

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 89%.

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 confinements 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.

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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

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referred antenatally to hospital and 29 220 admissions to the Khayelitsha MOU labour ward. The latter included women delivered in the MOU, the mothers of infants born before arrival at the MOU and patients transferred to the referral hospital in labour. A total of 32 614 patients were therefore cared for at the MOU. These data were obtained from the MOU's labour ward register.

The second group consisted of a systematic 1 in 10 sample of the vaccination cards of the 5 260 children vaccinated at three Khayelitsha clinics, viz. Site B, Nolungile and Zakhele, over the same period. The cards showed that 2 488 (47%) of the children had been born at the Khayelitsha MOU, 2 115 (85%) in one of the referral hospitals and 657 (13%) 'at home'. The latter category, however, included infants born before arrival (BBA) at the MOU. The number of BBA infants over the same period was 1 747, or approximately 5% of the patients cared for. The estimated prevalence of 'true' home deliveries was therefore approximately 8% (13% minus 5%) of all Khayelitsha deliveries.

The third group comprised all women who were offered contraception at clinics in Khayelitsha over the period 1992 - 1994. According to the family planning statistics for Khayelitsha, the number of family planning acceptors increased from 49 112 in 1992 to 71 401 in 1993 and further to 92 953 in 1994, an increase of 89% between 1992 and 1994.

The results of an unpublished survey have suggested a low prevalence of domiciliary deliveries in Khayelitsha.² This study has provided reasonably good evidence that the prevalence of home deliveries in Khayelitsha is approximately 8% of all deliveries. Although this is clearly too high, no evidence was found of a recent increase in that percentage. The 17% decline in the number of patients handled at Khayelitsha MOU is therefore unlikely to be due to an increase in home deliveries.

There were a number of other possible explanations for the decline in deliveries. These were: (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 confinements by private practitioners or private midwives; (iv) that patients had shunned the MOU; and (v) an increase in the number of family planning acceptors, resulting in fewer deliveries in the township.

The drop in the number of deliveries was mirrored, though to a lesser extent, throughout the PMNS region. Thus, between 1991 and 1994, total deliveries in the PMNS region decreased by approximately 6% (H A van Coeverden de Groot — unpublished data). An increase in hospital deliveries is therefore not a feasible explanation for the decrease in Khayelitsha deliveries.

There is no reason to assume that increasing numbers of patients had travelled to the so-called homelands to deliver there. On the contrary, even before the abolition of influx control in the late 1980s, women arrived in large numbers from those homelands in order that their infants might be born in Cape Town.

The prevalence of private deliveries in Khayelitsha is unknown. However, few private practitioners conduct home deliveries, although there are some private midwives who practise domiciliary midwifery. Moreover, as these home deliveries are generally supervised by trained personnel, they should pose little danger to the 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.

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