LETTER TO THE EDITOR

Common barriers to hospital delivery in rural Kenya and antenatal care in Japan

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Dear Editor

I read with interest the recent Rural and Remote Health article 'Barriers to hospital delivery in a rural setting in Coast Province, Kenya: community attitude and behaviours' by Mwangome et al. This study revealed some barriers to mothers delivering their babies in a hospital, namely: (i) financial problems; (ii) the expectation of an easy delivery; (iii) a primipara whose inexperience makes her unaware of pregnancy and the signs of labor; and (iv) the poor accessibility of hospitals. I am surprised that most of these barriers are also barriers to antenatal care in Japan.

The hospital birth rates in Kenya and Japan are 40% versus more than 99%, respectively, so obviously 'barriers to hospital delivery' are not an issue in Japan. However, the number of pregnant women who have no antenatal care has become a serious concern, especially in Japan’s rural settings.

Women without antenatal care compared with women with antenatal care are at high risk of preterm delivery (16% vs 5.8%), and of delivering a low birth weight infant (20% vs 8.2%), respectively. A quarter and a one-fifth of women without antenatal care had maternal obstetric and medical complications, respectively. These women are also of social concern. Although they comprise a group as low as 0.3% of pregnant women, almost all are urgently admitted at night after their labor begins.

Data from Hokkaido, Japan, where there are many rural areas, indicated the reasons for pregnant women not receiving antenatal care were: (i) financial problems (50%); (ii) intentionally declining it (16%); and (iii) unnoticed pregnancy (14%). The women who intentionally declined believed that the delivery would be easy and thus antenatal care was unnecessary, which is equivalent to Mwangome et al’s 'expectation of an easy delivery'. The group with...
‘unnoticed pregnancy’ consisted mainly of teen-aged, primiparous women\(^3\). Thus, of four barriers to hospital delivery in Kenya, three overlap with the situation in Japan. The fourth barrier to hospital delivery, ‘poor accessibility’, is not a barrier to antenatal care in Hokkaido at present\(^3\). However, with the centralization of obstetric hospitals under way and the number of obstetricians decreasing in Japan\(^2\), there is a fear that many Japanese rural areas will be without delivery clinics. If this eventuates, ‘accessibility’ will also become a barrier to antenatal care in rural Japan in the near future.

The answers to the question ‘Why not deliver a baby in hospital?’ in Kenya hold true for ‘Why not receive antenatal care?’ in rural Japan. They are: poverty; expecting an easy delivery; and unnoticed pregnancy. Thus, although Mwangome et al targeted a limited population in a specific situation in a developing country\(^1\), their conclusions may be generalized to developed countries. A strong similarity between Mwangome et al’s results\(^1\) and those of a Japanese study\(^3\) suggests that the reasoning and behavioral patterns of pregnant women may be similar worldwide. While Mwangome et al’s suggestion of tailoring strategies in an area-by-area manner to promote maternal–child health in rural areas is important\(^1\), taking into account the behavioral patterns of pregnant women may be equally so.

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References

