

SOCIAL ISSUES IN THE PREVENTION OF PERINATAL AND NEONATAL
MORBIDITY AND MORTALITY

BY

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INTRODUCTION

Over the last 10 years, a strong relationship between women's status including access to income and decision-making in the home have drawn increasing attention in the area of reproductive health. Changing trends in economic and social lives of many African countries, the family is increasingly faced with financial hardships. This in turn has forced women in the labour market thus affecting the hierarchy and the decision-making process within the family(10)(11). Subsequently, women's working patterns have changed and along with it their health, child care and rearing practices. Hence, the strong relationship between these variables and increased perinatal/neonatal morbidity and mortality.

This brief paper attempts to relate these trends in women's activities and health to perinatal and neonatal morbidity and mortality by asking two fundamental questions. Namely, how does the changing socio-economic status of women affect perinatal and neonatal morbidity and mortality and, what other social factors contribute to their high rates?

A number of studies have partially answered these questions.

Education of girls has been singled out as one of the major factors which significantly affect women's status and more specifically their health and that of their children(1)(6).

(2)

Education delays the age at which women /girls start bearing children. It is well established that the longer the girls are in school, the more they have a chance to develop both physically and mentally(2). They also have a chance to learn about their sexuality, family life education, nutrition and responsible citizenship. Unfortunately, a good number of cultures in the region tend to value boy's education to that of girls. This is more especially so in the face of economic difficulties prevailing in the region.

Solutions to this issue are twofold; one is universal primary education which many of our governments cannot afford. But even those which can afford this strategy need to address the content of the school curricula to include aspects related to reproduction.

Second, is legislating against girls marrying before the age 18 years. Uganda had taken steps towards the later. On the whole however, governments do lack means to enforce such laws.

Meanwhile, the region is registering high maternal, perinatal/ neonatal and morbidity and mortality. In most cases these occur in two cohorts; young mothers between 13 to 17 years and old mothers above the age of 40. To take the case of the former category, these are young girls, still children in many respects who find themselves pregnant and delivering.

(3)

Other factors include, traditional beliefs and practices, family income and access to services⁶(7). The above social issues can be classified as 'external' and 'internal'(11).

- a) External- These are the factors to which mothers have little or no control. For example, education, income of the family, cost of services, accessibility and quality of services.
- b) Internal- These are factors which mothers can effectively do something about, other things being equal. For example, parity, traditional beliefs and practices, access to household income and decision-making in the home.

In both categories there are issues which cannot be solved by academicians and practitioners at least not in the immediate future. Nevertheless, we are here to try and address those which we can effectively tackle.

In outlining the solvable issues, we need to recognise our limits. As we note from the external factors, the issues involved are not only political but also very sensitive and therefore beyond our scope. Nevertheless, we can produce facts which can influence the legislators, decision makers and implementors to alleviate the problem.

Let us explore the external factors and the issues surrounding them.

Education:



They most probably drop out of school. Because of the stigma, shame and attitudes expressed towards them, they are forced into hiding.

Subsequently, they never attend antenatal clinics yet they are most ignorant about what is happening to their bodies and all that is involved in child birth and baby care.

Thus in seeking for preventive measures, we need to carefully examine our communities by first addressing the source of the problem before it gets to the clinical setting.

Income and decision-making in the family

Poverty, which is related to the current wave of Structural Adjustment, is adversely affecting country after country as it gets introduced to region(9). As a result, household budgets get affected with less monies being allocated to health and education particularly that of girls. The situation is further aggravated by the family sizes which are usually big with one income earner who also make the final decision on how to spend it. Invariably, many families cannot afford to spend money for antenatal services where the mother is seemingly getting on well during pregnancy. Lack of awareness about the importance of antenatal attendance and therefore not availing fares and fees on part of the spouses has been found to contribute to low antenatal attendance. The majority of the women have to depend on their husband's income who may not be readily willing to pay for these seemingly endless trips especially when the wives are not particularly sick (5).

(5)

Scarce resources in the family force the mothers to initiate antenatal visits late in their pregnancy.

Cost of antenatal services

Health services are all too often very costly. User fees for antenatal clinics is a deterrent factor for antenatal attendance. This is more so given the above issue related to family income and decision-making within the home. A survey in Uganda revealed that 80 percent of the women had to first seek financial assistance of a male (husband relative) before going for treatment.

Accessibility and Quality of Services

Distances and means to health units particularly maternity homes and hospitals has been found number one amongst the deterrent factors to non-utilization of health services(1). Studies from different countries in the region indicate that the majority of the mothers deliver in the home with no professional help. The reasons given are always related to distance to the hospital, lack of transport, and preference to deliver at home because of the reception received at the health units. In Uganda for example, a number of surveys have shown high level of antenatal attendance. But upon further investigation, it was found that most mothers attend only once. The average attendance for the majority is only three times throughout pregnancy.

(6)

Most women attend once to probably re-assure themselves and to obtain antenatal cards with the belief that they will not be allowed to deliver at a hospital unless they produce the card. (Safe Motherhood Initiative Draft Report 1991)

There is that category of women who visit the maternity clinics or private doctors only when they are sick. The reasons given for non attendance are often related time and cost. Many rural women cannot afford to leave their daily chores for antenatal care when they physically feel fine.

These findings are cause for concern especially in light of poor facilities at the units. This means that very few high risk women will be detected early enough to prevent perinatal/morbidity and possible maternal complications.

Having reviewed the external factors, we now turn to the internal factors. It is hoped that with appropriate interventions (both at the family and community levels), women can improve on their poor health.

Parity and access to Income

The number of children a woman has is determined by the environment in which she lives. Often, there are different forces which include marital status (polygamy vs polygyny), the woman's occupation, single parenthood and head of household, gender of children already had, pressure from in-laws and the general

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socio-economic status, etc. Educated mothers have been found to have successfully tamed these forces. Unfortunately, however, the majority of the mothers are illiterate and vulnerable. This is an area where intensive mobilisation and health education has not been effective.

Working mothers are generally in position to use their income to pay for health services including family planning and antenatal care. In this respect, they stand better chances of averting pregnancy risks which might affect the unborn baby.

Cultural Beliefs and Practices

Lack of awareness to basic personal care during pregnancy is a function of illiteracy but also as a result of traditional myths and beliefs which translate into dangerous practices(1). Many young mothers learn and emulate their mothers and relatives who often pass on distorted information about sexuality, child birth and care. The culture of silence about reproductive tract infections during pregnancy do contribute to perinatal/neonatal morbidity and mortality. Group discussions during the Safe Motherhood Initiative Survey in Uganda revealed an interesting traditional value among Bakiga women in the south-west of the country; i.e., delivering at home was considered a sign of a woman's strength and endurance.

Health consciousness, attitudes towards health care which is already affected by stigma and awareness of modern health services are lacking among teenage mothers more so for those in

the rural areas. Elder mothers are usually under nourished, bear heavy workloads and lack rest. This render them weak and susceptible to pre-mature delivery and stillbirths.

Lack of communication further compounds the problem. Thus many beginners are surrounded by dangerous advice and practices which lead to perinatal and neonatal morbidity and mortality.

In Uganda, neonatal tetanus account for as many as 9000 deaths per year. The 1985-1990 UNICEF Situation Analysis indicated tetanus coverage was only 14% in 1988. It was further found that found that many causes of perinatal and neonatal morbidity and mortality are generally related to poor hygiene and inadequate care(12). A more recent study done by Uganda Expanded Programme for Immunisation (UNEPI) and the Child Health Development Center(CHDC), there were a total to 33 neonatal deaths out 2311 live births nearly half of which were due to neonatal tetanus(13).

Decision-making in the Home

Education changes the balance of power in family relationships. Educated mothers are knowledgeable and are in better position of influencing their spouses on issues of antenatal and postnatal attendance. Thus the decision of when to visit and not to visit in taken by the knowledgeable and empowered mother.

(9)

As we progress to a multi-centre research on the prevention of perinatal and neonatal morbidity and mortality, there is a need to consider in-depth study/ and analysis of our respective communities in order to delineate pertinent social issues which may affect our intended interventions. To this extent therefore, our working proposal lacks the qualitative side to bring out the salient issues just outlined.

(10)

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