also other socio-medical and demographic variables like age, religion and educational status were not adjusted for in this study.

The overall meaning of this study to clinicians and scientists is that rural obstetrics practice is real and needs special focus in Nigeria because of very high poverty ignorance and illiteracy levels. We must acquaint ourselves with it to save our people. The curricula of our medical and post medical training schools in obstetrics and gynaecology must be revisited to include rural postings. Our policy makers must urgently put in place policies to enforce, by legislation, organized antenatal care and delivery in health institutions for all pregnant women in Nigeria.

Antenatal care remains the most crucial and pivotal single factor influencing maternal and perinatal mortality rates. It is however important to stress that provision of organized antenatal care is not all that is required. Education and good economy are equally contributory and complementary. These help the individual to appreciate and access maternal care services. For example Cuba and Sri Lanka have good maternal mortality rate yet both are classified as poor nations⁸. All health professional associations in Africa must be involved in broad-based community education, public enlightenment and advocacy on reproductive health issues to stop negative religious, cultural and social factors common in our rural communities.

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