Causes of Maternal Mortality and Its Implications for Adult Education in Nsukka Local Government Area of Enugu State

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ABSTRACT

The study investigated the causes of maternal mortality in Nsukka Local Government Area of Enugu State, Nigeria and its implication for adult education. One research question was used to determine the causes of maternal mortality. The survey design was used. Data was collected using a questionnaire. A total of 108 pregnant women participated in the study. Data were analyzed using mean and standard deviation. The study revealed that hypertensive disorder of pregnancy, unsafe abortion and obstructed labour were among the highest causes of maternal mortality. Based on the study findings, the following recommendations were made: government should organize health education campaign for pregnant women in their communities; women should reduce the number of childbirth; and women should avail themselves of health care services such as family planning, emergency obstetric care and intrapartum care.

Keywords: *Causes, Maternal Mortality, Adult Education, Rural and Childbirth*

I. INTRODUCTION

Maternal mortality has devastated many families in developing countries. It is one of the major health problems of poor countries like Nigeria. Maternal mortality refers to the death of women during pregnancy or after birth. In the same view Houle, Clark, Kahn et. al (2015) defined maternal mortality as mother's survival status as early maternal death (during pregnancy, childbirth or within 42 days of most recent childbirth or identified cause of death) late maternal death(within 43 – 365 days of most recent childbirth) any other death and mother who survived. The causes of a mother's death during childbirth are numerous ranging from hypertension, malnutrition, stress among others. Identically, Asamoah, Moussa and Stafstorm et al (2011) reported haemorrhages, abortion, hypertensive disorders of pregnancy, sepsis and obstructed labour as the major causes of maternal deaths. It also listed major infectious diseases such as malaria and viral hepatitis as well as non-infectious conditions like anaemia.

In like manner, Lee, Odoi and Opare-Addo et al. (2012) pointed out the major contributors to maternal deaths are attributable to direct obstetric causes. They enumerated the top five causes as hypertensive disorders of pregnancy, haemorrhage, genital tract sepsis, early pregnancy deaths and infections. The first four accounting

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for about two-thirds of all deaths. In the same way, Morgan and Eastwood (2014) believe that structural support and family support influences maternal outcomes. Social disadvantage and social isolation adversely affect maternal health, which can lead to increases in maternal death. They noted that lack of access to skilled medical care during childbirth, barriers to accessing prenatal medical care and poor infrastructure all increase maternal deaths.

Delay in various forms such as lack of access to skilled medical care, barriers to accessing prenatal medical care and poor infrastructure contribute to a high rate of maternal mortality. Emphasizing the harm caused by delay, United Nations Population Fund (UNPFP) (2002) described three delays that are responsible for maternal mortality. They include delay in deciding to seek care, delay in reaching care in time and delay in receiving adequate treatment. In their view, the first delay is on the part of the mother, family or community not recognizing a life-threatening condition. This is because most deaths occur during labour or in the first 24 hours postpartum. Recognizing an emergency is not easy. Most births occur at home with unskilled attendants and it takes skill to predict or prevent bad outcomes and medical knowledge to diagnose and immediately act on complications. By the time the unskilled midwife or family realizes there is a problem, it may become too late to resuscitate the concerned mother. The second delay according to them is in reaching a health-care facility and may be due to road conditions and lack of transportation or location.

Many villages do not have access to paved roads and many families do not have access to vehicles. Public transportation may be the main transportation method. This means it may take hours or days to reach a health-care facility. Women with life-threatening conditions often do not make it to the facility in time. Finally, they opined that the third delay occurs at the healthcare facility. Upon arrival, women receive inadequate care or inefficient treatment. Developing countries with fragile health-care facilities may not have the technology or services necessary to provide crucial care to haemorrhaging, infected or seizing patients. Omissions in treatment, incorrect treatment and lack of supplies contribute to maternal mortality.

In a developing country like Nigeria, women are exposed to various practices that could cause maternal mortality. Those practices may be cultural, social or economic beliefs in many rural communities. Fathalia (1986) has a long list of factors to include, early marriage, haemorrhage from placenta preview, anaemia due to parasitic infection and malnutrition, late arrival at the hospital with already existing complications, lack of basic prenatal care, inadequate health facilities and supplies, non-seeking of medical help, multiparity, lack of family planning, poverty, poor socioeconomic status, illiteracy, poor nutrition, poor residential location and pride in having many children. In agreement, Nair, Kuriuczuk, Brocwehorst et al (2015) listed several causes of maternal mortality as follows: gestational diabetes, hypertensive disorders of pregnancy, anaemia, multiple pregnancies, inadequate use of antenatal care services due to lack of access or other reasons, substance misuse, previous pregnancy problems, pre-existing medical conditions including epilepsy, mental health problems, cardiac problems, and essential hypertension. Other factors according to them are maternal age and body mass index, which include obese and overweight. Equally important, Heise Koblinsky, Timyan and Gay (1993) complained of the vulnerability of pregnant women to physical violence. Violence may be responsible for a sizeable portion of maternal mortality.

In their view, women who are battered during pregnancy are twice as likely to miscarry and four times more likely to have a particular grave impact on women who are malnourished and overworked. Women are violated

variously, namely Female genital mutilation (FGM) among others. FGM is female circumcision which may often heal with contraction and tight introits. Similarly, Yirga et.al (2012) described Female circumcision (FC) or (FGM) as the practice that manipulates, alter, or remove the external genital organs in young girls and women. In about 15% of cases, infibulations, the most severe form of FGM, involves the removal of the labia and the suturing together of the vulva. FGM is the form of violence against women most commonly linked to maternal mortality.

This practice according to Ivazzo et al (2013) may place the victim's life at risk of health complications which include staphylococcus infections, urinary tract infections, excessive and uncontrollable pain, and haemorrhaging. Following the same view, the World Health Organization (WHO) (1996) stressed that the rate of maternal death is doubled by FGM and the risk of stillbirth increased several times. FGM can have a profound effect on the outcome of pregnancy, causing difficulties and intense distress during sexual intercourse and obstruction at the time of delivery.

In continuation, Olafimilan(1993) classified the long term effect of FGM as a gynaecological problem, urinary tract problems, marital conflicts, psycho-sexual complications and obstetric problems. Following the same opinion, UNICEF (2001) emphasized that FGM is a regular practice in Nigeria with the highest absolute number of cases of FGM in the world, accounting for about one-quarter of the estimated 115–130 million circumcised women worldwide. Furthermore, UNICEF stressed that in Nigeria, FGM has the highest prevalence in the south-south (77%) (among adult women), followed by the south-east (68%) and south-west (65%), but practised on a smaller scale in the north, paradoxically tending to in a more extreme form of 2:4 ratio. Nigeria has a population of 150 million people with the women population forming 52%. Again Adegoke (2005) reported that the national prevalence rate of FGM is 41% among adult women.

Early marriage is an act of violence where decisions in marriage are made by parents and community leaders. The young girl is denied the privilege of choosing a matter that will last all the life of anybody involved. According to UNICEF, (2001) early marriage is defined as the marriage of children and adolescents below the age of 18. They continued by pointing out that pregnancy that occurs too early when a woman's body is not fully mature constitute a major risk to the survival and future health of both mother and child. The risk of early marriage can expose girls to social and health complications in future ranging from low-income living, poor home and life management and health issues.

Supporting the above, The Global Partnership To End Child Marriage (2014) purported that pregnancy and childbirth are dangerous for child brides. The consequences according to them include: that girls who give birth before the age of 15 are five times more likely to die in childbirth than girls in their 20s. Complications in pregnancy and childbirth are the leading cause of death in girls aged 15-19 in low- and middle-income countries, where girls survive childbirth, they are at increased risk of pregnancy-related complications. For example, 65% of all cases of obstetric fistula occur in girls under the age of 18. They further stated that the children of child brides are at substantially greater risk of perinatal infant mortality and morbidity, Stillbirths and newborn deaths are 50% higher in mothers younger than 20 years than in women who give birth later and child brides are also more likely to have babies with low birth weight.

Bearing many children contribute to maternal mortality. Many pregnant women lose their lives as a result of bearing many children. Garba, Castello and Azad. (2006) opined that the risk of dying in pregnancy also

depends on the number of pregnancies a woman had in her lifetime. The higher the number of pregnancies, the greater the risk of pregnancy-related death. Some of these women who bear many children patronize traditional birth attendants due to poverty. According to WHO, ICM and FIGO (2017) a traditional birth attendant (TBA) is a non-formally trained and community-based provider of pregnancy-related care. Their unskilled nature places them in the position to use unsterilized equipment during delivery, lack of knowledge in discovering complication, when and where to refer patients with complications. Mrisho et al (2007) stated that due to the lack of education, the way the TBAs, attend to the delivery is risky for women and their babies, leading to poor health outcomes and even death.

It follows, therefore, that the care of a pregnant woman deserves the highest priority in every community for maternal mortality is an important indicator of the standards of health care of different countries. Likewise, a new report by the World Health Organization (WHO) (2015) agreed that Nigeria's maternal mortality rate is at an all-time high with 814 women per 100,000 live births, making Nigeria the 4th worst place to give birth in the world, and accounting for over 10% of all maternal death in the world. World Bank report rate of maternal death in Nigeria are as follows: In 2011 – 824 women death per 100,000 live births, in 2012 – 819 women death per 100,000 live birth and 2013 – 821 women death per 100,000 live birth.

With the economic situation as we find it today in Nigeria, the average mother is subjected to a lot of anxiety about being able to provide for the family with the necessities of life. Women in the Nsukka Local Government Area as one of the rural communities in Nigeria is likely to be challenged with all the causes of maternal mortality discussed in the study. It is of paramount importance for adult education to play its role to awaken rural women's consciousness to hazards they can prevent. The term adult education according to UNESCO (2012) denotes the entire body of organized educational processes, whatever the content, level and method, whether formal or otherwise, whether they prolong or replace initial education in schools, colleges and universities as well as in apprenticeship, whereby persons regarded as an adult by the society to which they belong develop their abilities, enrich their knowledge, improve their technical or professional qualifications or turn them in a new direction and bring about changes in their attitudes or behaviour in the twofold perspective of full personal development and participation in balanced and independent social, economic and cultural development; adult education, however, must not be considered as an entity in itself. It is a subdivision and an integral part of a global scheme for life-long education and learning.

The above definition, therefore, specifies the role of adult education through community enlightenment to create awareness among women and girls in the rural community of Nsukka Local government to diagnose the cultures such as FGM, early marriage, bearing many children among others as the bedrock of all the causes of maternal mortality and give it needed attention.

II. METHOD

The study used a descriptive survey research design. One research question on what are the causes of maternal mortality in the Nsukka local government was used for the study. The area of study is Nsukka Local Government Area in Enugu state, Nigeria comprising of eight health centres as follows: District hospital Nsukka, Nsukka. Health Centre, Comprehensive Hospital Okpuje, Edem–Ani Health Centre, Ibagwa-Ani

Primary Health Centre, Comprehensive Health Centre Obukpa, National Primary Health Care Agbamere and Opi Health Centre. The people of Nsukka Local government are Igbos. They are known for bearing many children. The population is 245 pregnant women registered in the government health centres in Nsukka Local Government Area. The sample used for the study was 108 registered pregnant women in three health centres in Nsukka local government area. A simple random sampling technique was used to determine the sample size.

The instrument used was the Causes of Maternal Mortality Questionnaire (CMMQ) self-developed by the investigators. The number of items in the questionnaire was 8. The instrument was validated by three experts. Their inputs were incorporated into the instrument by the researchers. Data was collected on their antenatal days which lasted for weeks. The instrument was distributed to 108 women while 102 women properly responded and returned theirs.

Data were analyzed using mean and standard deviation to answer the research question. The mean of 2.5 becomes the boundary range and any mean of 2.5 or above was regarded as important.

III. RESULT

The result is hereby presented according to the research question.

What are the causes of maternal mortality in Nsukka Local Government Area?

Table 1: Mean scores of pregnant women on causes of maternal mortality. (102)

S/N	ITEM	SA	A	D	SD	X	SD	Decision
1	Evil powers are responsible for maternal mortality.	37	17	30	18	2.72	0.89	A
2	Maternal mortality could be due to Obstructed labour.	52	31	10	9	3.24	0.95	SA
3	A haemorrhage may cause maternal mortality.	47	37	12	6	3.23	0.88	SA
4	Puerperal infection is responsible for maternal mortality.	52	18	24	8	3.12	1.02	SA
5	Maternal mortality can be caused by Unsafe abortion.	48	43	8	3	3.33	0.75	SA
6	Hypertensive disorder of pregnancy contributes to maternal mortality	63	27	8	4	3.46	0.68	SA
7	Anaemia leads to maternal mortality	53	21	19	9	3.16	1.02	SA

8	Cardiovascular disorder causes maternal mortality	55	22	18	7	3.23	0.96	SA
	Grand mean					3.19	7.15	SA

The data in the Table 1 revealed that item 6 with the highest mean of 3.46 causes maternal mortality more. The items in 2,3,4,5 and 7 have a mean of 3 and above. The respondents strongly agree that they are among the major causes of maternal mortality. While the respondents agree that item 1 with a mean of 2.75 also causes maternal mortality. The grand mean of 3.19 is evidence that the respondents strongly agree that all the items cause maternal mortality.

IV. DISCUSSION

The findings indicated that pregnant women in Nsukka Local Government Area strongly agree with the causes of maternal mortality. Some of these causes are hypertensive disorder of pregnancy, unsafe abortion, obstructed labour, haemorrhages, cardiovascular disorder, anaemia etc. The findings may be because of personal experiences during pregnancy. The study agrees with Asamoah, Moussa and Stafstorm et al (2011) that haemorrhages, abortion, hypertensive disorders of pregnancy, sepsis and obstructed labour as the major causes of maternal deaths. It also listed major infectious diseases such as malaria and viral hepatitis as well as non-infectious conditions like anaemia.

Most pregnant women in the Nsukka health district strongly agreed that maternal mortality could be a result of obstructed labour. The finding is not surprising as most researchers have discovered that obstructed labour is a major factor in the maternal mortality rate in developing countries. In line with the above claim, Heise, Koblinsky, Timgan, and Gay (1993) pointed out that physical violence inflicted on women such as FGM and early marriage are likely causes of obstructed labour. In agreement, Ivazzo (2013), Yirga et al (2012) and WHO (1996) stressed that the rate of maternal mortality is doubled due to FGM and early marriage resulting in difficulties and intense distress during sexual intercourse and obstruction at the time of delivery.

Pregnant women also strongly agreed that puerperal infection and unsafe abortion could lead to maternal death. In conformity, to research, WHO, ICM, FIGO (2017) asserted that unskilled birth attendants could expose pregnant women to unsterilized equipment during delivery, lack of knowledge in discovering complications due to lack of education. Also, Mrisho et al (2007) saw TAB attending to pregnant women as being risky with poor health outcome. Also, the study lends support to Garba, Castello and Azad. (2006) that the risk of dying in pregnancy also depends on the number of pregnancies a woman had in her lifetime. Thus, the higher the number of pregnancies, the greater the risk of pregnancy-related deaths.

V. CONCLUSION

In rural communities, as is the case in developing countries, poverty is a major obstacle to receiving adequate health care. A high rate of maternal mortality still occurs among women with low or no income class

in developing countries. Most maternal deaths can be waged as health care interventions to avoid and manage available complications. Since the health of both mother and child are tired, access to high-quality care before, during and after childbirth can salvage moth and baby from death.

VI. Recommendations

Based on the finding, the following recommendations are made:

1. The government should carry out Health Education campaigns to pregnant women to help them recognize and ensure that prompt decision is made on their health needs and when care should be sought.

2. Women should avail themselves of health care services such as family planning services, emergency obstetric care and intrapartum care.

3. Women should endeavour to eat a balanced diet during pregnancy.

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