DETERMINANTS OF MATERNAL CHOICE FOR PLACE OF DELIVERY IN AYIVU COUNTY, ARUA DISTRICT, UGANDA

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ABSTRACT
Childbirth anywhere in the world has its risks particularly where there is no proper antenatal care and attention during labour, delivery and puerperium. In Uganda despite the good antenatal attendances, very few expectant mothers return to deliver in the health facilities. This study set out to establish the key determinants which expectant mothers in Arua District, considered vital in their choice of delivery place. It was also undertaken to determine the key socioeconomic, cultural and health care factors that influenced a mother’s decision on where to deliver.

The study was typically descriptive and cross sectional with both quantitative and qualitative components. Data was collected by means of questionnaires, focus groups and interviews with key informants. The study sample comprised women within the reproductive age, elderly men and women, community health workers, traditional birth attendants, married men and young males.

The findings revealed various factors to be important in a mother’s choice of place of delivery and indicated socio economic, cultural and health care factors as crucial in these decisions. The findings also indicated that a mother’s level of education significantly impacted on her decision as to where to deliver, and that the majority of the mothers had no or little knowledge on the dangers of home deliveries.

KEY WORDS: Choice, Delivery, Determinants, Maternal, Mortality.

INTRODUCTION
Childbirth anywhere in the world has its risks, particularly without proper antenatal care and attention during and after delivery. For most women in developing countries, the risks are multiplied. One out of every 21 African women will die as a result of pregnancy or childbirth, yet every one of these deaths (over 500,000 a year or one every minute of every day) could be prevented. A woman in Africa is 200 times more likely than an European woman to die as a result of bearing her child (Nafis, 1989).

The Uganda Demographic Health Survey reports of 1995 & 2000/1 indicate that the overall antenatal services coverage was close to 90%. Unfortunately despite the high coverage, only about 39% of deliveries took place with a doctor, nurse or midwife in attendance. Records from the Arua regional referral hospital, which serves the area, under study indicated that of the women who attended antenatal services, only 10% returned for hospital deliveries during the period that of the women who attended antenatal services, only 10% returned for hospital deliveries during the period January 1994 – December 1997. It is clear that actually most women deliver at home, alone, with relatives, friends, or traditional birth attendants.

The Uganda Population and Housing census, (Ministry of Finance and Economic Planning, 1991) revealed that Ayivu county had a maternal mortality rate of 500 for every 100,000 births and the infant mortality rate was 137 per every 1000 live births in the face of a high fertility rate of 6.7%. In Uganda, the risk of maternal and infant mortality and morbidity is unacceptably high. In 1995 the national infant mortality rate was 97 per 1000 live births while the maternal mortality rate 506 per 100,000 births (Uganda Demographic Health Survey, 1995). These unacceptably high rates of infant and maternal mortality and morbidity continue to cause immense suffering in homes and in the communities and have been linked to Uganda’s low socio-economic productivity.

PROBLEM STATEMENT
In Uganda, various studies indicate that whilst the antenatal coverage seems to be adequate sometimes even up to 90%, it is deplorable that 74 to 90% of deliveries still take place outside health facilities (Ministry of Health, 1989). This picture seems to be similar in nearly all the health facilities in Uganda. For instance, patient records from the Arua regional referral hospital, in the period January 1994 – December 1997, indicated that only 10% of the antenatal mothers returned for hospital deliveries. This pattern of health seeking behaviour is a great cause of concern since this area has alarming rates of infant and maternal mortality and morbidity. Consequently it is imperative that the factors that hinder mothers from utilizing health facilities for delivery purposes are explicated.

SIGNIFICANCE OF THE STUDY
It was envisioned that the findings of the study would serve as an indicator for evaluating the impact of a safe motherhood initiative in the district. These findings would also be used to educate the community members about practical and effective means to improve maternal health, especially to identify mothers at obstetric risk. In addition, the findings may be used as a solid foundation for further research into related areas of maternal health. It was also envisaged that the study would unveil the existing taboos that surround childbirth among the local population.

REVIEW OF RELATED LITERATURE
In 1985, the World Health Organisation estimated that nurses, midwives, or trained traditional birth attendants attended 34% of births in Africa and Oceania, 49% in countries; (Morocco, Senegal, Liberia and Burundi) and two Latin American countries;
(Ecuador and Peru); indicated that doctors or midwives attended 20 to 60% of births in the proceeding five (5) years (National Demographic and Health Surveys, 1986-87). In many cases these numbers are low because trained personnel are not available. Even when they are, some women are reluctant to use such facilities, even if they developed complications during labour and delivery (Kwast, Kindane-Mariam, Saed, & Fowkes, 1984; Sangaret & Diarra, 1987).

The Population Reports: Issues in World Health (1988) attributed to the low maternal turn-up for delivery in the health facilities for a number of reasons, some of which are now explicated:

- Most countries do not have a sufficient number of clinics and hospitals for every delivery, nor can they even afford to build, staff and equip such facilities. In addition, many women prefer giving birth at home because of the familiar surroundings while others prefer it in order to perform customary rituals.
- Most women prefer health facilities within walkable distances, however most health facilities are quite far away from their homes. However in some places, the clinic/hospital atmosphere keeps women away. In Islamic societies for example, women often prefer female health care providers and yet many times all the trained health care providers are men.
- Labour wards often do not offer adequate privacy when examining women or vaginal examination is done, sometimes by seemingly young people and students which is embarrassing to the women who consider these young people as they could have been their own children.
- Its also common that some health care providers do not treat women with respect or give them enough time and attention during labour and delivery, unlike the traditional birth attendants who tend to treat them well.
- Some health facilities turn pregnant women away because they have run out of supplies or have broken equipment or the staff may not be present at the facility. In addition, unlike antenatal services, delivery services are often expensive and many mothers cannot afford these costs.
- Some women do not use health facilities for delivery because they see them as places to die. In some cultures, married women need permission from their husbands or in-laws to leave the house, and especially to go to hospital. If these relatives and husbands are reluctant to accompany them or are absent when the women need emergency care, the women may be unable to use the health facility for delivery (Population Reports, 1988).

O’ Mahoney, & Steinberg, (1995) reported that a population based survey of obstetric practices among rural women in the Bizara District, Transkei indicated that two-thirds of women had delivered at home and one-third within the health facilities. Of those who delivered at home, 47% were alone at the time of delivery while the remainder, were assisted by a close relative or neighbour; and 38% had one or more risk factors for obstetric complications. It was concluded that antenatal care should include education about the home management of a normal childbirth.

In Uganda, several surveys confirm that delivery without trained attendants is common. The National Demographic Health Survey of 1988/1989 found that 88% of the women received antenatal care, but only 39% delivered with a trained doctor, nurse or midwife in attendance. Nalwanga and Natukunda (1988) reported similar findings in a study, which also found that 67% of the rural women had no formal education compared to 33% of their male counter-parts within the household. They documented that only 34% of women had access to a radio. It was concluded that inaccessibility to information coupled with high illiteracy levels estimated at 55%, isolated the rural woman from adopting new ideas to promote their health.

The Uganda Demographic Health Survey, (1995) revealed that one of the major factors associated with low utilization of health facilities by pregnant mothers was the fear of HIV/AIDS. This fear was so widespread that communities and especially pregnant mothers believed that health facility delivery is associated with the contraction of the dreaded HIV virus. This survey also implicated the long distance from health facilities. Only 25% of the population lives within 5km from a health facility while 43% live over 10km away from any health facility.

Another reason for the low turn up at the health facilities has been linked to unregulated practices in some facilities. For instance, due to low salaries some health workers reportedly demand bribes for services that should otherwise be free of charge in government units. These unregulated practices cause poor patients to avoid health care, while those who are able to afford, prefer go to non-governmental units and private practitioners where they feel they are more likely to get better health care (Ministry of Health, 1989).

**STUDY DESIGN**

The study was typically descriptive and cross sectional with both quantitative and qualitative components. Quantitative data was obtained by administering questionnaires to mothers within the reproductive age bracket of 15-49 years. While qualitative data was generated from focus groups that comprised of elderly men and women, community health workers, traditional birth attendants, married men, young male, and key informants in the community. Participation in the study was limited only to members of the community who had resided in the study area for at least two years, and residency of less than two years was the exclusion criteria.

**Participant Selection and Data Collection**

A total of eighty, (80) mothers were randomly sampled and subsequently enrolled into the study. The eligible respondent was a woman in her reproductive age who
had at least one child and had been a resident in the area for at least two years. In every division (sub-county), twenty (20) mothers were administered questionnaires to generate quantitative data, while focus group discussions and key informant interviews were conducted to generate qualitative data.

**Ethical Considerations**

The approval and permission from the relevant district and county authorities was sought. In addition, all participants consented prior to enrolment into the study and their identities remained anonymous throughout the study period. Keeping all questionnaires and responses under lock and key enhanced participant confidentiality and they were only taken out during data coding and analysis.

**LIMITATIONS OF THE STUDY**

The study area is largely a rural area with a high level of illiteracy. It is possible that the findings of this study may not be generalizable to urban and peri-urban communities where the literacy and the socioeconomic status are different.

Secondly, there was a lack of adequate relevant related literature on the subject, as this study had not been attempted before in this area. Such literature would have facilitated the researcher’s understanding and articulation of some of the pertinent issues regarding mothers’ choice of place of delivery. This might have significantly limited the “richness” of the interpretation of the findings.

**FINDINGS OF THE STUDY**

Long distances, biting poverty, and lack of transport were some of the main factors that prevented mothers from delivering in health facilities. Other factors included lack of knowledge on the dangers of home delivery and the mothers’ inability to take decisions about their own health. Out of these, poverty emerged as the most critical hindrance possibly because of the large majority, (up to 88.8% of the women) were either peasants or self-employed with low financial returns, except the 2.5% in civil service. Consequently, the low income made expectant mothers very vulnerable.

1) Problems faced by women in pregnancy and childbirth

Narratives from focus groups and key informants indicated that during pregnancy and childbirth, women face a number of problems ranging from having not enough to eat, overworking, ill health, biting poverty, to delivering alone at home, without any assistance. It also became apparent that the community except for their husbands and close relatives paid little attention to pregnant women when they developed problems.

2) Mothers who deliver at home, with relatives or traditional birth attendants

Illiterate women with strong cultural beliefs against delivering in modern health facilities, mostly fell in this category. Likewise were the multi gravidae who believed that health facility delivery was a waste of time especially if they have had good history of home delivery without any childbirth related complications.

The statement; "...my wife has given birth to more than 8 children at home, now what is the point sending her to the hospital for delivery?” concretizes this assertion! It was also reported that young girls who got pregnant “accidentally” shunned health facilities for fear of being labeled “bad mannered girls” by the nurses and doctors. Similarly, these young primigravidae absented themselves during antenatal care because of the fear of being harassed by health workers.

Furthermore, poor mothers who are unable to provide the basic necessities for the newborn baby eschewed the hospitals as well. Hence they delivered at home, with relatives or with traditional birth attendants as affirmed by the narrative; "Afa te mani muzu ma alio e’da zu ri adonia?” ...translated as ..., “Why should I get out there (health facility) to expose my poverty?”

iii) Cultural beliefs and practices that hinder health facility delivery

Most mothers, up to 67.5% accepted having and practicing cultural beliefs and when asked to elaborate, a participant described that; “Our culture prohibits us from drinking soon after delivery, that after birth a baby is not to be bathed for the first 3-4 days, and that the baby should not be given breast milk immediately”. The participants also argued that their cultural beliefs and values would not hold true in health facilities where mothers are compelled to take plenty of fluids, bathe and even breastfeed soon after delivery. Also reported was the fact that this community believes that colostrum (first breast milk) is ‘ poisonous’ and that it should not be given to a newborn baby.

Other related narratives were that birthing in public places including health facilities was an abomination and that mothers would lose their babies or they would get exchanged for unwanted children as alluded to in the description; “In our culture, it is an abomination for a woman to deliver in public (hospital) where she will expose her nakedness. If one does so, she risks rejection by the community; that the babies will be either stolen or exchanged, their organs taken out and brains used to make aspirin; and that they will undergo forced operation”.

iv) Expectant mothers who deliver in modern health facilities

The study found that if a mother usually had difficulty during childbirth or bleeds a lot during delivery, she would always try to deliver in the hospital. This observation was affirmed by one respondent who asserted that; ...my wife always delivers through hospital. This observation may be due to their knowledge of the dangers associated with childbirth.

When asked to comment on the category of mothers who would deliver in health facilities, a focus group of trained birth attendants commented that; “Some mothers who end up delivering in hospitals are those who (trained TBAs) refer because of complication or ill health”. However the youth suggested that teenagers who conceived accidentally and got supportive treatment during pregnancy were more likely to turn up for hospital...
delivery compared to those who were rebuked by peers, teachers and parents, a pattern common among school dropouts.

v) Why modern health facilities are less commonly utilized for delivery

One of the explanations is that many on the job trained midwives and nurses and other health care personnel treated mothers very harshly, sometimes to the extent of slapping them and hurling insults at them. Those particularly victimised were the prime gravidae and fearful mothers. Insults like, “Alu andra emini mva nde tiria, mi di ba dri eza adosi?” ...translated as... “You enjoyed yourself when you were making this baby; why do you now disturb us?” were some of the ‘biter pills’ these mothers endured. Such statements often irritated them making them lose confidence in the service providers, as they felt offended. Most mothers who suffered such shocking experiences opted to deliver at home, with relatives or with traditional birth attendants where they hoped to be treated with dignity and respect.

Another deterrent was the birthing position adopted in hospital. A focus group of community health workers reported that they have heard lots of complaints from mothers about the lithotomy position, the “bed belt” as they call it. They described it disrespectful and abominable and viewed it as a form of torture. In fact most mothers interviewed preferred the squatting position, claiming that it enhanced descend of the baby during delivery.

Further still, low hospital deliveries were partly explained by the fact that many mothers do not actually know their dates well. This frequently resulted into abrupt onset of labour, culminating very often in such mothers delivering on their way to the health unit. Another reason was that many pregnant women do not know the significance of health facility delivery; hence awareness of the risks of home delivery was not widespread. Government was blamed for not doing adequate sensitization on this important subject.

Negligence by support systems – husbands, in-laws, and neighbours were identified as another hindrance to health facility delivery. The study was informed that often when mothers begin to labour, support persons are unavailable to give them help or take them to health units as labour progressed. As a result such mothers ended up delivering at home because they had no choice. This observation was reinforced by one of the mothers who reported that; “...mite mini le mu ozi aro joa, tee mi esu ba azi mi jipini adri yo; de mva nde di vini mi okpo bo!”...meaning that, “...you may want to go and deliver in hospital, but you find there is no one to accompany you as the labour pains intensify!

Another disincentive identified was the belief that traditional birth attendants are better than the midwives in the health units. Consequently, some expectant mothers saw no point getting to health facilities when the ‘experts’ – the traditional birth attendants were just nearby. It was also observed that some mothers fear surgery and believed that in the health facility they would be subjected to a forced caesarean section, an operation they want to avoid at all costs.

Poverty was also blamed for keeping mothers away during childbirth. It took the form of having no transport to get to hospital, inability to afford the dues and incapacity to meet the basic requirements for birthing. Likewise poverty also forced some men to restrain their wives in order to avoid embarrassment because of their inability to provide them with basic requirements while admitted. The narrative; “Wadi la ayo ejini ma ailo dori, eda anveleku dini”...translated as... “Madam I insist that you won’t go out there [health facility] to expose my poverty” concretizes this claim. Wives of such poor men are compelled to deliver at home even if they personally wanted to deliver in a health facility.

When asked to explain why most mothers preferred to deliver with them instead of the health units, some traditional birth attendants reported that their delivery charges are lower than those at the health units. Some even claimed that they often offer credit terms...a situation where a mother is allowed to settle her dues after delivery. A few others reported that they usually accept payments in kind...in the form of cassava, chicken, millet and casual labour which mothers find quite easy to fulfill. They argued that such alternative modes of payment are non-existent in the health facilities and yet most poor mothers find them very attractive.

Polygamy significantly hindered the utilization of the health facilities. It was observed that if the co-wives were on good terms, then the expectant one would normally be assured of the safety of her children while being admitted. However if there existed severe misunderstandings between them, the expectant one would resist hospital admission for fear that her children would be harmed or mistreated.

The low educational preparation especially among the young prime gravidae was also seen as a major barrier to the utilization of the health facilities for delivery. It was reported that these young prime gravidae were easily influenced by their grandmothers to deliver at home, or with traditional birth attendants instead of the health facilities. This was contrary to the educated mothers (those with secondary and tertiary level education) who mostly delivered in health facilities, possibly because they know the dangers of home delivery.

VI). Preferred place for delivery during future pregnancies

When mothers were asked for their preference for the next delivery, 80% said they would prefer to deliver in a health facility. This change was rather surprising since 50% of the mothers had their previous deliveries at home or with a relative compared to 11.3% in health facilities. Such a change may be attributed to the safe motherhood initiative that had been operating in the area in addition to the efforts of the health workers in creating
awareness about the merits of health facility delivery. Omondo (1995) obtained similar findings in a study done in Apac district, in Uganda. He described that mothers who developed complications like swelling of the legs and bodies, anaemia, and those with poor obstetric history were referred to the health units by community health workers and some trained traditional birth attendants. Consequently, Omondo (1995) declared that the higher the educational level of husband and wife, the more likely it was for the expectant mother to seek medical attention during pregnancy and childbirth.

CONCLUSIONS
On the basis of the findings of the study it was concluded that:
A mother's level of education had significant effect on where she delivered her baby the more educated she was:

a. A mother’s level of education had significant effect on where she delivered her baby the more educated she was the more likely to seek professional healthcare during pregnancy and childbirth.

b. Certain prohibitive cultural beliefs, values and practices prevented pregnant women from utilizing the available health facilities for delivery.

c. Poverty negatively affected expectant mothers’ decisions; in most cases it barred them from seeking delivery services from the health facilities.

d. The initial response and treatment a mother received at a health facility either acted as stimulus or hindrance for future utilization of such and other similar health care facilities especially during delivery.

e. In fact a large majority of pregnant women actually delivered in other places than the established modern health facilities.

f. Trained traditional birth attendants contributed enormously to the delivery of maternity services especially in rural areas, hence their high rating among the local population.

g. The community offered little support to pregnant women when they developed complications during pregnancy except for close relatives.

IMPLICATIONS FOR NURSING PRACTICE

1. As health care providers, nurses and midwives handle expectant mothers. In so doing it is imperative that they realize that a mother’s level of education significantly impacts her decision to choose or refuse to deliver in a health facility. This means that nurses and midwives should tirelessly educate mothers to abandon home delivery and instead opt to deliver in the modern health facilities. The trusting relationship that emerges between the nurse and/or midwife and the pregnant mother during the antenatal period should be the perfect timing for this education.

2. Nurses and midwives ought to be aware that certain cultural beliefs and practices hinder expectant mothers from utilizing modern health facilities. If the nurse/midwife becomes aware of any existing harmful beliefs and practices during the antenatal period, she/he should endeavour to address them early in pregnancy. This means that nurses/midwives need to be taught how to elicit such beliefs and practices in order to deal with them.

3. There is a need for nurses/midwives to fight poverty because it is a major obstacle to adequate utilization of health facilities for delivery. Nurses, as care givers must become active partners in alleviating poverty. One of the plausible remedies would be to encourage pregnant mothers to save during pregnancy in order to have sufficient funds to cater for at least the basic hospitalization costs during and after childbirth.

4. It is vital that nurses and midwives realise that the treatment a pregnant mother receives at a health unit either acts as impetus or a disincentive for her use of such facilities during future deliveries. As a result every nurse/midwife must strive to offer the best quality of care in his/her nursing/midwifery practice. All nurses and/or midwives should treat every mother with the utmost dignity and respect they deserve. In so doing such mothers get motivated to return to health units for childbirth, a situation likely to reduce the alarming rates of infant and maternal morbidity and mortality.

5. In the practice of nursing midwifery, there must be renewed awareness of the importance of the traditional birth attendants in the delivery of maternal and child health services. All nurses and midwives must collaborate with these birth attendants who contribute enormously to health care delivery at the grass root level. These caregivers have high ratings among the local population, and through such good working relationships; nurses and/or midwives could easily reach out to many more mothers through them.

6. The fact that the community offers little support to pregnant mothers when they develop complications means that nurses and midwives need to educate the community about the importance of supporting pregnant women during pregnancy. This crucial information may be given through community health education talks, usually conducted by community health workers and public health nurses. It is envisioned that.
such educative talks may change the attitude of community members thereby making them more supportive to expectant mothers who develop problems during pregnancy.

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