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Maternal Health in Urban Areas: Therapeutic Use and Barriers Identified by Pregnant Women, Parturients, and New Mothers in the Commune of Koumassi in Abidjan

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Abstract

The supply of care is diverse and varied in urban areas. This may influence women's use of health care. The goal of this study is to investigate the therapeutic use of pregnant women, parturients, and new mothers and the barriers revealed by the latter in the commune of Koumassi in Abidjan. The data for this study come from the 2020 database of the Groupe de recherche espace territoire, société et santé (GRETSSA) of the Institut de Géographie Tropicale (IGT). Indeed, GRETSSA conducted a large cross-sectional survey in the 10 communes of the city of Abidjan among 3600 households. There were 102 parturients, new mothers, and pregnant women identified in the sample for the commune of Koumassi. Based on descriptive statistical analysis, the results of this study show that women go more to a modern health service at the beginning of their pregnancies (69%). This tendency, paradoxically, decreases as the pregnancy progresses and is again high when women are at term (70.2%). On average, mothers-to-be have made a total of 3.3 prenatal visits (PNC) to the maternity hospital regularly. This represents at least one PNC per pregnant woman. Our study identified barriers to seeking care. Among these barriers, the lack of quality of care and the still-high costs of some health services affect the demand for maternal care.

Key words: Koumassi; Pregnant women; Parturient; New mother; Health care; Prenatal consultation; Health service

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INTRODUCTION

The question of access to maternal health care in the world and in particular in developing countries remains one of the issues at the heart of national and international policy debates in the health sector. The alarming fact is identified in the rate of death of women during the prenatal and postnatal periods. Each year, more than half a million women die from causes related to pregnancy and childbirth (L. Liu et *al*., 2016; WHO, 2017). The majority of these deaths occur in resource-limited settings, most of which could be prevented (WHO, 2010).

In West Africa, the maternal and neonatal mortality rate continues to rise, including 50% of these maternal deaths and 30% of neonatal deaths (E. Robert, 2017). The example of Burkina-Faso and Cameroon is noticeable. Indeed, Cameroon's Demographic and Health Survey (DHS, 2011) shows the maternal mortality ratio to be 762 deaths per 100,000 live births (P. M. Eloundou, 2014). And Burkina where the maternal mortality ratio is 484 per 100,000 live births in 2003 (UNICEF, 2012).

Côte d'Ivoire is not immune to this situation, which is a real problem for women of childbearing age. Indeed, the Côte d'Ivoire Demographic and Health Survey revealed in 2012 that the maternal mortality ratio increased from: "543 to 614 deaths per 100,000 live births between 2005 and 2011. In other words, for every 1,000 live births, six women die during pregnancy, childbirth, or within two months of childbirth (EDSCI-III, 2012)." This is highly correlated with the neonatal mortality rate, which also remains very high. There were 41 deaths per 1000 live births according to the Analysis of the Situation of the Child in Côte d'Ivoire (ASECI, 2014). For this reason, the

Ivorian State has signed partnership agreements with the World Health Organization (WHO) and other international development institutes such as UNICEF, UNDP, etc. to develop response strategies. The partners' investments are aimed at building and equipping basic first contact centers to facilitate access and improve the quality of services in the available structures. Also, to ensure good health coverage throughout the country to compensate for the unequal distribution of health structures (S. N'doli, 2016). The continuity of efforts is remarkable. To reduce inequalities, for example, several strategies have been advocated. They focus particularly on increasing preventive measures (prenatal consultations, family planning) and obstetric care at the level of health facilities (L. Belaid, 2014). The actions undertaken by the Ivorian state aim to bring women closer to health services and improve access to prenatal care (S. N'doli, 2020; D. Adjoba, 2017).

Thus, from February 2012, a policy of free care called selective or targeted is implemented. It targets pregnant women and children aged 0 to 5 years. Free care covers prenatal consultations, complementary examinations (ultrasound and laboratory); free normal childbirth and childbirth-related complications (episiotomy, repair of perineal tear, hemorrhage), and free cesarean sections (T. Bissouma-Ledjou, *al.*, 2015). It should be noted that for each of these situations, there are appropriate kits that will be available in all maternity units in the country, both in villages and cities (MSHP, 2020). Free services encourage parents to move their patients more than 10 km to reach the health centers, (V. Ridde, 2012). It allows patients to travel to health care services to be treated and cured; it also allows prenatal consultations (PNC) to establish a link between pregnant women and health care personnel to encourage deliveries in specialized services.

In addition, there is universal health coverage (CMU), a project decided by the State in 2001 and effective in 2015. This project aims to contribute to the fight against poverty by covering the health expenses of the population. A national system of compulsory health coverage whose objective is to guarantee access to quality health care to the entire population residing in Côte d'Ivoire, under sustainable financial conditions. These efforts take into account the health challenges facing Côte d'Ivoire and the prospect of accelerating the achievement of the Sustainable Development Goals (SDGs), which is to reduce the ratio of maternal deaths to below 70/per 100,000 live births by 2030.

Despite the efforts made, these strategies face several obstacles, the factors of which are both on the demand side and the supply side (Ensor and Cooper, 2004). Access to general health care services, particularly maternal services, remains a problem because of the deaths recorded in the various communes of the city of Abidjan. Indeed, Cocody and Bingerville record a ratio of maternal deaths of 51.1 per 100,000 out of 9,704 live births, and the communes of Marcory and Treichville record a ratio of maternal deaths of 18.5 per 100,000 out of 5,414 live births. The communes of Port- Bouët, and Koumassi recorded respectively maternal death ratios of 28.5 and 35 per 100,000 out of 23,121 live births (RASS, 2018). This finding is alarming, and leads us to question, like several authors, the demand for maternal health services and the obstacles encountered by patients (Gnanderman and Sirpe, 2011; M. Eloundou and Y. Waibai, 2017; Magadi et *al.*, 2004; Stephenson et *al.*, 2006; Gage 2007). This study project aims to investigate the therapeutic recourses of pregnant women, parturients, and new mothers and the barriers revealed by the latter in the commune of Koumassi in Abidjan.

1. DATA AND METHODS

1.1 Presentation of the Study Area

The commune of Koumassi is located in the southern part of Abidjan (Côte d'Ivoire), more precisely on the island of Petit Bassam. It is one of the thirteen communes that make up the District of Abidjan (Figure 1). The commune of Koumassi is composed of eleven (11) neighborhoods. It covers an area of approximately 874 hectares or 2.4% of the area of Abidjan. Its resident population is estimated at 445,671 inhabitants in 2014 (INS-RGPH 2014), with a gross population density of 1231 inhabitants/km^2. From a health perspective, the commune of Koumassi includes several public and private maternal health centers accessible over short distances (M. Ymba et *al.*, 2020). However, there is no university hospital (CHU) in the commune.

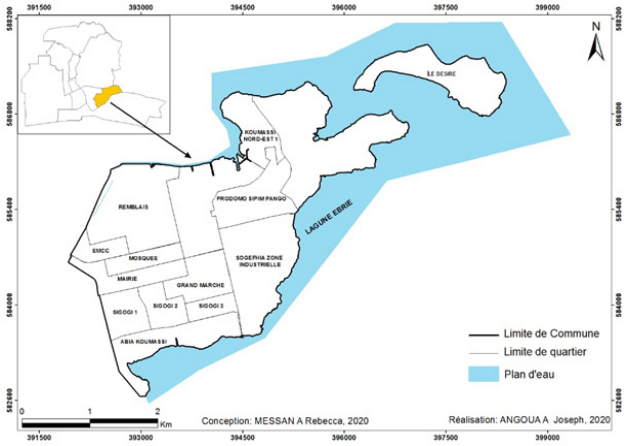

Figure 1
Location of the commune of Koumassi

1.2 Data

The data for this study come from the database of the Groupe de recherche espace territoire, société et santé (GRETSSA) of the Institut de Géographie Tropicale (IGT). From March 20 to July 19, 2020, GRETSSA conducted a large cross-sectional survey of 3600 households in the 10 communes of the city of Abidjan.

During the 20-week survey period, 1,706 concessions or blocks were surveyed in the different types of neighborhoods (residential, popular, precarious, and Ebrié villages). These households were divided into four age groups: children 6 months to 5 years old, youths 15 to 25 years old, adults over 30 years old, and pregnant women and new mothers 20 years old and older.

There were 102 parturients, new mothers, and pregnant women identified in the commune of Koumassi, which represents 2.83% of the people interviewed in the sample.

The items in the questionnaire concerned the therapeutic uses of the prenatal and postnatal phases of their pregnancies. We define the therapeutic itinerary of this social group as the succession of health care consultations during pregnancy up to the moment when the women give birth and the child reaches the age of 6 months.

Of the 102 women who responded to the questions, twelve were two months pregnant, six of these women were under 20 years of age, and five were under 25 years of age. Thirty-five women were more or less advanced in their pregnancies (3 to 6 months), and their ages were between 20 and 30 years.

Near-term women represented the largest group in the sample (7 to 9 months) and numbered forty. These women are between 25 and 36 years of age. Only fifteen women in our sample had given birth. All of the children were less than 4 months old.

The distribution of pregnant women by place of residence is not representative; there were three women in the residential areas, i.e. 2.94%, one of whom had given birth two months previously; in the working-class areas, there were thirty-three pregnant women, i.e. 32.35%, five of whom had given birth an average of four and a half months previously. In the villages, twenty-nine women, or 28.43%, including five who had given birth less than four months ago. The precarious neighborhoods had the highest number of women, thirty-seven or 36.27%, including four who had given birth within the last five months. Table 1 summarizes the numbers and percentages explained.

Table 1
Distribution of pregnant women, parturients, and new mothers by residence

Type of neighborhoods	Neighborhoods residential		Popular neighborhoods		Neighborhoods precarious		Ebrie Villages	
Stage of pregnancy	Workforce	%	Workforce	%	Workforce	%	Workforce	%
2 months	0	0	11	10,78	9	8,82	4	3,92
3 to 6 months	2	1,96	14	13,72	15	14,70	9	8,82
7 to 9 months	0	0	3	2,94	9	8,82	11	10,78
A new mother with a child under 6 months old	1	0,98	5	4,90	4	3,92	5	4,90
Total	3		33		37		29	

Source: Gretssa, 2020

1.3 Methods

The completed questionnaires for the cross-sectional household survey were quality controlled. The data were then entered into a data entry mask developed in Epi Data and transferred to sphinx v5 and Excel. We extracted the data for pregnant women and new mothers, after data cleaning to enhance data quality. Then, we performed a descriptive statistical analysis of the data to study the therapeutic recourses and the revealed barriers of pregnant women and new mothers.

2. RESULTS

2.1 The Therapeutic Action(s) for the Prenatal Phase

The therapeutic actions of the 87 pregnant women are represented in Table 2.

According to the table, women go more to a modern health service at the beginning of their pregnancies (69%). This tendency, paradoxically, decreases as the pregnancy progresses and is again high when women are at term (70.2%). Seventeen percent (17%) of pregnant women resort to self-medication, the rate being higher from the third month of pregnancy to the seventh month (27%). Traditional medicines are used much more by women during this self-medication than modern medicines (65% against 35%). Self-medication is practiced by 17% of women at the beginning of pregnancy, 31% after a visit to a health service, and 39% at the same time as modern and traditional medicine.

Traditional medicine is used during all stages of pregnancy, but the rate is highest at the end of pregnancy (63%).

Women who do nothing at the beginning of their pregnancies represent 2%, but until the seventh month, they seek care in a health service. None of them use Chinese medicine or street medicine during the prenatal phase.

In any case, the proportion of women who forego PNC is remarkably low, even though our sample is not representative.

This type of service is now so ingrained in the habits that it has become the rule for many women: "*You have to go to the doctor when you are pregnant*".

Table 2
Therapeutic use of pregnant women by stage of pregnancy

Therapeutic remedies	2 months	3 to 6 months	7 to 9 months
Self-medication	17%	21%	27%
Modern Public Medicine	69%	42%	70,2%
Modern private medicine	1%	4%	3%
Traditional medicine	27%	52%	63%
Did not do anything	2%	0,5%	0%

Source: Gretssa, 2020

2.2 Number of Visits for Prenatal Consultations (PNC)

On average, expectant mothers have made a total of 3.3 prenatal visits to a maternity hospital, a PMI, or an urban health facility. This represents at least one PNC per pregnant woman. All the first PNCs take place in local maternity hospitals or very close to the place of residence of the households.

However, of the 87 women, 35 reported attending PNC regularly and 12 irregularly. These thirty-five women were young and in their first pregnancy, and said they wanted to reduce the risks associated with pregnancy. Of the 12 women, nine were in their third pregnancy, perhaps because of habit and experience, they attend PNC health services less frequently. The other three said they did not come frequently due to lack of time. "*I came for a first consultation to get my booklet to make the birth certificate of my child, the rest of the time I sell at the market, I will return to the hospital for the delivery*.

Daily family burdens prevent some women from regularly using health services for their PNC. These women are obliged to take charge of their pregnancy despite being married, as the husband's resources are insufficient, and they engage in petty trading to prepare for the arrival of the child.

Among women who regularly attend health facilities, foreign women are more numerous than Ivorian women (57% versus 43%). These women perform 5.3 PNC, from the beginning of pregnancy and regardless of their place of residence.

How to explain this?

We are going to rely on the words of two women, the first one, Mrs. Kaboré of Burkinabe nationality, living in the popular SICOGI- Koumassi district, and the second one, Mrs. Oladepo of Nigerian nationality, living in the precarious district of the industrial zone of Koumassi. *Ladies, why do you go to the hospital for your PNC? According to* the testimony of these women, they go to the hospital for PNC out of habit. They also added that the lack of sufficient integration into Abidjan society leads them to spontaneously attend health services. They said that they had been in Abidjan for one year. It is true, that they do not meet all the conditions, because we were keeping the people living in Abidjan for more than 5 years. The testimony of these pregnant women should be taken with some reservations because they have been in Abidjan for one year.

Perhaps they are not sufficiently integrated, but we have those who have been residents in Abidjan for more than 6 years, and who also attend the health services.

There was no significant difference in our survey between Muslim and Christian women using health services for PNC (1.3 vs. 2).

On the other hand, the questionnaire tells us that PNC is less important at the second, third, and fourth PNC. PNC decreases as the pregnancy progresses.

Older women in our sample are less attracted to PNC (1 PNC on average), compared to younger women (3 PNC on average).

Younger women cite lack of experience and fear of the risks of pregnancy as reasons.

Childbirth is still a mystery in our societies and frightens young pregnant women, who are often frightened by what their elders tell them about the process of childbirth.

More than six women made more than five visits to a health facility because of hospitalization for a health problem.

Modern community health services are the most popular PNC services for pregnant women.

There are different therapeutic remedies used by pregnant women, but the observation we make is that, whatever the remedy, these women use a health service at least once. It was felt that using a health service seemed normal and mandatory for these women because of their condition. Some even reject self-medication, considering it dangerous for the baby.

For the pregnant women interviewed, the health services have a preventive vocation for the good health of their babies, which is why they use them for their PNC.

Out of 87 pregnant women, 65 plan to give birth in their neighborhood maternity hospital because of the proximity. The others prefer to give birth in general hospitals because of the specialized care available in case of complications.

In the end, it can be said that the therapeutic recourses of pregnant women depend on the stage of pregnancy and the age of the pregnant women.

2.3 The Therapeutic Actions of New Mothers: A Strong Attraction to Public Health Services

The fifteen new mothers in our sample, aged 25 to 36, all gave birth in the maternity hospital, except for one woman. Four of them gave birth in their neighborhood maternity hospital, six gave birth in a maternity hospital in the commune of Koumassi, two gave birth in the maternity hospital of the general hospital located in

Koumassi by cesarean section, and one gave birth in a clinic because she had individual insurance.

The use of the different hierarchical levels is, therefore, more respected and balanced for deliveries and even for PNC. The basic level ensures the bulk of visits and deliveries, while the top of the health pyramid receives very few pregnant women and parturients, who are often referred in case of complications.

The HG, gathers several activities, in case of complications the pregnant women can be taken care of, that is why two women preferred to consult directly in this second-level health establishment compared to the maternity of proximity.

In choosing maternity hospitals, women choose proximity services, where they sometimes even walk to them.

All 14 women were assisted in their delivery at a health facility. They stayed an average of one day at the health facility. Among these fourteen women, three had not previously attended PNC more than once. These are women from the *Promodo* and *Remblais neighborhoods,* respectively. These women each live less than one kilometer from a maternity hospital. Family responsibilities prevent these women from regularly attending health services as recommended. However, they are aware of all the risks related to pregnancy despite their low level of education.

In addition, therapeutic actions towards health services for these fourteen women are regular vaccinations and some post-natal care.

On the other hand, more than half of these women use traditional medicine in addition to modern care to take care of their babies. These are mainly remedies for bathing and some protection against certain diseases.

The traditional medicines come mainly from the market and from the health professionals they consult. For these women, doctors even encourage the simultaneous use of both types of medicine to facilitate childbirth.

However, there are still women who give birth unassisted. In our sample, one woman delivered her second child at home and never had PNC. Her child is four months old and has never been vaccinated. This woman, who lives in the village of Ebrié *Anoumabo,* is an isolated case in our study, but according to the Ministry of Health, 25% of women give birth without being assisted. There are several reasons for this, including the surprise effect. It can happen that women do not have the time to go to the maternity hospital, notably because they are several kilometers from a health center, but also because they fear the delivery rooms or even because of a lack of financial means.

Some women go to a health service very late and risk giving birth on the road or losing the child once in the hospital because of a lack of proper care.

2.4 Some Barriers Identified by Pregnant Women, Parturients, and New Mothers

Midwives do not respect some of the rules of modesty for pregnant women during consultations. In our sample, 49% complained about the behavior of the midwives who saw them.

One woman, in particular, caught our attention with what she told us:

I have been attending the maternity hospital in my neighborhood (Sicogi) since the first month of my pregnancy, but in this center, my privacy is not respected during PNC. The nurses and other health personnel allow themselves to enter the consultation rooms without knocking beforehand while I am naked. This is unacceptable for us Muslims because only our husband has the right to see us in these conditions. If I told my husband about this, he would forbid me to go to this health center for good. But I don't talk about it, because this service is close to my home and I am used going there since my first pregnancy.

The situation explained by this woman is not an isolated case; several women have changed maternity hospitals or health services for PNC or childbirth because of the inappropriate behavior of health professionals and the malice of midwives. For these women, proximity is an advantage but also a disadvantage, because the health professionals do not know how to hold their tongues and tell anyone who will listen about the delivery of certain women by making fun of them.

In Côte d'Ivoire, there is not yet a code of ethics governing the profession of midwifery. It would seem that it is currently being drafted. This deplorable situation allows midwives not to keep information about their clients confidential to preserve the right to privacy and to act with discernment when it comes to transmitting this information.

The women interviewed were unanimous on the fact that they sometimes have conflictual relations with the staff, even if some are courteous. For these women, the health worker's image is tarnished because of the poor reception, racketeering by health workers in the health centers, and often the poor quality of care and lack of hygiene.

The behavior of some health professionals tarnishes the image of midwives. The lack of respect for professional secrecy by health workers creates a lack of trust and a barrier to access to care.

Midwives are the most universally known of all health care workers because they practice a profession that is both medical and social.

In addition, women criticized the lack of hygiene in the consultation and delivery rooms (Picture 1). The poor quality of care still discourages many women from using maternity facilities and encourages wealthier households to turn directly to private health care facilities for PNC and deliveries.

They provide primary maternal health care (prenatal consultation, ultrasound, etc.) and are generally characterized by the absence of medical staff and by the obsolescence of hospital equipment (Picture 1).

Picture 1
Hospitalization room
The condition of the hospital room is dilapidated and the equipment is in a poor condition. A minimum comfort that requires patients to bring with them the fans to improve themselves. even their comfort in the hospital rooms.
Credit: Gretssa, 2021

3. DISCUSSION

Women's therapeutic actions are marked by a significant recourse to a modern health service at the beginning of their pregnancies (69%). This trend, paradoxically, decreases as the pregnancy progresses and is again high when the women are full term (70.2%). The high utilization of health services by pregnant women, parturients, and new mothers can be explained by a high concentration of primary health care services, particularly private or public maternity hospitals, close to their homes in the city of Abidjan. Studies conducted by M. Ymba et al. in 2020 corroborate our results. In their work entitled "Measurement of geographic accessibility to health structures offering maternal health services in the Abidjan agglomeration (Côte d'Ivoire)", they mention a high level of accessibility to local maternal health centers.

It should be noted that the use of health care services by this social category does not depend solely on their place of residence, but rather on their health status. It is not surprising to see that the vast majority of women use health services. Indeed, "according to the head of the Koumassi health district, pregnant women used to wake up at 5 a.m. and travel more than 5 kilometers to line up at 9 a.m., just for a health card. Today, it's different, women no longer do all that to have access to a maternity hospital, they are informed of the risks related to childbirth and the benefits of prenatal consultations, hence their strong presence in maternity hospitals.

In Koumassi, the PNC rate is close to 70%. Since 1995, a vast campaign has made it possible to considerably improve maternal and infant access in Abidjan and throughout the country. The result is spectacular, as the PNC rate reaches 73% in Abidjan and the number of women assisted in childbirth is more than 75% (DIIS, 2018). The Ivorian health authorities want to go further because, since 2011, free delivery kits are given to all parturients, the expenses are only to be expected if complications arise.

In addition, this study highlighted the difficulties encountered by women. Several factors constitute barriers to their access to quality, local, and low-cost care. This justifies, as our results show, that PNC decreases as the pregnancy progresses. Several studies have identified barriers related to the demand for care (Ensor and Cooper, 2004). Among the factors associated with the demand for care, the cost is considered one of the most important barriers to accessing the health care system, particularly for maternal health services (L. Balaid, 2014; P.M. Tebeu et al., 2004).

This financial barrier was also highlighted in our study. Women even if they each live within one kilometer of a maternity hospital; certain financial burdens (ultrasound, examinations, etc.) prevent these women from regularly attending health services as recommended. This leads to low utilization of health services for deliveries and obstetric complications and contributes to an increased financial burden on households (S. Dzakpasu et *al*., 2013).

As for the quality of care, studies are unanimous on the fact that the quality of care improves the demand for care and makes it possible to compensate for the negative effect of price on the consumption of health care (M. Audibert and J. Mathonnat, 2000; Mariko, 2003; B. Cissé et *al*.)

However, the women interviewed were unanimous on the fact that they sometimes have conflictual relations with the staff, even if some are courteous. For these women, the health worker's image is tarnished because of the poor reception, racketeering by health workers in the health centers, and often the poor quality of care and lack of hygiene in the health centers.

The behavior of some health professionals tarnishes the image of midwives. The lack of respect for professional secrecy by health workers creates a lack of trust and a barrier to access to care.

Midwives are the most universally known of all health care workers because they practice a profession that is both medical and social.

The Ministry of Health recognizes the sometimes conflicting relationships between women and midwives. For the Ministry, midwives are under strong pressure while there are many shortcomings in their training. This training is not always of good quality. There is a gap between theory and practice. Until now, there has been no revision of the training curriculum from 1998 to 2020. The revision of the curriculum consists of researching the health needs of the population, identifying the difficulties of practitioners, and determining what they want to

improve in their work. This was done in 1996, but there has been no follow-up. Midwives need to be educated about the changes in society and all the new things that are happening in the health sector. There are new diseases that are emerging and some diseases that are disappearing. But this is not being done, and the inexperience in the practice of some, leads them to sometimes commit medical errors to the point that the population sees them as incompetent people who no longer deserve to be called upon in case of emergency.

The increased lack of equipment also limits their tasks. Indeed, the maternal mortality rate is still high (543 deaths per 100,000 live births in 2005), largely attributable to a low level of skilled birth attendance (56%), and newborn health (41‰ live births) remains a concern despite efforts in recent years to reverse the trend.

Also, the number of midwives is still insufficient to meet the needs of women of childbearing age (1/9,345 FAP). One midwife for every 9,345 women of childbearing age (WFA) is below the WHO target of 1/5,000 WFA.

Our study did not show this, but about the determinants of antenatal care barriers, Kachou and Rweng (2014) find that ethnicity, degree of modernity, distance, and household standard of living account for 60% of antenatal care-seeking behavior in Côte d'Ivoire. However, several sociocultural barriers preventing the use of antenatal care were identified in Côte d'Ivoire by Bouchon (2012). He cites the perception of pregnancy as not being an illness, the lack of knowledge of preventive measures for pregnancy-related pathologies and their symptomatology, the idea that a pregnant woman should live her pregnancy in complete discretion, the multitude of prohibitions for the pregnant woman, and the perception of certain pathologies as, he concludes that there is a large gap between medical norms and sociocultural attitudes or practices in Côte d'Ivoire just like everywhere else in sub-Saharan Africa (M. Balde, 2020).

CONCLUSION

The goal of this study was to investigate the therapeutic use of pregnant women, parturients, and new mothers and the barriers revealed by the latter in the commune of Koumassi in Abidjan. Women go more to a modern health service at the beginning of their pregnancies. This tendency, paradoxically, decreases as the pregnancy progresses and is again high when women are at term. According to our results, pregnant women made an average of 3.3 prenatal visits to the maternity hospital. This represents at least one PNC per pregnant woman. The high concentration of maternal health services near women's places of residence could explain this situation. However, our results showed that many women encounter difficulties in accessing care because of the cost of certain services and the quality of care. This situation is still the main cause of maternal mortality in Côte d'Ivoire and even in Africa.

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