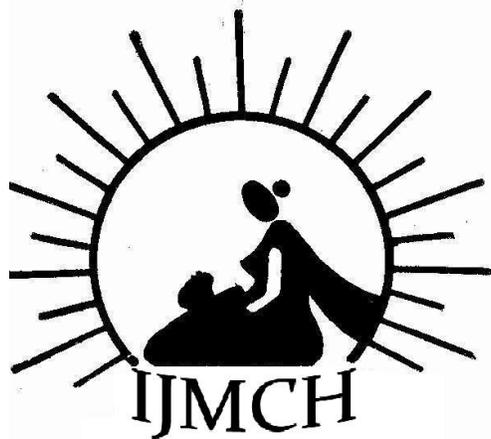


What determines urban women's choice of maternity care? A qualitative approach in Lagos, Nigeria

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This study was undertaken to understand the determinants of choice of maternity care (antenatal care and delivery) among urban dwelling women in Lagos, Nigeria.

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ABSTRACT

Background: This study was undertaken to understand the determinants of choice of maternity care (antenatal care and delivery) among urban dwelling women in Lagos, Nigeria.

Methods: Three Focus Group Discussions (FGDs) were carried out with women of reproductive age who had recent deliveries. Discussions were tape-recorded and later transcribed. Content analysis was done.

Results: Enabling factors for public facilities were: affordability, availability of specialists and facilities. Deterrents were: numerous bureaucratic protocols, long waiting queues and poor staff attitude (especially nurses). Enabling factors for private facilities include: better quality of care and short waiting time. Deterrents include high cost of care and 'sharp' practices. Enabling factors for TBA centres were affordability, cultural acceptability and spiritual prowess while deterrents include their inability to handle certain emergencies.

Conclusion: Combinations of factors determine choice of maternity care. Stakeholders from public, private and traditional health sectors as well as other stakeholders should come together to address the negative issues.

Key words: *Community; ANC; Qualitative; Healthcare; TBA; Urban; Nigeria*

INTRODUCTION

Motherhood is often a positive and fulfilling experience, but for too many women it is associated with suffering, ill-health and even death. Nigeria still has an unacceptably high maternal mortality ratio of 545 per 100,000 live births contributing more than one-tenth of the number of women who die from pregnancy related causes worldwide.^{1,2} In addition, it has the world's second worst maternal health statistics, with one in 13 women dying during childbirth.³ The high maternal mortality ratio in Nigeria like in many developing countries has been mainly attributed to poor utilization of maternal health services and previous research has shown that utilization of maternal health services is associated with improved maternal and neonatal health outcomes.^{4,5} Improving maternal health is one of the United Nations' Millennium Development Goals and this is of particular relevance in sub-Saharan Africa, where women's health indicators lag behind the rest of the world.⁶

Maternal mortality is the result of the interaction of several factors which include medical, economic, environmental and social factors. Although the objective of maternal health services is to reduce to the barest minimum maternal morbidity and mortality, a major challenge in developing countries is the identification of vulnerable groups.⁷ The absence of

accurate data on the number of women accessing such services, causes of maternal death and local factors influencing adverse maternal outcomes may constitute an obstacle in the appropriate distribution of resources targeted towards improving maternal health.⁸

Utilization of maternal health services is related to the availability, quality, cost of services, social structure, health beliefs and characteristics of the users.^{7,9} This readily explains the regional variations in the utilization of maternal health services reported in the Nigerian Demographic Health Survey of 2008. In general, maternal mortality rates are higher in rural areas than in urban areas.¹ However, it is important to note that there are many slum dwellers in urban areas and pregnant women inhabiting urban slums are a high risk group with limited access to health facilities. There is also the issue of hazardous maternal health practices which are very common in slum areas.¹⁰ It has been documented that non-utilisation of maternal health services increases the likelihood of having adverse outcome in a pregnant woman.^{11,12,13} Barriers to utilization of maternal health services in Nigeria include financial constraints, cost, distance to health facilities, attitude of health care providers, unavailability of drugs and the need to obtain permission to access healthcare.¹ Despite the progress made in reducing maternal mortality ratio in Nigeria in the last decade, the proportion of births attended by a skilled health worker has remained low and threatens to hold back further progress.¹⁴ Against this backdrop, the objective of this study was to assess the utilization of maternal health services by urban women in Lagos, Nigeria.

MATERIALS AND METHODS

Lagos state is one of the most populated states in Nigeria with a population of about 10 million of which approximately two-thirds comprises women of child-bearing age.¹⁵ The study was conducted between February and March, 2010 in Surulere, one of the 20 urban Local Government Areas (LGAs) in the State, which was selected by simple random sampling. Three wards out of the 23 in the LGA were then selected also by simple random sampling. At the time of study, there were 6 Primary health care centres, 1 secondary health institution and about 263 private health facilities within the LGA. Traditional Birth Attendants (TBAs) and other alternative healthcare providers also operate in the LGA. Three Focus Group Discussions (FGDs) were conducted with purposively selected women of child bearing age who had deliveries within 2 years prior to the study and were residents of these areas. They were identified with the assistance of health workers and female CDA members within the communities. The prospective discussants (40 of them) were initially approached in their respective homes 3 weeks earlier and told about the study. Thereafter, SMS reminders were sent a week and a day before the FGD. Eventually, 23 (57.5%) of them honoured the invitation at the agreed time and date. The rest had other matters to attend to or simply lost interest.

The 3 FGDs were held in May 2010, 2 at the Town Hall and one at the Community leader's residence. The first 2 groups consisted of 8 women each and the last had 7 women in attendance. Each session lasting between 1-2 hours and conducted by a moderator, note taker and time keeper. A semi-structured FGD guide was used for data collection and basic demographic data were also collected from the discussants with a short questionnaire. Participation was voluntary and formal consent was obtained from the participants. Before commencement of each session, the purpose of the study was explained to the participants and group rapport was encouraged.

Discussions were held in English and pidgin English. Probes and follow-up questions were used to encourage further discussion where necessary. De-briefs were held after each

session. The entire discussions were tape-recorded and notes were also taken. These were all used during analysis. The tapes were transcribed and translated into English; inaudible comments were considered lost data. Content analysis was then done and presented under major themes.

Ethical approval was obtained from the Health Research & Ethics Committee of the Lagos University Teaching Hospital. Written informed consent was obtained from the respondents prior to interview.

RESULTS

Women's utilization of health care facilities and TBAs

It was found that a majority of the women use health care facilities (HFs) more than TBAs for pregnancy and childbirth related services, while some attend ANC at both the HFs and TBA's. In some urban communities, those who attend HFs, used mostly private hospitals. One of the respondents reported, *"Out of 10 women in my community, 6 of them will be attending private hospital, 3 will be attending general hospital while 1 will be attending teaching hospital"* (35 years). It was disclosed that the major reasons for this preference for private hospitals is the quick service delivery and minimal bureaucratic protocols encountered at private hospitals, unlike in the public hospitals with the characteristic protocols and long waiting queues.

The women also prefer private hospitals because the hospital staff was courteous. Nurses are friendly and pay attention to them, whereas in the public hospitals there is poor staff attitude to clients/patients (especially the nurses). In addition, many clients are bothered by the medical students and nurses in training in public hospitals. A respondent had this to say: *"Women in my community prefer private hospital to government hospital because more attention is given to them. The doctors are always there and when you get there, you don't waste time."* (27 years) Another reason for their preference for private hospital is fear. One respondent remarked that in her community, they have this belief that the hospital staff 'exchange babies' in government hospitals and that government hospitals, especially teaching hospitals are for bad and hopeless cases. Antenatal clients are also statutorily required to donate blood at the hospital's blood bank in preparation for any emergency. Some of the women complained that once you don't know any staff personally (ie have an insider), you are not likely to receive optimum care.

For the urban women who prefer government hospitals, their major reason is the availability of specialists and facilities. They also run many tests and are cheaper. For them, the private hospitals are more expensive and they have a lot of 'sharp' practices like using 'left over vaccines'. One of the discussants said, *"In my community, the women who go to government hospital do so because of the price and the facilities. They have a lot of specialist doctors, the cost is low and you have all the facilities you need."* (34 years) Those of them who go to private hospitals do so because of time. *"In government hospitals, they have a lot of protocol so if you don't want to waste time, you go to private hospital where they attend to you immediately but the price is higher."* (34 years)

The quest for spiritual support was also found to determine where some women seek healthcare for their ANC and delivery. *"In the missionary hospital, they give you a lot of attention, both physically and spiritually. Their ANC clinic is everyday and they give you one hundred percent attention."* (29 years)

Cost, health outcome and influence of in-laws were mentioned as factors which influence the health seeking behaviour of the urban women as regards pregnancy and childbirth. One

woman recounted an experience in her neighbourhood: *"The women prefer going to the TBA because they don't have the money but there was a case that made them to start attending hospital. The woman gave birth at the TBA centre, she then had bleeding and died, so this made many women to start attending hospital."* (26 years) *"Some women go to TBAs because their in-laws demand that they should use them. They tell them that their husbands were delivered by the TBAs so they want their grandchildren to be born there."* (28 years) During the discussion, it was revealed that some urban women use both HFs and TBA centres for antenatal care and eventually delivers at the TBA centre to 'avoid complications from childbirth.' The major reason why some women use the TBA is because they give them a special form of 'agbo', a herbal concoction which will make the baby to be small and easier to deliver. There was one interesting reason mentioned by one of the urban respondents, *"Some women use "Ile Alagbo" (ie TBA) because there, they 'hang' their pregnancy to prevent miscarriage or attack from the enemy. When it is time to deliver, they 'bring it down' and have the baby safely."* (25 years)

Some women do not attend ANC

In the Urban area, the discussants observed that some women do not go for antenatal care mainly because they felt that they have enough experience from previous pregnancies. They already know all the things they will tell them in the hospital and they know all the drugs. One of them said, *"They believe they have all the experience especially the women with many children."* (27 years) Other reasons mentioned were lack of time, lack of money or simply because they were lazy or do not want to take drugs. *"Some women do not attend ANC because they give them so many drugs which they do not like to swallow."* (29 years)

DISCUSSION

Majority of the women used health care facilities (HFs) more than TBAs for pregnancy and childbirth related services, while some attended ANC at both the HFs and TBA's. This is similar to the findings of a study in Anambra State, Southeast Nigeria, which found over 95% ANC attendance in HFs, less than 2% used the TBA for ANC while the rest did not attend ANC at all.¹⁶ High utilization of hospital for maternal services is probably because their services are more convenient, readily accessible and are more likely to be staffed with a doctor than the lower levels of healthcare.¹⁶ An earlier study in southeast Nigeria reported that the presence of a doctor in a healthcare facility as one of the factors influencing the utilization of hospitals for ANC.¹⁷ Private hospitals were preferred by urban women mostly due to the minimal bureaucratic protocols encountered at private hospitals. Another study in Tanzania, Kenya and Ghana also found greater preference for private health facilities over public health facilities and this was not due to differences in technical competence but primarily due to the processes of service provision including bureaucracy and long waiting times.¹⁸ For the urban women who prefer government hospitals, though they recognized the issues related with using public health facilities they preferred the public hospitals because of the availability of specialists and facilities at a much more affordable rates. They also expressed distrust in the private hospitals. Unlike the public setting, the private institutions need to make profit much more so with the current unfavourable economic conditions. This may further pre-dispose to sharp and unwholesome practices as expressed by the women. The quest for spiritual support was also found to determine where some women seek healthcare for their ANC and delivery. From the discussion, it was said that some women seek spiritual refuge for their unborn babies at the TBA centres. The TBAs are perceived to

possess spiritual powers. In a study in Sagamu, South Western Nigeria as high as one in five women who may not have had ANC at all used non-health institutions such as TBA or spiritual homes.¹⁹ In another study in Equatorial Guinea, ANC attendees expressed that TBAs were better than orthodox practitioners in some respects because TBAs possess spiritual powers and can intervene in certain situations where medical interventions cannot help.²⁰ Many of the women report that the spiritual institutions pay a lot of attention, both physically and spiritually to them and the timing of their clinics were more flexible.

Cost, health outcome and influence of in-laws were mentioned as factors which affect the women's use of health facilities. In Anambra state it was found that most of the women did not consider cost of services as a barrier to accessing maternal services.¹⁷ Iyaniwura and Yussuf also found that very few women indicated cost consideration as the reason for their choice of ANC facility,¹⁹ however, other studies have highlighted poor staff attitude, long waiting time and relative high cost of services as disincentive to the utilization of these services.^{17, 21} Many of the women in the community use the services of the TBA even though they would prefer to attend ANC at a hospital because they are required to respect the wishes of their in-laws especially their mothers-in-law. This is consistent with the findings of a Nepalese study that found that mothers-in-law are perceived as having an influential role in the uptake of ANC in Nepal and as an important member of the family hierarchy, her active role in decision-making went largely unchallenged.²² In rural Bangladesh, older women, especially mothers-in-law did not consider ANC essential during pregnancy and often discouraged their daughters-in-law from attending.²³

Some of the urban women used both HFs and TBA centers for antenatal care and eventually delivered at the TBA centre in the bid to avoid complications from childbirth and the forestall the risks to their babies given that the traditionalists give them concoctions to keep their unborn babies small. In Sagamu a lower proportion of the women were found to receive ANC at the HF and eventually deliver there while others delivered at private clinics and TBA centers. This may be due to the ease of access to these facilities.¹⁹ The increased proportion of deliveries at TBA home may also be associated with the prevalent supernatural concept of diseases in many African communities.¹⁹ Interestingly, in spite of current readily available and scientific knowledge about pregnancy and delivery, many of the women still believe and adhere to traditional myths concerning pregnancy, ANC and delivery hence their choice of care.

Some of the women did not attend ANC, the major reason being that they assume that they have enough experience from previous pregnancies and knew what to do to ensure they stayed healthy through pregnancy and delivery, and that they did not have the time or the money to attend the health facility or TBA's centre. A study in the West Java Province of Indonesia also found that some women did not use any antenatal care services or postnatal care services even though the services were available.²⁴ In Enugu state it was found that 52.9% delivered outside health institutions their choice being influenced mostly by socioeconomic level, level of knowledge, cost of healthcare and lack of confidence in the health system as well as age and parity amongst others.²⁵

CONCLUSION

The women in this study are aware of the need for antenatal care and assistance during pregnancy and most use HFs for ANC and delivery. However, considerable proportions still use non-medical institutions or do not use any of these facilities at all. Cost, health outcomes and the influence of in-laws are some of the factors that determine the type of care sought by the women. Government facilities were less preferred for ANC and delivery for many reasons including long waiting time, inconsiderate policies and protocols and perceived poor attitude and trustworthiness of the staff. Effort should therefore be made to improve the quality of services at the health facilities, minimize waiting time and train health care providers to communicate better with patients. Educating the communities should be strengthened with emphasis on the need to use formal ANC and delivery health services. Empowering women by ensuring universal education at least to secondary school level, improvement of their economic status and targeted health education of women groups should be given priority. Also educating the significant others like in-laws will improve utilization of formal maternity services.

In the interest of maternal health, empowering TBAs and spiritual healing centres through training and retraining by health professionals and possible referral of deliveries to health facilities is vital.

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