Safe Motherhood

Sociocultural aspects of haemorrhage in pregnancy

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The knowledge, attitudes and practices of rural women in southern Nigeria are at least as important as the availability of modern obstetric care in the fight against haemorrhage in pregnancy. Community-based interventions taking this into account are necessary if the considerable mortality associated with the condition is to be significantly reduced.

A study in northern Nigeria over a decade ago revealed a death rate in childbirth of 29 per 1000 deliveries among women who had received no formal education and no prenatal care, whereas for women not thus disadvantaged the figure was much lower: 2.5 deaths per 1000 deliveries (1). Observations made on women in the south of the country more recently (2) revealed that:

- there was a lack of knowledge of the warning signs and risk factors of haemorrhage during pregnancy and delivery, and of the potential danger of bleeding after delivery;
- certain food taboos were potentially disadvantageous for pregnant women;
- a belief existed that supernatural forces caused some cases of haemorrhage in pregnancy and delivery, which could not, therefore, be treated in the modern sector of obstetric care;
- women continued to obtain care from traditional birth attendants and traditional healers even when haemorrhage was present.

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Views

It was felt that mortality from haemorrhage among pregnant women would not diminish until their knowledge, attitudes and practices were understood and brought more into line with the norms of modern obstetric care. With a view to working towards these goals a project was conducted in Ekpoma, a grouping of 13 villages with a population of some 70,000 people about 70 km north of Benin City. Between March 1989 and June 1990 a focus group discussion on haemorrhage, the leading cause of maternal mortality in the locality, was held with selected women.
in each of the villages. In addition, two such discussions were held with selected men from the whole of Ekpoma, and one was held with 13 female traditional birth attendants. Each women’s focus group comprised individuals who were in one of the following categories:

- educated and working;
- educated and not working;
- not educated and working;
- not educated and not working.

“Educated” was taken to mean completion of at least primary education, and “working” to mean working outside the home for a regular income. The two men’s groups contained both “educated” and “not educated” individuals; no reference was made to the working status of the men. The number of participants in the women’s groups ranged from 7 to 13, and each group was made up of individuals falling within a particular age range (15–25, 26–35, or over 35) so as to facilitate the smoothest possible flow of discussion and to obtain a fair spread of ideas. The two men’s groups comprised 10 and 12 individuals aged 20–40 and over 50 respectively. The members of each group knew each other and the venues were familiar to them. These departures from the classic guidelines for focus group discussions are justified on the ground that the cultural context in Ekpoma is such that individuals are more ready to discuss their views and experiences with people they know than with strangers. A female sociologist and a retired male schoolteacher acted as facilitators for the women’s and men’s groups respectively.

The following themes were introduced:

- local ideas concerning signs of haemorrhage and times when a woman may bleed during pregnancy;
- perceived causes, dangers and sequelae, and ways of dealing with the problem, both orthodox and unorthodox;
- patterns of use and accessibility of various types of intervention;
- strategies for community health education.

Unstructured interviews, covering themes similar to those outlined above, were also conducted with traditional birth attendants, members of village development committees, village heads, and some women who were not in the focus groups. The proceedings of all the focus groups and interviews were recorded and analysed.

**Action**

The following interventions were undertaken:

- upgrading of facilities in the first referral hospital, notably the repair of equipment and improvement of the supply of obstetric emergency drugs and consumables;
- establishment of a revolving drug fund scheme;
- establishment of an emergency transport loan scheme;
- retraining and refresher courses for medical officers and nursing staffs;
refresher courses for medical records officers and laboratory technicians;

- mobilization and reorientation of all hospital staff;

- community education, information and mobilization.

Community education and mobilization continued until 1995, through village meetings, court sessions in chiefs’ palaces, meetings after church services, and school meetings. An effort was made to influence traditional beliefs and practices of community members and to inform them about the benefits of the obstetric care services, which, before upgrading, had been perceived with some disapproval, probably because of bad experience with malfunctioning equipment, shortages of drugs and supplies, and unfriendly and unsympathetic staff. The other interventions were completed by the end of 1992.

**Responses**

Further focus group discussions and interviews were held between 1993 and 1995 on the same lines as earlier but not necessarily with the same individuals. The views, attitudes and practices of the community members before and after intervention were compared.

In contrast to what we expected, the findings on knowledge, attitudes and practices did not vary with the sex, age or education of community members, or between persons who worked outside their homes for a regular income and those who did not. Perceptions of the causes of haemorrhage were more rational, and there was a marginal decline in folk beliefs. However, the practice of inducing bleeding after delivery, supposedly to cleanse the womb of bad blood, persisted.

Among community members participating in the focus groups and interview sessions, or their wards or spouses, the only significant shift from long-established habits was in the use of modern obstetric care facilities. This increased threefold between 1993 and 1995, and there were correspondingly large decreases in consultations with traditional birth attendants and traditional healers. The use of the modern facilities by the same people for deliveries more than doubled, while deliveries in traditional birth attendants’ clinics, traditional healers’ clinics, and people’s own homes declined steeply.

Hospital records show that maternity admissions, including those of women admitted for normal deliveries and whose stay lasted only 10 hours, increased from 35% of total admissions in 1993 to 46% in 1995, and that attendances for antenatal care increased from 40% to 68% of total outpatient attendances over the same interval.

The traditional birth attendants’ concept of haemorrhage, their knowledge of the signs associated with it, and their understanding of its causes, possible times of occurrence, dangers and probable results were very similar to those of members of the general community. They began referring their patients at a sufficiently early stage, either
as a result of the community education that was undertaken or because of their training in primary health care.

Given the relatively short period of informal community education, anything more than the modestly positive adjustments in attitudes and practices actually achieved among the general population was not to be expected. Of course, sustained community education, together with improved levels of formal education and literacy, especially among women, can be expected to have a marked influence eventually on the way people regard modern obstetric facilities.

Evidence from other countries confirms that the upgrading of facilities and the reorientation and mobilization of health personnel cannot, in themselves, induce the general public to change traditional beliefs and practices. Sociocultural factors should always play an important part in attempts to raise the health status of women.

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Complications of abortion requiring emergency care

The major life-threatening complications resulting from unsafe abortion are haemorrhage, infection, and injury to the genital tract and internal organs. Retained products of conception often contribute to these complications; this topic is covered in Chapter 6. Toxic reactions to chemicals and drugs used to induce abortion may add to the complications among women who ultimately seek care from the formal health system. Health care services at all levels must be available 24 hours a day to provide emergency care for these complications in line with their capabilities.