



(CASE REPORT)



## Holistic health care and maternal death in a hospital in south Nigeria: A case report

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### Abstract

According to the World Health Organization (WHO), the maternal mortality ratio (MMR) of Nigeria is 814 (per 100,000 live births). The Sustainable Development Goal aims to achieve a maternal mortality ratio of less than 70 maternal deaths per 100,000 live births by 2030. This may be feasible only if the perception, values, religious beliefs and practices of the pregnant women observed as factors implicated in the poor utilization of health facilities in Nigeria as in other developing countries are properly addressed. While effort is being made to provide standard well-equipped Health facilities, integration of holistic care into reproductive health programs by taking a detailed spirituality history of the pregnant women early enough in the antenatal clinic to elicit and effectively address these monsters, need also be explored. We present a 27yrs old primigravida who duly attended antenatal care in the zonal hospital Bori, was booked for an elective caesarian section at 38 weeks of gestation for cephalo-pelvic disproportion (CPD), but she went to a church where during prayers and deliverance it was prophesied that she would deliver like the 'Hebrew women'. She remained in labor at a mission home for 3 days. She had an intrauterine fetal death and subsequently died on arrival at the hospital.

**Keywords:** Holistic health care; Maternal death; Spiritual history; Socio-cultural belief; Antenatal care; Mission home

### 1. Introduction

Maternal mortality ratio (MMR) in Sub-saharan Africa is alarming, with about 34% of global maternal deaths occurring in Nigeria and India alone.(4) According to the World Health Organization (WHO), the MMR of Nigeria is 814 (per 100,000 live births). Apart from the five major causes of maternal death such as hemorrhage, infection, unsafe abortion, hypertensive disorders of pregnancy, and obstructed labor; spirituality/religious and socio-cultural belief to achieve vaginal delivery at all cost, as well as aversion to caesarean delivery have contributed significantly to high incidence of maternal mortality especially in the rural Areas of Sub-Saharan Africa(5) Ignorance, illiteracy, late referrals, difficulty in transportation are also factors identified as causing poor utilization of health care facilities in the area(6) It is therefore important to know that availability of health care facilities and services in an environment does not necessarily translate into increase in the utilization of such facilities (7–9 ). Most often, the utilization of a health facility by the pregnant women is based on their perception of care. (6) It is obvious that a pragmatic holistic approach in the reduction of maternal death need to incorporate awareness of religion/spirituality and cultural beliefs and practices into the care of the pregnant women which can only be possible by obtaining a detailed spiritual history from them as they come for antenatal care.(8)

This will help the health professional identify the woman's spiritual values, beliefs, perceptions and preferences. Spirituality/Religious beliefs that would have affected their medical decisions and conflict with treatment options would then be properly addressed early enough during the antenatal care visits (9) Christina M. Puchalski (1996) developed a guide in taking a spiritual history called the FICA method as follows (8):

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*Faith and belief:* The pregnant woman should be asked whether she has spiritual beliefs that would help her cope with stress or difficult times? What gives her meaning and purpose in life?

*Importance and influence:* She could be asked whether spirituality is important in her life?

What influence does it have on how you take care of yourself? Are there any particular decisions regarding your health that might be affected by these beliefs?

*Community.* Ask whether she is part of a spiritual or religious community/organization/mosque or church  
*Address/action.* Then think about what you as the health care provider need to do with the information the pregnant woman has shared with you.

Thus based on their obstetric history, clinical findings and investigation results, those pregnant women at risk of any of the five major causes of maternal death namely hemorrhage, infection, unsafe abortion, hypertensive disorders of pregnancy or obstructed labor should be properly counselled in the light of their perception and belief elicited in the spiritual history. The health care provider can also invite their pastors or Imans for discussion on the issue at an antenatal visit. The chaplain of the healthcare facility could also be involved if indicated. This will allay their fears and encourage their utilization of the health care facility with consequent reduction in maternal death.

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## 2. Case Presentation

Mrs. A.E. was a 27years old primigravida who leaved in Gokana Local Government Area. She had a secondary level of education and a Christian of The Apostolic church she was an Ogoni. Her last menstrual period was 12<sup>th</sup> February 2020 and the expected date of delivery was on the 19<sup>th</sup> November 2020. She registered for antenatal care at Zonal hospital Bori at 16 weeks gestation and had 6 visits She also registered at a Mission home at 27weeks gestation when a friend told her that hospital delivery most often result into operation. The pregnancy was diagnosed with a urine pregnancy test and a two missed periods. She had her first ultrasound scan done at 16<sup>th</sup> week gestation. The investigation results at booking were; blood group- "O" rhesus D positive, genotype "AA", PCV- 28% and urinalysis was normal. Her height was 150cm. She had 3 doses of fansidar for malaria chemoprophylaxis and also had 2 doses of intramuscular tetanus toxoid immunization. Her antenatal care period was uneventful. Clinical pelvimetry done at 36 weeks gestation revealed a contracted pelvis (diagonal conjugate of less than 11.0cm and prominent ischial spines). Obstetric scan done at 36weeks revealed a fetal weight of 4.2kg. A diagnosis of contracted pelvis in a primigravida with fetal macrosomia was made. She was counseled and booked for elective Caesarian Section at 38weeks. Mrs. A.S refused to present to the hospital for the procedure but rather went to church in order to have a vaginal delivery at 40 weeks gestation when labor started.

History revealed that the mission maternity team was composed of two elderly women and two traditional birth attendants who were members of the Prayer and Prophetic ministry. Mrs. A.E was admitted and reassured by a birth attendant that she would have normal delivery. In spite of the strong regular uterine contractions Mrs. A. E. could not deliver the baby for three (3) days in labor. She was rather getting weaker and exhausted while the birth attendants were always reassuring her of normal delivery. By 12:00 midnight on the third day there was no more strong uterine contractions; she became completely exhausted and fainted. She regained consciousness when cold water was poured on her. The Pastor was called to pray for her and Mrs. A. E. was thereafter referred to Zonal Hospital Bori. Movement to the hospital was delayed because of the difficulty of getting a means of transportation that midnight.

On arrival at the hospital by 6:30am the following day, Mrs A.E. was examined and found to be very pale, with cold extremities, absent of peripheral pulse and lost apex beat. Fetal heart sound was absent and vulva pad was soaked with blood. She was then confirmed death on arrival due to uterine rupture and intrauterine fetal death at 6:40am

The husband requested for a postmortem caesarian Section which was done. Findings at surgery were; massive hemoperitoneum and a posterior uterine tear that extended from the fundal region to the lower uterine segment involving the right round ligament with the macerated male baby in the peritoneal cavity. The birth weight of 4.5kg.

### 2.1. Extract from the husband of Mrs. A. E

P1 "The death of my wife is not ordinary, they tied her womb. The prophesy in the church was true. It's demonic. The 'nurse' asked us to go to Zonal hospital for operation at midnight. There was no vehicle to carry us that time. I know it was the enemy that caused all these and they have succeeded in killing my wife"

Extracts from Church sister who took Mrs. A.E. to prayer and prophetic ministry and eventually to the mission home for delivery.

P2 “... they tied her womb. Other women have been delivering normally, why should hers be different. It will not be well with the person that did this...”

Extracts from the birth attendant that accompanied them from the Mission home

P3...”...everything happened like magic because even when she fainted we poured her cool water and she recovered herself. This thing that happened is devil that caused it.”

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### 3. Discussion

The death of Mrs. A. E would have been prevented by a holistic health care through an additional complementary approach in taking her detailed spiritual history during the antenatal visit. Such a history would have elicited her aversion to hospital delivery and fear of caesarian section that made her register at mission home at 27weeks gestation after that of the Zonal Hospital at 16weeks after persuasion from a friend. The spirituality/religious belief that “the enemy tied her womb” was a perception that would have been also elicited and effectively addressed early enough before booking her for the surgery. The unaddressed fear, perception and religious belief compromised her medical decision which eventually conflicted with the treatment option.

As regards the obstetrics record of Mrs. A. E, the clinical pelvimetry done at 36weeks gestation revealed a diagonal conjugate of less than11.0cm with prominent ischial spines (a possible contracted pelvis), the Obstetric scan done at 36weeks showed a fetal weight of 4.2kg. She was short in stature (height 150cm) and that was her first pregnancy(primigravida).All these were pointers of the red flags for possible obstructed labor necessitating her booking for an elective Caesarian section at 38weeksof gestation but the health care provider did not take cognizance of Mrs A. E's religious/spirituality belief and how they can affect her disposition on the treatment option.

Amongst the Ogonis culturally, there is the firm belief that childbirth should be through vaginal delivery and not by operation. When the husband of Mrs A. E. was interrogated he said “The death of my wife is not ordinary, they tied her womb..... it's demonic”. The church sister said “..... It will not be well with the person that did this...”

Religion forms the foundation and the all-governing principles of life for most people, particularly Africans also pointing to the fact that superstitious belief plays a role in the poor outcome of the case. The African cosmological perception is overtly religious; such that all forms of misfortunes, illness, death, failure and natural mishaps are attributed to either evil spirits , angry ancestors or gods (10). This still points to superstition (a place of both attributes of a Christian and that of a typical African belief)

The church sister who visited Mrs A.E. at home and took her to a Prayer and Prophetic Ministry and to the pastor who conducted deliverance on her because in African Mythology the Supreme being ( God) is seen to be at the apex of the pantheon followed by divinities/ lesser spirits before the ancestors(11).There is therefore a strong belief that the power of a supreme being (God) is greater than that of the divinities(demons). This belief might have been the reason the church sister took Mrs. A.E. to a Prayer and Prophetic Ministry for God's intervention. Thus Mrs. A. E. had to abscond the scheduled elective C/S since she was reassured, she would “deliver like the Hebrew women” with the hope that all the problems have been settled.

The church mission home who referred Mrs A.E. in the midnight after three days in labor cannot be completely absorbed from blame. The three forms of maternal delay proposed by Thaddeus and Marine clearly played themselves out here (12). These barriers include delay in making decision to seek maternal health care; delay in locating and arriving at a medical facility; and delay in receiving skilled pregnancy care when the woman gets to the health facility(11) If they had basic training and knowledge in midwifery they would have been able to select and refer people with high obstetric risks especially as was the case of the index patient ( Mrs A.E) early enough. Failure to properly monitor progress in labor and recognize early signs of obstructed labor contributed to the late referral and it's sad sequel. Difficulty in getting a means of transportation at 12:00midnight from the mission home constituted another delay for the late arrival in the hospital.

### *Recommendation*

To achieve any significant reduction in maternal death, practice of holistic health care should be integrated into reproductive health programs to ensure effective utilization of available health care facilities by the pregnant women.

A detailed Spirituality history should be included in the clerking of pregnant women at the antenatal clinic. This will help the health professional (HP) identify and properly address the woman's spiritual values, preferences, perception, religious beliefs and practices early enough to avoid their conflicting with medical decisions and treatment options.

Religious organizations (churches, mosques etc.) that run maternity homes should properly upgrade them with employment of well-trained and experienced midwives, and other health workers who can effectively detect obstetric risks in pregnancy and refer such persons to designated Hospitals for continuation of care instead of rushing them as emergencies.

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## **4. Conclusion**

The case reported here has shown how religious and socio-cultural belief of pregnant women can conflict with treatment option with grave consequences. It was also noted how unskilled birth attendants in the community could not detect obstetric risks for early referral to a designated hospital. Means of transportation at odd hours also contributed to the late arrival at the health facility. This asserts to the fact that the availability of a health facility in an environment does not necessarily translate into utilization of such facility by women. Thus, for a significant reduction in maternal deaths, holistic health care incorporating taking of spirituality history at antenatal clinic is imperative. This will effectively address the religious and socio-cultural beliefs and practices of pregnant women which will subsequently increase their utilization of health care facilities.

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## **Compliance with ethical standards**

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### *Disclosure of conflict of interest*

There is no conflict of interest.

### *Statement of ethical approval*

This study has the approval of the management of zonal Hospital Bori. The deceased family members encountered during the investigation have given informed consent for this report.

### *Statement of informed consent*

Informed consent was obtained from all individual participants included in the study.

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