The prevalence of domiciliary deliveries in Khayelitsha, Cape Town

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Objective. To determine whether the 17% decrease in the number of patients cared for at the Khayelitsha Midwife Obstetric Unit (MOU) between 1991 and 1994 could be ascribed to an increase in home deliveries.

Method. Survey of Khayelitsha labour ward records, vaccination cards and family planning statistics at various clinics in Khayelitsha, Cape Town.

Results. The prevalence of home deliveries in Khayelitsha during the study period was estimated at 8%. Between 1992 and 1994, the number of acceptors at family planning clinics in Khayelitsha increased by 99%.

Conclusion. As the number of home deliveries had apparently remained static, it was unlikely that an increase in the former had been responsible for the observed decrease in Khayelitsha MOU patients. Other possible reasons for the decline, viz. (i) an increase in hospital deliveries; (ii) an increase in the number of patients returning to the so-called homelands to be delivered there; (iii) an increase in confinement by private doctors and midwives; and (iv) that patients had shunned the MOU, were equally unlikely. The decline in the number of patients cared for at Khayelitsha MOU between 1991 and 1994 was most likely due to the evident success of the local family planning programme.

Between 1991 and 1994, the number of patients cared for at the Khayelitsha Midwife Obstetric Unit (MOU), one of 5 MOUs in the Peninsula Maternal and Neonatal Service (PMNS) in Cape Town, decreased by 17%. Khayelitsha is a huge township on the outskirts of Cape Town, with a large informal settlement component.

As domiciliary delivery is a dangerous practice in the Third World,1 a study was undertaken to determine whether the abovementioned decrease could be ascribed to a significant increase in the prevalence of home deliveries.

Three groups were studied. The first comprised all women cared for at the Khayelitsha MOU over the 6-year period 1989 - 1994. This group was made up of 3 394 patients
The major criticism of this study is that there is no way of determining the number of women in Khayelitsha who, for whatever reason, had shunned the available health facilities. Those women would then not have taken their children to be immunised and there would have been no vaccination cards for those children. A number of those women might have delivered at home, with no or, at best, inadequate supervision. It is, however, unlikely that such women would have refrained from attending the MOU or the adjacent community health centre (CHC), in cases where the labour or delivery had become complicated. Should such a patient have attended the CHC, she would immediately have been referred to the MOU or to the referral hospital. The number of unbooked patients who presented at the MOU with a BBA infant further refutes the suggestion that women might have shunned the MOU.

Conclusions

1. The most likely explanation for the decline in the number of patients cared for at Khayelitsha MOU is the success of the local family planning campaign.

2. The PMNS, largely because of the establishment of a community-accepted MOU, appears to have been successful in limiting home deliveries in Khayelitsha to a relatively low 8% (approximately). In view of the very serious sequelae of domiciliary deliveries in the Third World, it is recommended that the perinatal system pioneered in the PMNS region be implemented throughout South Africa. This is especially important wherever there are large informal settlements.

REFERENCES


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