

Factors Influencing Non-Utilisation of Maternity Care Services in Sagamu, South Western Nigeria.

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Abstract

Objective: To determine the factors influencing the utilization of maternity care in the public health facilities in the Sagamu Community.

Materials and Methods: With the aid of pre-tested structured interview questionnaires, a comparative cross-sectional study was conducted in Sagamu among expectant mothers patronizing the traditional birth attendants (TBAs) and the public maternity centres to determine the factors responsible for the non-utilization of skilled maternity care and utilization of health services by the expectant mothers in Sagamu community in September 2002. The process indicator of skilled care at delivery (i.e. percentage of births assisted by skilled attendants) is the United Nations General Assembly recommendation (1999) being used as a benchmark indicator to measure progress towards reducing maternal mortality.

Results: Religion, cost of services and distance to the health facilities were found not to be contributory to the non-utilization of health facilities. Rather, socio-cultural beliefs in the TBA services, low educational status, and husband and family decision (gender influence) were found to be strong determinants of the non-utilization of the maternity centres by expectant mothers in this community.

Improving the educational status of women, reducing the waiting time at hospitals, improving the quality of care and raising women's status so that they are empowered to make critical health decisions will enhance the use of skilled maternity care and utilization of health facilities by expectant mothers.

Conclusion: It is recommended that qualitative research should be conducted in every community to identify traditional beliefs, customs and taboos that may be a deterrent to utilization of skilled maternity care. The information obtained should be used to develop a health communication plan for the community on maternal care.

Key Words: Maternal Mortality, Maternity Services, Traditional Birth Attendants (TBA)

Introduction

The most recent figures from the World Health Organisation estimates that 515,000 women die annually from life-threatening complications of pregnancy and childbirth. These deaths are only part of this tragic picture. For every woman who dies, about 30 suffer from devastating health problems such as infertility and damage to reproductive organs. Ninety percent of these deaths occur in the less developed countries^{1,2,3}.

The situation appears to be worsening. In a hospital-based review of maternal deaths in Sagamu, South western Nigeria over a 10-year period (1988-1997), the Maternal Mortality Rate (MMR) was found to be 1936.1/per 100,000 live births⁴. This figure is more than double the national MMR figure of 800/100,000 live births. Further analysis of the maternal deaths showed that obstetric causes (ruptured uterus, eclampsia, post-partum haemorrhage and puerperal sepsis accounted for 86.4% of the maternal deaths. The MMR reached the peak of 4393.3/100,000 live births in 1992 and 4864.9/100,000 live births in 1994. These are about four to five times higher than the quoted national MMR for Nigeria.⁴

Women's lives can be saved and their sufferings reduced if health systems could address serious and life-

threatening complications of pregnancy and childbirth when they occur. One of the best ways to do this is to make sure that women receive skilled care at delivery. For many decades, traditional birth attendants have been involved in providing maternity care and delivery services in both rural and urban Nigeria, with less than half of deliveries in less developed countries take place with the assistance of skilled health personnel⁵. Providing skilled care means those health professionals such as doctors, nurses, or midwives can manage normal deliveries and treat the life-threatening complications of pregnancy and childbirth. With support from functioning health and transportation systems, these professionals can treat or stabilize women and refer them for appropriate care.¹

The existence of skilled care, however does not guarantee its use. Women face multiple delays in seeking and receiving life-saving care when they need it. Thus skilled care can only be effective in the context

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of a health-care system that addresses women's health needs and the obstacles women face in getting such services. This obstacle is not only that of transportation but also of an early and wise decision to seek skilled health care for women who may need it.⁶

In 1999, the United Nations General Assembly recommended that countries use the process indicator of skilled care at delivery as a benchmark indicator to measure progress towards reducing maternal mortality.¹ There is a strong association between skilled care at delivery and lower levels of maternal mortality. The non-usage of skilled maternity care could therefore be a prime factor in the very high maternal mortality in Sagamu and many other centers in developing countries. The main objective of this paper is to determine the factors responsible for the low utilization of skilled maternity care in the public health facilities in the Sagamu Community.

Materials and Methods

The Community

Sagamu where the study was conducted is a town situated in Sagamu Local Government in the diversely populated Southwest region of Nigeria and at the intersect of two major highways connecting Lagos to the North and the East of the country. It has a population of about 195,000. Majority of this population belongs to the Yoruba ethno-linguistic group dominant in Ogun State with a significant population of non-indigenes predominantly Hausa and other tribes from all over Nigeria.

Sagamu metropolis apart from numerous private hospitals has 2 major public maternity centres namely Makun and Sabo Health Centres and the apex health institution of the State, which is the Olabisi Onabanjo University Teaching Hospital. Major religious groups are Islam, Christianity, and traditional religion. The people's main occupation is trading in Farm products and Kolanuts. Sagamu is a semi-urban community with some social amenities and infrastructures like motorable roads, water supply, electricity and telecommunications, schools and markets.

Methods

With the aid of pre-tested structured interview questionnaires, expectant mothers patronizing the traditional birth attendants (TBAs) and the Primary Health Care Facilities in Sagamu community (Makun and Sabo Health Centres) were interviewed in a comparative cross-sectional study conducted during the month of September 2002.

Using a total sampling technique, a total of 200 expectant mothers were interviewed. 100 expectant mothers from the PHC Facilities and 100 expectant mothers were interviewed as they were seen in the

Traditional Institutions in Sagamu during the study period. Relevant information collected included age, religion, educational status, socio-economic status, parity, the place of booking of their present pregnancies and their reasons for preference for their place of delivery, (TBA homes or Maternity health facilities) were obtained. Data was analyzed using EPI-INFO computer software version 6.04d.

Results

Two hundred expectant mothers were interviewed using the structured questionnaire in two PHC Facilities in Sagamu and five different locations of the TBAs. One hundred women were attending the primary health facilities and one hundred women were attending the Traditional birth attendants for antenatal care. The age of the respondents ranged between 15 and 49 years. The mean ages of women in the two groups were similar being 32.05 ± 1.24 and 32.9 ± 1.32 years respectively. (Table 1) Christianity was the major religion between the two groups of respondents while none of the respondents belonged to the traditional religion group (Table 1). There is no statistically significant difference in religion between the two groups. ($P > 0.05$). Between the two groups, primigravidae were the largest number of attendants (18% & 33% respectively) while other parities were almost equally distributed among the two clinic groups. There is no statistically significant difference in the gravidity of the two groups of women. ($P > 0.05$). (Tables 2).

Table 3 is the analysis of the women along educational and socioeconomic status. Statistically significant differences were seen in the educational and socioeconomic status. ($P = 0.00008$ and $P = 0.00007$ respectively). None of the women that attended the TBA had post-secondary education while over two-third of the women had either primary (23%), or no formal education (12%). Among the PHC group, about one-fifth (19%), had post-secondary education. As a reflection of the socioeconomic status, the proportion that occupied flat was more among the PHC group compared with the TBA group. (20% and 1% respectively)

Various reasons were given for preference for the TBA homes (Table 4.) Six (6%) chose TBA homes because of the proximity to their homes. Eighteen (18%), did so because of the long waiting time experienced at the government hospitals, 33(33%) chose TBA services because of their husband and other family members' preference and 42(42%) preferred the TBAs homes because of their ability to establish a rapport and closer relationship with their clients, privacy and traditional approach of treatment. Only 1% of the respondents chose the TBAs because the fees charged in the government facilities were unaffordable.

Table 1:
Age and Religious Distribution of Expectant Mothers Patronizing the TBA and the PHC

	TBA		PHC		Total		
	No	%	No	%	No	%	
Age(Years)							$\chi^2=6.008$ p=0379 p>0.05
15-19	8	8.0	9	9	17	8.5	
20-24	24	24.0	18	18	42	21.0	
25-29	29	28	33	33	62	31.0	
30-34	23	23	30	30	53	26.5	
35-39	15	15	7	9.0	22	11.0	
40-44	1	1.0	3	3.0	4	2.0	
Religion							$\chi^2=6.008$ p=0379 (p>0.05)
Christian	60	60.0	66	66.0	126	63.0	
Islam	40	40.0	34	34.0	74	37.0	

Discussion

Results from several studies have shown a direct relationship between the attendance of PHC facilities and the educational level of the women, with the utilization of medical services increasing with increasing levels of education^{6,7,8}. In Jordan and Philippines respectively, non-use of prenatal services declined steadily from 76% and 31% among illiterate women to 59% and 17% among those with elementary education. Among those with secondary education it was 30% and 9% respectively^{9,10}.

Similarly, data from Ethiopia corroborate the association between the use of prenatal care services and women's educational level¹¹. Only 7% of the women with over 12 years formal education had not received prenatal care compared to 50% of women with no formal education. An examination of the relationship between educational levels and place of delivery also showed that the use of hospitals for delivery increases with increased education. The percentage increased from 31% for women with no education to 88% for those with more than 12 years. Conversely, the percentage of women delivery at home declined from 57% for women with no education to 4% for those with over 12 years of education. The data showed that a woman's education is a very important determinant of place of delivery. Husband's education may, however, influence the decision to seek care, especially in areas where women require their spouses' permission to travel and where husbands are major decision makers¹¹. This study also confirms the significance of education on the choice of place of antenatal care and delivery.

Women of high socio-economic status, higher education, higher income, house owners, and in a good occupation, more commonly made use of prenatal care

than women of low socio-economic status. Fifty-four percent of all deliveries and abortion take place in health institutions^{6,11}. Further more, as monthly income increased, the proportion of women who delivered in hospitals increased rapidly, while the proportion of those who delivered at home in declined.^{10,11}

Approximately, 35% of deliveries are supervised by a medical personnel¹². There is a strong dependency on the locally organized or traditional health care system of which the traditional birth attendants is one of the principal elements.¹⁰. In this treatise, the distribution of the expectant mothers patronizing the TBAs by the delivery of 199 children from 196 previous pregnancies according to the type of institution, showed that 40.2% were delivered in a Health facility, while 58.8% were delivered by the traditional birth attendants, with 1.0% of the, delivery taken by relations or friends¹⁰. This is similar to the findings in the NDHS 2003, recently released which shows that two-thirds of births in Nigeria occur at home, with deliveries taken by indigenous midwives or traditional birth attendants, while one-third occur in health facilities¹⁴.

Even though the place of delivery is an important indicator of service coverage, the proportion of those who preferred the TBAs was found to be 42.0% despite the availability of skilled manpower in this community. In the southwest region where the community is situated, the TBAs still deliver more births. However, the significant difference in the educational status in both groups is consistent with the findings in NDHS 2003 that the percentage of births that occur in a health facility increases with education, from 10.3% of women with no education to 88.1% among those with higher education¹⁴.

Surprisingly, only 6.0% of the respondents who booked

Table 2:
Distribution of the Respondents patronizing TBA and PHC by Gravidity.

Gravidity	TBA		PHC		Total		
	No	%	No	%	No	%	
1	36	18.0	30	15.0	66	33.0	$\chi^2=2.85$ $p=0.05$
2	9	4.5	12	6.0	21	10.5	
3	23	10.5	21	10.5	44	22.0	
4	13	6.5	10	5.0	23	11.5	
>5	19	9.5	27	13.5	46	23	

with the TBAs gave proximity or nearness to the traditional institution as their reason for the non-utilization of the PHC clinics. Distance exerts a dual influence, and they can be a disincentive to even trying to seek care. In addition, the effect of distance becomes stronger when combined with lack of transportation and poor roads. Distance to health facilities does not seem to be a major factor responsible for the non-utilization of the health facilities in this semi-urban community. Most roads in this community are fairly motor able at affordable costs to health facilities.

Many previous studies, has implicated distance separating potential users from the nearest health facility as an important barrier to seeking health care especially in rural or semi-urban communities⁶. The findings are that the attractiveness of a health facility decreased with increasing distance. It was estimated that less than 4% of people living within five miles of a dispensary receive care at the dispensary⁶. People living further away from a facility were even less likely to use it. The investigation concluded that the attraction of the health center decreased at a geometric rate, as the distance from the client increased at an arithmetic rate. Greater caution and understanding are needed in the tendency to see road improvements and shorter distances as a simple remedy or 'quicker fix' to wider utilization of third world health facilities. Airey suggested that institutional barriers,

such as the financial cost of treatment at the fee-charging mission hospitals, might limit the advantage of shorter distances¹⁵. In three large rural departments of Guatemala, government health posts were strategically located even around frequently visited market centres, even though findings appear to confirm a distance decay effect on utilization, distance was found not to be the main obstacle to the utilization of health services, the magnitude of the impact of distance on the decision to seek care appears to be shaped by other factors as well, such as the severity of the conditions, the perceived severity of illness, and the reputation of the provider including the perceived effectiveness of the health care or the quality of care.¹⁵ Stock found that the effect of distance on utilization varies with the quality of care. His findings in Nigeria showed that facilities that are well staffed and well equipped attract more patients than the understaffed and less equipped ones.¹⁶

The study also showed how gender roles do influence maternity care. Thirty-three percent of the respondents gave the reasons of husband and family consent as their reasons for the non-utilization of Health facilities and patronization of TBAs. When complications of pregnancy and childbirth develop, women are often not able to make decisions about their care. This places the male family members in decision-making roles. However men often make wrong decisions about seeking care during pregnancy and childbirth, in part because they do not understand the dangers involved.

Maternal mortality is influenced by a number of factors. For example, social, economic, and political context of the health care system and the cultural and biological realities of women seeking care. This complex interaction means that even when skilled care is available, women may not seek it out or receive it.¹¹ At several stages of the journey through pregnancy and childbirth, women face delays or take wrong decision in receiving the care. These delays pose barriers to safe mother-hood¹⁷. Women and their families or caregivers may not recognize the warning signs of life-threatening

Table 3:
Educational and Socio economic Distribution of expectant mothers patronizing the TBA and PHC.

	TBAs		PHC		Total		
	No	%	No	%	No	%	
Educational Status							
No Formal Education	12	12.0	8	8.0	20	10.0	$\chi^2=21.62$ $p=0.0000$ ($p<0.05$)
Primary Education	32	32.0	23	23.0	55	27.5	
Secondary Education	56	56.0	50	50.0	106	53.0	
Post-Sec Education	-	0.0	19	19.0	19	9.5	
Accommodation							
A room apartment	62	62.0	49	49.0	111	55.5	$\chi^2=19.24$ $p=0.00007$ ($p<0.1$)
Room and parlour	37	37.0	31	31.0	68	34.0	
Flat	1	1.0	20	20.0	21	10.5	

Table 4:
Distribution of the Respondents by Reasons Given for Utilization of TBA Services

Reasons	No	%
Proximity	6	6.0
Long waiting time at hospital	18	18.0
Husband and Family consent	33	33.0
I prefer TBA (rapport, privacy, traditional approach)	42	42.0
Fees charged by hospitals	1	1.0

complications. Women may have difficulty reaching a decision to seek medical care; they also may fear the treatment they would be given, a high medical fee, or the standard of care at the health facilities in terms of available facilities and supplies. When the decision is finally taken the women may also face delays in reaching health facilities in time. These delays are interrelated and reflect a country's level of socio-economic development⁶.

Delay in deciding to seek care on the part of the individual, the family or both (Phase one delay) also depends on the previous experience with the health care system, and the perceived quality of care. Eighteen percent of the respondents patronizing traditional birth institutions complained of the long waiting time in hospitals before being attended by skilled medical personnel. When patients are dissatisfied with services, the reason more often than not lies in the institutional factors, such as the procedures performed, staff attitudes and long waiting times.

Only 1.0% of the respondents patronizing traditional institutions gave cost as reasons for non-patronization of PHC Clinics. Costs include financial cost of receiving maternity care, transportation costs and cost of medications and other supplies. Surprisingly, the review indicates that compared to other factors, the financial cost of receiving care is often not a major determinant of the decision to seek care. Among factors affecting in-patients choice of hospitals in Nigeria's Oyo state, cost

was a priority consideration for only 12% of the 859 Respondents¹⁸.

Religious considerations were not found to be a major factor in health care utilization in this community. There is no significant difference in the patronization of the Traditional and the Health facilities with regards to religion ($p > 0.05$). This agrees with previous authors in factors influencing choice of hospitals¹⁸.

Even when women recognize life-threatening complications, they may fail to seek care quickly enough. Often, women do not make these decisions alone but may be aided by other family members, members of the community. Successful programs should address this delay, by encouraging families and communities to develop plans of action in case of obstetric emergencies; raising women's status so that they are empowered to make critical health decisions; enhancing links between communities and health care providers; improving relationships between traditional healers and skilled health care providers; improving interpersonal skills of health care providers by using information about how the community defines quality of care; educating women and their families about where to seek care for complications; encouraging communities to create insurance schemes to pool the costs associated with emergency care; and encouraging the use of health care facilities by adolescents, single or unmarried women and ethnic and linguistic groups who are reluctant to use services because of socio-cultural barriers^{6,9}.

Finally, to make sure women receive care at health facilities, the quality of care at health facilities need be upgraded, including improving providers' interpersonal skills, motivation and performance, ensuring adequate and sustainable supplies of emergency medicines, essential equipment, blood and staffing levels at health facilities, providing 24 hours service at facilities that provide emergency obstetric care, enhancing referral systems between communities and health facilities; improving communication between the units that provide care in order to generate referrals.

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