

Orthodox versus unorthodox care: A qualitative study on where rural women seek healthcare during pregnancy and childbirth in Southwest, Nigeria

IP Okafor¹, AO Sekoni¹, SS Ezeiru¹, JO Ugboaja², V Inem¹

1. Department of Community Health & Primary care, College of Medicine University of Lagos Nigeria

2. Department of Obstetrics & Gynaecology, Nnamdi Azikiwe Teaching Hospital, Nnewi, Anambra State, Nigeria

*Dr Ifeoma P Okafor - email: iphoomaa@yahoo.com

Abstract

Introduction

Utilization of orthodox health facilities for maternal health services is determined by factors operating at the individual, household, community and state level. The prevalence of small family norm is one of the identified variables operating within the community which influences the decision of where to access care (orthodox/traditional). The objective of the study was to determine the use of orthodox versus unorthodox maternity healthcare and determinants among rural women in southwest Nigeria.

Methods

A qualitative study was done and involved three focus group discussions. A semi-structured interview guide was used to collect information from women of reproductive age group within a rural Local Government Area in Lagos state.

Results

Most of the women access some form of healthcare during pregnancy, orthodox, unorthodox or both. Those who patronize both services concurrently do so to benefit from the two as each has some unique features such as herbal concoctions for traditional, ultrasound and immunization of babies for orthodox. Traditional belief exerts a strong influence on decision of where to access maternal healthcare services. Actual place of delivery is determined by individual and household factors including financial resources.

Conclusion

Rural women utilize one or both orthodox and unorthodox maternal health services for different reasons. Ward Development Committees should be strengthened so as to reach the communities, educate and convince women to dispel myths which limit their use of orthodox care. Training and monitoring of Traditional Birth Attendants (TBAs) are vital to eliminate harmful practices. We also recommend improved financial access to orthodox healthcare.

Introduction

Proper care during pregnancy and delivery is important for the health of both the mother and the baby and is an indicator of the status of maternal and child health in the society. Complications during pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in developing countries even though majority of these deaths are due to preventable causes. Consequently, improving maternal health is one of the Millennium Development Goals with a target of 75% reduction in maternal deaths by 2015.^{1,2,3} However, with less than three years to 2015; maternal mortality still remains a major public health challenge in Nigeria with an unacceptable ratio of 545 per 100,000 live births.⁴

Regular antenatal care has long been viewed as important for identifying the minority of women who are at increased risk of adverse pregnancy outcomes and for establishing good relations between the women and their health care providers.⁵ Previous studies among pregnant rural women

in Nigeria have identified that they seek pregnancy related health care services from government health facilities, private health facilities and Traditional Birth Attendants (TBAs).^{6,7,8} The health seeking behavior of rural women is influenced by several socio-cultural, religious and environmental factors and sometimes the decision to seek antenatal care, when to start and where to receive care may lie solely with a woman's husband, mother-in-law, neighbors and in some instances the village chief.⁹

It is a known fact that in Africa, culture plays a major role in a woman's experience of pregnancy and perceived client satisfaction from antenatal clinics. Traditional birth attendants receive a remarkable level of patronage from pregnant women as they are perceived to be more compassionate than orthodox health workers and provide other services deeply rooted in culture which are not available in the orthodox health centres.⁷ In addition, the TBAs speak the local language, have trust and respect of the community members and allow traditional birthing practices.¹⁰ Although women are generally positive about both antenatal and postnatal care, antenatal care may be sought very late in pregnancy and postnatal care not received at all in some instances. In a Zambian survey, late initiation of antenatal care was found to be a deliberate decision by pregnant women to avoid several visits to the clinic or to reduce spending.⁹ Among rural women in Tanzania, it was reported that fear of caesarean section prevented pregnant women from seeking antenatal care from health institutions.¹¹

According to Demographic and Health Survey data from 23 African countries, two-thirds of women in Sub-Saharan Africa give birth at home.¹² Similarly, 62% of births in Nigeria occur at home with women in the urban areas more than twice as likely to deliver in a health facility compared to their rural counterparts.^{4,8} About three in ten births to rural women in Nigeria are attended by a skilled provider who is expected to manage complications that may arise during delivery or refer the mother to the next level of care. It is important to note that in Nigeria, an auxiliary nurse as well as a midwife is considered a skilled health worker.⁴ Factors associated with the choice of place of birth include age, education, distance from health facility, attitude of health providers, quality of service and cost.^{6,13} The aim of this study was to determine rural women's preferred choice of health care provider for pregnancy and delivery services in their communities in Lagos, Nigeria. The findings will provide an insight into community level factors influencing uptake of maternal healthcare services by women in rural areas.

Methodology

Fieldwork was conducted in Ibeju-Lekki Local Government Area (LGA) classified as rural area by the Lagos state government. Three rural communities namely Okunraye, Magbon-Segun and Apakin were selected using simple random sampling method. At the time of study, each of the communities had a Primary Health Care (PHC) centre, none of which ran 24 hour services. The nearest General Hospital

was about 10-15 minutes travel time from Okunraye and Magbon-Segun and about 30 minutes from Apakin. There are very few private clinics and hospitals. Several traditional and alternative medicine practitioners also practiced in these areas.

Only women within the reproductive age group (15-45 years); resident in the area; and delivered a baby in the previous 2 years prior to the study were included in the study. They were identified with the assistance of Community Health Extension Workers and the women leaders in the three communities the week preceding the study. Prospective discussants were selected purposively and approached face-to-face. Follow up visits to remind the women was done the previous day prior to the date fixed for the FGD. Out of the 35 women contacted, 25 (71.4%) turned up at the agreed date and time. The remainder did not make it largely due to attendance to other pressing engagements.

Three FGDs were held at the town hall in April 2010, two sessions had 9 participants while the third session had 7. Thirty-five percent of them utilized unorthodox practitioners, 26% orthodox, 30% both while 9% did not use any. Each session lasted for about two hours and had a note taker, time keeper and moderator. The instruments of data collection were a pretested FGD guide and a short questionnaire which was used to collect demographic information from the participants. Participation was voluntary and informed verbal consent was obtained from the participants. Before starting each session, the purpose of the study was explained to the participants and they were encouraged to communicate and interact with each other. For the purpose of this study, orthodox care was defined as services and medicines received from skilled health workers and health institutions.

Discussions were held mainly in the local language most understood by the participants, prompts, probes and follow-up questions were used during the session to encourage further discussion. The discussion focused on community-level practices and not on individual experiences. De-briefs were held after each session. The discussions were recorded on audiotapes in addition to notes being taken. The field notes, audiotapes and questionnaire were used for analysis and had no identifiers that could be linked. The tapes were transcribed verbatim in the local languages and translated into English; participants' comments that were inaudible were so indicated and considered lost data. Data was analyzed manually applying the "framework" method done in stages, reviewed and separated, emerging patterns were noted and a report was written based on this¹⁴.

Ethical approval was obtained from the Health Research and Ethics Committee of the Lagos University Teaching Hospital, LUTH.

Results

A total of 25 women participated in the FGDs. The age range was 20-42 years with mean of 28.92. About half of the women completed primary school, 20% completed secondary education while the remaining had no formal education.

Most rural women seek some form of healthcare during pregnancy and childbirth

The first question the moderator asked the participants was to find out if the women in the community go for ANC or seek any form of healthcare during pregnancy and childbirth.

All of the women were of the opinion that the pregnant women in the community seek healthcare during pregnancy and childbirth. The main reason for non-attendance of ANC by some women is that they don't like taking drugs or injection. For others, it is lack of money or they don't see the need for it since they're not experiencing any problems.

"From my own observation, the women who do not attend ANC are not many. They do not want to take drugs or use injections." (37 year old housewife)

"The non-chalant attitudes of some women make them not to attend ANC. They assume that they are alright and they are not having any problems so there is no need for ANC." (42 year old caregiver in a daycare centre)

"Some don't attend because of financial reasons. Their husbands will tell them that there is no money." (26 year old petty trader)

Maternity healthcare is sought from orthodox, unorthodox or both providers

The discussants were then asked about where the women go to access health care during pregnancy and childbirth and the reasons for their choices. A majority of the discussants reported that women in their community receive antenatal and delivery service from both orthodox and unorthodox providers. Some women use TBAs, some use healthcare facilities especially government hospitals while others go to both TBA and health facilities in the same pregnancy for different reasons.

"Most of them go to the TBA more than the hospital." (20 year old housewife)

"Most women in my community use TBA. They all like TBA." (20 year old housewife)

"I think most women go to the hospital especially General Hospital." (25 year old housewife)

"When the women are pregnant, they use both the hospital and TBA. The same set of people who use the hospital also use the TBA." The one they go to first depends on the clinic day. They register first at the centre with an earlier clinic day in the week. (37 year old housewife) ie if the ANC day in the hospital is on Thursdays and the ANC day at the TBA centre is Monday, they will register/book first at the TBA centre. When labour sets in, and depending on the prevailing circumstances, they may deliver with either provider.

Several factors determine maternal healthcare source

The participants identified 'aseje', (a special concoction, mainly herbs) as one of the attractions of seeking care from TBAs. It is believed that the 'aseje' prevents development of any complications during pregnancy and labour and keeps pregnant women healthy. They also receive 'agbo' (liquid herbal concoction) so as to have a small baby and easy delivery. They prefer to deliver with the TBAs because it is cheaper. Most of them stay away from the HFs to avoid injections and tablets.

"Most women prefer TBA because they give them "aseje". The women feel dizzy after delivery and so they give them medicine for it. They don't like going to the hospital because they give them tablets and injections." (25 year old housewife)

"Most women use TBA because they don't like injections and the TBA would give them herbal mixtures made of roots and leaves. When labour starts, they will go to the TBA, because they will charge them little money." (20 year old housewife)

"During the pregnancy, they use hospital when they fall sick. They then use the TBA for delivery to avoid complications from childbirth." (37

year old housewife)

Follow-up questions and probes revealed that the complications being referred to were mainly episiotomy and caesarian section. Another reason given for this preference is that TBAs possess special skills.

“Apart from massaging their belly, they feel and tell the position of the baby. If it is not well positioned, they will turn it and put it in the correct position.” (28 year old housewife)

Other reasons given were to prevent miscarriage and some diseases like ‘maridejo’, ‘kaka’ which affect children, and ‘kambutu’ which affects pregnant women. These can only be managed by the TBA and not in the hospital. ‘Maridejo’ was described as any sickness which attacks babies before the 8th day postpartum and has jaundice as part of its presentation. The 8th day is significant because traditionally, the baby is formally named on that day. ‘Kaka’ and ‘kambutu’ are basically the same and the description seemed to fit that of a tetanus-like disease.

“They use the TBAs because they cure some diseases that the hospital cannot cure. They also diagnose some diseases which the hospital cannot do even after several tests. If the baby is not coming on time (post-date), the labour can be induced in the hospital. Also some women become very weak during labour and the hospital can handle it better.” (23 year old hair dresser)

Other women use HFs because they get to do ultra sound scan, check their blood pressure, do blood and other tests and any problems detected will be taken care of. They also deliver at HFs because their babies receive immunization immediately after birth and they can handle cases of prolonged labour.

“Women in my community go to both TBA and hospital because if a woman has prolonged labour and is taken to the hospital, she would be given an injection and within a short time, she will deliver the baby. The TBAs cannot do this.” (36 year old peasant farmer)

“There is a disease, ‘Maridejo’ which attacks babies before 8 days of age, so they use the TBAs so that their babies will not be attacked by the disease because it has no cure in the hospital. They use the hospital to check their BP, weight, to know the position of the baby and other tests. Also after delivery, they take immunization in the hospital.” (32 year old petty trader)

“In the hospital, they will test the mother and see how the baby is moving. They will test and see if the baby will come out on time. After delivery, they check if the baby is not crying, they will know what to do. They want the mother and the baby to be alive.” (39 year old trader)

The government HFs are the common choice because they are cheaper than the private ones.

Discussion

Living in a socioeconomically disadvantaged neighborhood such as rural areas has been associated with lack of access to and inadequate utilization of maternal health services in previous studies.¹⁵⁻¹⁷ The result of a national study conducted in Democratic Republic of Congo in 2007 showed that compared to women living in rural areas, those living in urban areas were 24% more likely to have delivered their child in an orthodox health facility and that this was influenced by a combination of individual and community-level variables.¹⁸ This corroborates the result of an earlier study carried out in India.¹⁹

Over the years, some studies have reported negative association between living in rural locations with the use of maternal health services^{20,21} while others did not show any

significant difference in the use of antenatal care between urban and rural women.²²⁻²⁴ The determinants of maternal health care service utilization has been noted to vary across and within cultures.²⁵ Community level variables specifically the high prevalence of small family norms operating within a LGA was a factor significant in predicting one or more indicators of use of services.²⁶ The traditional and religious beliefs of the community as well as the perception of women with regards to comparative efficacy of the orthodox versus traditional birth attendants will play a role in determining the small family norms. In this study community, some of the women did not like going to the orthodox health facilities because they give them drugs and injections but would rather go to the TBAs for herbal concoctions. This is comparable to the practice of women in Tajikistan where some prefer to deliver at home because they perceive available medical services to be of low quality and unsafe.²⁷ A study carried out in rural Sumatra Indonesia among married women showed that preference for TBA as a service provider was associated with the traditional beliefs of the women. The women used the TBAs for antenatal services but showed preference to deliver in an orthodox health facility.²⁸ In this study, some women patronize both the TBAs and orthodox health facility for ANC while place of delivery is based on individual and household factors. Unfortunately, the procedures they perceive as complications (episiotomy and caesarian section) which make them prefer delivery with TBAs are usually done for optimal maternal and foetal outcome. This observation is similar to reports in rural Tanzania.¹¹

In most rural African communities, orthodox health facilities coexist with indigenous health providers with maternal health care services provided by TBAs. Women may have to choose between the two options or combine the two, small family norms may play a role in influencing the woman's choice. A high proportion of women in this study access maternal health services from TBAs. This corroborates the result of a study carried out in a rural LGA in Ogun state Nigeria, where almost two thirds of the respondents had visited a TBA. Sources of information about TBAs were mothers, family members and friends.⁷ In a study carried out in Ghana, the women reported that TBAs were more considerate and provide more compassionate care.²⁹ Women in rural Guatemala were also less likely to deliver in medical settings because of lack of social support from orthodox health-care professionals compared with traditional midwives³⁰ while previous studies carried out in Nigeria had also reported that many rural Nigerian women rate the quality of services rendered by TBAs to be of higher quality compared to orthodox health facilities.^{31,32} In this study the traditional belief of the community is that the TBAs possess special skills which they use in providing preventive and curative services to pregnant women and newborn babies.

The cost of accessing services from TBAs according to the women in this study was ranked to be cheaper and therefore more affordable to the majority than that of orthodox health facilities and this plays a role in the choice of where they go to access maternal health services. This is similar to findings in West Java province Indonesia³³ and south-eastern Nigeria.³⁴ Some TBAs in another study allow payment over a period of time which provides some relief since payment is from out of pocket while others accept payment through a barter system.²⁸

In Nigeria, Ward Development Committees (WDCs) were

set up to bridge the gap between the community and the health system at the grass-root level. Among the several responsibilities they have is out-reach to the community to enlighten them on the need for good health-seeking behavior and use of orthodox care.³⁵ They need to convince community members, especially women that the health facilities are there to provide safe maternity services to them for optimal maternal and foetal outcomes.

The respondents seem to have faith in the prowess of the TBAs and the natural herbs they use. It then becomes necessary that these herbs and other ingredients they use are subjected to pharmacological analysis to determine the components and the beneficial or harmful effects on the human body especially the foetus. The findings would be communicated to the TBAs, the beneficial harnessed while the harmful discarded. The TBAs are very important in the referral system. One of the main targets of MDG 5 is the proportion of deliveries taken by skilled health personnel of which the TBAs are not. They should then be enlightened, educated and persuaded to refer all their clients to health facilities for delivery, and if possible given incentives.

The TBA's co-operation and involvement will also be useful in the area of birth preparedness and complication readiness. They live within the community, familiar to many families and are well respected. They can be trained to assist in creating awareness and sensitizing the community members to prepare for births and complications in advance since pregnancy outcomes may not be predictable. Blood donors can be identified and contributions made to ensure financial access.

Conclusion

Rural women use one or both orthodox and unorthodox maternity services for reasons peculiar to both providers. Traditional beliefs, cheaper charges, and certain practices (which are harmful) endear them to the unorthodox providers. Conduction of regular check-ups and investigations (BP, weight, ultrasound scan, urine and blood tests), better management of post date pregnancy and prolonged labour; and immunization of the newborn are reasons for choosing orthodox care. Free or subsidized maternity services should be provided at the rural hospitals. Women should be educated on appropriate health-seeking behavior. Myths about 'perceived obstetric complications' and negative attitude to orthodox drugs should be addressed. In addition, TBAs need training and monitoring to eliminate their harmful practices. Strengthening the Ward Development Committees (WDCs) is vital in engaging the community for this education.

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Table 1: Demographic characteristics of the FGD discussants

| Discussants | | | |
|--------------------|--------------------|------------------------------|-----------------------------|
| Session 1 | Age (Years) | Educational Level | Occupation |
| 1 | 37 | No formal education | Housewife |
| 2 | 23 | Secondary school uncompleted | Hair dresser |
| 3 | 38 | No formal education | Petty trader |
| 4 | 32 | Secondary school completed | Petty trader |
| 5 | 26 | Secondary school uncompleted | Housewife |
| 6 | 37 | Primary school uncompleted | Fisher woman |
| 7 | 26 | Primary school completed | Fisher woman |
| 8 | 20 | Primary school completed | Housewife |
| 9 | 20 | Primary school completed | Housewife |
| Session 2 | | | |
| 1 | 20 | Secondary school uncompleted | Housewife |
| 2 | 31 | Secondary school completed | Primary school teacher |
| 3 | 28 | Primary school completed | Housewife |
| 4 | 25 | No formal education | Hair dresser |
| 5 | 36 | Secondary school uncompleted | Peasant farmer |
| 6 | 28 | Primary school uncompleted | Petty trader |
| 7 | 30 | Primary school completed | Housewife |
| Session 3 | | | |
| 1 | 25 | Primary school uncompleted | Housewife |
| 2 | 34 | Secondary school uncompleted | Petty trader |
| 3 | 20 | Secondary school completed | Housewife |
| 4 | 25 | Primary school completed | Petty trader |
| 5 | 42 | Primary school uncompleted | Care giver, Day-care centre |
| 6 | 30 | No formal education | Petty trader |
| 7 | 25 | Primary school completed | Housewife |
| 8 | 26 | Secondary school completed | Petty trader |
| 9 | 39 | Primary school completed | Trader |