



Challenges of Utilization of Emergency Obstetric care as Experienced by Midwives in Selected Secondary Health Facilities in Oyo State, Nigeria: A Qualitative Approach

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Abstract

Background: *The use of Emergency obstetric care is essential in reducing maternal mortality, especially in developing countries where maternal mortality is low. There are high unmet needs for Emergency obstetric care. One of the reasons may be due to challenges faced by healthcare workers.*

Objectives: *The objective of the study was to explore the challenges of the utilization of emergency obstetric care as experienced by midwives in selected secondary health facilities in Oyo State, Nigeria.*

Methods: *The study utilized a qualitative research design using a self-developed interview guide to elicit responses from twenty-two participants from eleven secondary health facilities.*

Results: *Two themes emerged from the findings of the study which are organizational and Patients factors. Five subthemes were generated from the organizational factors which include non-availability of training on emergency obstetric care, inadequate equipment, staff shortage, non-availability of drugs, and inadequate basic amenities. Three themes emerged from the patients' factors which include financial constraints, religious belief, and uncooperative attitude.*

Conclusion: *It is therefore recommended that there should be periodic training should be organized on Emergency Obstetric Care, there should be the provision of equipment, and drugs needed for managing obstetrics emergencies on the ward and there should be the recruitment of staff. Modalities should be put in place to educate pregnant women on the need to comply with the use of emergency obstetric care and religious leaders should be educated on Emergency obstetric care and encourage pregnant women to utilize emergency obstetric care when there is a need for it.*

Keyword: *Challenges, Emergency Obstetric Care, Midwives, Oyo State, Secondary health facilities, Utilization.*

Introduction

Pregnancy and childbirth are a thing of joy but if not well managed can bring sadness into a human's life. Despite various efforts that have been put into place to reduce maternal mortality, maternal mortality is still high in developing countries. Maternal mortality is highest in low and lower-middle-income countries, contributing to 94 percent of all maternal deaths, with Sub-Saharan Africa and Southern Asia accounting for 86 percent of all maternal deaths (Geller et al., 2018; Kyei-Nimakoh et al., 2017). Nigeria is ranked second in the world for its contribution to maternal mortality (Sageer et al., 2019). Nigeria had a maternal mortality rate of 917 per 100,000 live births in 2017, compared to 19 per 100,000 live births in Ukraine and Mordovia. This high rate falls far short of the Sustainable Development Goal of 70 live births per 100,000 people.

According to Geleto et al., (2018), 15% of complications arise during pregnancy and labor which can arise as an emergency and can result in mother and newborn morbidity and mortality if not addressed effectively (Geleto et al., 2018). The prompt use of emergency obstetric care has been documented can help avert emergency complications that may lead to death during pregnancy and childbirth but inadequate use of obstetric emergency care, particularly in developing and underdeveloped nations in managing obstetric emergencies that may occur during pregnancy and childbirth can lead to death (Wright et al., 2017). EmOC is defined as care delivered in health facilities to manage direct obstetric emergencies that cause the great majority of maternal mortality throughout pregnancy, birth, and the postpartum period (Banke-Thomas et al., 2017).

The challenge of unmet needs for Emergency obstetric care is a factor hindering the effectiveness of EmOC. The unmet emergency obstetric care is the emergency obstetric care a woman should have access to but could not have benefit from. According to a systematic review by Holmer et al., (2015), the global met needs for

EmOC was 45 percent. This means that there was a 55 percent global unmet need for EmOC (Holmer et al., 2015). In developing nations, emergency obstetric care (EmOC) remains a burden on the health system and there are quite some challenges in the use of EmOC in managing obstetric emergencies that may require the use of EmOC (Ijase & Makwe, 2018). There is variation in the use of EmOC in different parts of the world, few facilities were able to meet the UN standard of four facilities that provide basic EmOC and one facility that provides comprehensive EmOC, while some facilities, particularly in developing countries, were unable to meet the standard (Holmer et al., 2015).

The met needs for EmOC in studies conducted in Nigeria where this study was conducted ranged between 9.9% and 25.1% (Kabo et al., 2019b; Lam. & Jamilu, 2019b). The implication of this is that unmet needs for EmOC are still high. The consequences of the unmet needs for EmOC include an increase in maternal and child mortality. The high unmet needs of EmOC suggest that some factors are militating against the success of the use of EmOC (Abegunde et al., 2015; Bamgboye et al., 2016; Kabo et al., 2019; Limam et al., 2021). This suggests there is a need to explore this aspect. Midwives are one of the health professionals very close to women during pregnancy and childbirth, hence this study explores the challenges experienced by midwives in the use of EmOC in selected secondary health facilities in Oyo State.

Methodology

Research Design

The study utilized a qualitative research design to explore the challenges of midwives in the use of EmOC in selected secondary health facilities in Oyo state.

Research Settings

The settings of the study were eleven selected secondary health facilities in Oyo State, Nigeria.

Population for Qualitative

The population of the study was Midwives in the eleven selected secondary health facilities in Oyo State, Nigeria.

Inclusion Criteria and exclusion criteria

Midwives who are currently registered with the Nursing and Midwifery Council of Nigeria and that have worked in the maternity center of the selected secondary health facilities for at least three years and who have given informed consent to participate in the study were included in the study. While a midwife working in another health facility that is not part of the selected secondary health facilities but not working in the maternity center of the selected secondary health facilities, being a Midwife having working experience in the labor ward of fewer than three years and a midwife who refuses to give informed consent to participate in the study.

Sample size and Sampling technique

A total number of twenty-two participants was used for the study. Two midwives were picked from each of the eleven health facilities using a purposive sampling technique.

Instrument of Data collection

A self-structured key informant interview guide was used to explore the challenges of the use of EmOC as experienced by midwives in selected secondary health facilities in Oyo State. Digital tape recorders, field notes, and field note takers are some of the other instruments that were used for data collection. In qualitative research, the researcher is also a data collection instrument, hence the researcher was also a data collecting instrument.

Pilot Study

A key informant interview was conducted among midwives in another secondary health facility that was not part of the main study. This setting has a similar characteristic to where the main study was conducted. This was done to identify errors that may be in the interview guide.

Method of Data Collection

An Introductory letter was collected from Babcock University, Ogun State. Ethical approval

was obtained from the Babcock University Health Research Committee and the ethical committee of the ministry of health, Oyo State. The Hospital management and the heads of nursing services were informed about the study. The participants were met to explain the objectives of the study. Informed consent was obtained. The key informant interview was conducted among midwives from each of the selected secondary health facilities using a self-developed key informant interview guide. A digital tape recorder was used for recording interview sessions while a journal book was used for taking field notes. The researchers facilitated the interview sessions. A private office was used in each of the participating hospitals. After the discussion, the researcher summarized what the discussion is about for the key informant to agree if that is what the participants mean. Data collected were transcribed by the researcher within 24 to 48 hours of collecting the data while the researcher still remembers all that was said and observed as field notes. In qualitative research, data should be transcribed as soon as possible after the interview when the dialog or conversation with participants is still salient and fresh in the memory of the researcher.

Method of Data Analysis

Thematic analysis was done using Collaizi's (1978) approach to qualitative data analyses. It established seven processes in qualitative data analysis that should be followed in order. Which include familiarization, identifying significant statements, formulating meanings, clustering themes, developing an exhaustive description, producing the fundamental structure, and seeking verification of the fundamental structure. The approach is robust and vigorous. It also improves the credibility and dependability of a study's findings.

Scientific rigor (trustworthiness) of the study

Some methods for evaluating the trustworthiness of a qualitative inquiry are credibility, reliability, conformability, and transferability (Korstjens & Mose, 2018; Polit & Beck, 2012; Shenton, 2004).

For credibility, the researchers confirmed that the data collected from participants were true and correct. To assure the study's dependability, the researchers provided a detailed description of the technique that was used, and an audit trail was also done. Bracketing was done by the researchers to guarantee conformability. To ensure transferability, the researchers provided a full description of the study's process in an accurate, cohesive, and logical manner that any reader can understand.

Ethical consideration

An introduction letter was collected from Babcock University. Ethical approval was obtained from Babcock University Health Research Ethics Committee with approval number BUHREC640/22 and the Oyo State Ministry of Health with approval Number AD 13/479/44523^B. The participant was given informed consent to sign after they understand the objective of the study and voluntarily consented to participate in the study. All data given were kept confidential. Privacy was maintained. Anonymity was maintained too as data collection does not involve the participants' names instead; pseudonyms were used in identifying each participant.

Findings

The findings of the study generated two themes which include the organizational factor and the patients' factor. Five subthemes were generated from the organizational factors which include non-availability of training on emergency obstetric care, inadequate equipment, staff shortage, non-availability of drugs, and inadequate basic amenities. Three themes emerged from the patients' factors which include financial constraints, religious belief, and uncooperative attitude.

S/N	Themes	Sub-themes
1	Organizational factor	1.1 Non availability of training 1.2 Inadequate equipment 1.3 Shortage of Staff 1.4 Non-availability of drugs 1.5 Inadequate Basic amenities
2	Patients' factors	2.1 Financial constraint 2.2 Religious belief 2.3 Uncooperative attitude of patients

Theme 1: Organizational factors

Non-availability of training on EmOC for midwives on the use of EmOC in the care of pregnant women in the facilities

As asserted by almost all the respondents, there was no access to training on EmOC in the facilities. The participants reported that it was the knowledge of the training they had at the nursing institution before they graduated from the training institution they are still using the few training that was done was not on EmOC. As generated from the respondents,

“There is training in the labor ward though it is done among ourselves though it is done occasionally. Though the training is not on EmOC“ (Respondent 13, study setting 7)

“Apart from the training we have from our school where we were trained to be a midwife, we do not have any training on EmOC in recent times in this facility“(Respondent 18, study setting 11)

“We do not have any form of training in this health facility on EmOC. We have never had training in recent times” (Respondent 21, study setting 11)

“Ennnhnn, We do not have the training on EmOC and there should be up-to-date training. It has been long time training has been done on anything in this health facility. I cannot even remember when it was done” (Respondent 1, study setting 1)

Inadequate instrument/equipment for EmOC -

There were complaints from all the respondents that their facilities lack the needed instrument/equipment for EmOC and the ones available are not sufficient to handle cases of emergency obstetric care while some of the equipment is malfunctioning and that may prevent them from providing quality emergency obstetric care.

“We do not have enough instruments like an MVA kit, Vacuum extractor, forceps for assisted delivery, no functioning

suctioning machine, It is not as if we do not have the knowledge and skills to do EmOC but we do not have most equipment and supplies”(Respondent 9, study setting 5)

The complaint was similar to the experience of other respondents, who also pointed out that there is no equipment for EmOC as presented in the excerpts below

“Instruments sometimes to perform EmOC services are sometimes not adequate for example there is no oxygen for resuscitation” (Respondent 13, study setting 7)

“Some of the instruments are not functioning well. So, how can we give a quality EmOC? When you know what to do in an emergency and there is no instrument to work with how do you go about it?(Respondent 17, study setting 9)Are)

“The equipment needed is not sometimes available, for instance, the anticonvulsant is not supplied by the institution, it is the head of the labor ward that buys it on our own and we use and replace it. We do not have an MVA kit, we have not even used it once since I have been working here, no equipment for assisted vagina delivery, and the option is cesarean section if there is an indication” (Respondent 5, study setting 3)

“The government did not provide the equipment and we cannot use our money to buy it. This is a government hospital and should be provided but they were not provided. There is no ambulance to transfer the patients”(Respondent 17, study setting 9)

“ They do not provide some equipment needed too for carrying out EmOC. Some patients will tell you they will not replace what you have used for them during an emergency, hence there will be a problem using such for other people that may come subsequently that requires EmOC “(Respondent 15, study setting 8)

“The major challenge is inadequate equipment in our facility for example in the delivery room, there is not much equipment to perform many obstetric services. For example, if a patient is bleeding now, we do not have the most injection that is needed to control the bleeding...The emergency room is not well equipped, for instance, there is no oxygen in the oxygen cylinder and there is nothing the government is doing, the suctioning machine has spoilt and it is not functioning, we will need to refer patients not to delay patients much because a delay will be dangerous.. there is no equipment and staff to work with a doctor. Even to transfer, there is a problem because we do not have an ambulance and when you refer them and ask them to get the vehicle to transfer the patients, they may go for hours”(Respondent 2, study setting 1)

Staff Shortage - Another major challenge identified by the respondents is the insufficient staff. Most time, there are few midwives on duty and some maternity units are handling five other units within it. The insufficient staff has sometimes led to the referral of pregnant women when the Doctors are not around to perform the Cesareans section. This challenge is common to all the facilities as extracted from other respondents.

“We do not have enough staff. Nurses, and doctors are not many. Only a nurse will be on duty with the ward's assistance. The

doctors will work from 8 am to 5 pm from Monday to Saturday” So, any emergency that may require coming into the facility after 5pm on Monday to Saturday and on Sunday that may require a cesarean section and blood transfusion is referred out and you know, any complication may occur during that process” (Respondent 9, study setting 5)

“We do not have adequate personnel. Now we are few on duty and the ward has five units, if there is an emergency we will not be sufficient to handle it because a midwife cannot attend to more than a patient and we are having just a single doctor on duty too. That is too small” (Respondent 14, study setting 7)

“We are also short staff, midwives are retiring and some are resigning but there is no replacement. The maternity ward has about five units, about a month ago, there was only one midwife and an attendant on duty, how will she be able to manage an emergency with a ward full of postpartum patients, patient in the labor ward, preparing patients for cesarean section and so on “(Respondent 5, study setting 3)

...Only a midwife is on duty and there is an emergency couple with other work on the ground and there is no one she can discuss with, it is a challenge because if you are more than one, you can take decisions together “(Respondent 19, study setting 10)

“We do not have enough midwives too, it is not all that are working here are midwives for example a psychiatric nurse taking delivery. This is a problem because we are short staff of midwives. The nurse who is not a certified midwife will still take the delivery since there is no other person to assist in taking the delivery including the doctor, so, you know there is a limit to

what such a nurse can do“(Respondent 1, study setting 1)

“Shortage of manpower is a hindrance to rendering EmOC. Assuming the patients need a cesarean section, there may not be a doctor that will attend to the patient, especially at night and this maternity center is five units in the maternity center. In case of emergency, a single midwife may not be able to function as appropriate. This happened recently when a midwife was on duty, she has a patient in the labor room, a patient that requires an emergency cesarean section and needed to be prepared for surgery, she prepared and before she came back from the theatre, the person in the labor ward has started bleeding”(Respondent 6, study setting 3)

Non-availability of drugs (especially after morning sessions or at night) - Also, respondents expressed that most of the emergency drugs are not on the ward, they are in the pharmacy and that midwives hardly have access to drugs after the morning sessions when the pharmacy may not be around because the pharmacy is also short-staff as they run morning shift alone sometimes which will end by 4pm. Hence, drugs are written out for patients to procure outside the hospital when there is a need especially when it is not during morning duty.

“In the morning duty, the drugs are available but for afternoon and night shifts, it will be written for the patients to buy outside the hospital as the pharmacy is opened from 8am to 4pm, the pharmacists are few too”(Respondents 13, study setting 7).

“The challenge is that most of it, it may be at night that we will need it and the pharmacist will not be around before they procure the drugs from the town, so there

may be a problem. The hospital policy is not supporting that all those things be supplied. It was done in the past that those drugs are available but presently, they do not make it available” (Respondent 7, study setting 4).

“...due to the non-availability of drugs, for example, anticonvulsant drugs, that can lead to delays in attending to the patients promptly and when you asked the patient's relatives to go and procure it, they will not come back on time complications may have set in” (Respondent 20, study setting 10)

“There may be some drugs that may be out of stock in the pharmacy and the patient will need to go outside the hospital to buy and you know it may not meet up in case of emergency” (Respondent 16, study setting 8)

“Then due to the non-availability of drugs, for example, anticonvulsant drugs, that can lead to delays in attending to the patients promptly and when you asked the patient's relatives to go and procure it, they will not come back on time complications may have set in”(Respondent 20, study setting 10)

“The pharmacy is not working after 4 pm, if there is a need to collect drugs in case of emergency, there is no one that will give us drugs to use for the patients”(Respondent 2, study setting 1)

“hospital management did not provide drugs on the ward, it is the patients that procure what is needed to treat them. Health care is not free here and when cases of emergency occur, there may be a problem” (Respondent 12, study setting 6)

Inadequate basic amenities - From the generated responses, the respondent also mentioned the issue of lack of basic amenities like electricity especially at night to see what is being done for pregnant women during an emergency. They also

added that there was no provision for fuel to be put in the generator.

“...there may even be no electricity for easy visibility of what you are doing for the patient in an emergency, this may prevent you from giving the best EmOC to the pregnant women when the midwife is unable to see clearly” (Respondent 14, study setting 7)

“There is no light and fuel to put on the generator to see at night, this makes the working condition tense for both the midwives and the pregnant women. This can have an impact on the quality of care rendered because the midwives may not be at their best” (Respondents 13, study setting 7).

“Also at night, we do not do a cesarean section and blood transfusion because there is no electricity, the small generated cannot lighten everywhere, so if there is an indication for cesarean section, we refer at night if there is no electricity,” said (Respondent 2, study setting 1)

Theme 2: Patient factor -These refer to challenges from the patients or their relatives. This theme generated three sub-themes which include **Financial constraint** - The midwives also expressed that financial constraints on the part of the patients hinder EmOC because when there is a need for the patients to buy things needed to take care of the pregnant women in cases of emergency, sometimes, they may not have the money to procure the things needed.

“ most of the patients do not have money to buy things they may need to take care of the woman and in cases of emergency, you must not wait, but if those supplies are not on the ward and the patients and her relatives do not have money to buy those things, what can we do? r” (Respondent 1, study setting 1).

“Poverty is another factor because when there is no money to take transport to the hospital, that can cause delays, and when they get to the hospital, buying things needed for an emergency is a problem” (Respondent 21, study setting 11).

“Financial problems and lack of funds on the part of the patients and their relatives, I have seen cases where patients that had emergency conditions were dropped and no one was there to pay for them and when the relative are available, they will be complaining they do not have money to buy things needed to buy what we need to care for the patients in case of emergency” (Respondent 14, study setting 7)

“the financial aspect is another thing, in an emergency, when you ask them to go and buy things needed, they will tell you they do not have money, and when we do not have the materials to use in the hospital, how do we go about it?” (Respondent 7, study setting 4)

Religious belief - According to a few of the respondents, the religion of some patients affects their responsiveness to EmOC services. This is because they may feel it is preferable to pray than to submit themselves to EMOC and most times before they come back to the health facilities, the complication may have set in.

“There are some patients because of religious beliefs will reject some treatments for example blood transfusion” (Respondent 21, study setting 11).

“Some patients even after educating them on the need to take some actions will not want to cooperate with you in carrying out some EmOC services, they may not want to consent and go for prayers where they will be told there is nothing God cannot do and before they come back, the

complication may have set in” (Respondent 10, study setting 5)

“The women will not also listen to the instruction you give them to follow. When you ask them to do an investigation, they will not do it. When you tell them there is an indication for cesarean section, they will tell you they reject it. I had an experience where the woman rejected a cesarean section and went back to church to pray, she eventually lost the baby” (Respondent 8, study setting 4)

The uncooperative attitude from patients and their relatives - The respondents pointed out that most of the time, patients do not cooperate with the midwives and doctors in the use of EmOC until they are about to die.

“Sometimes, the patient may not cooperate too on time until sometimes when complications have set in. When you try to explain to them, and it is when they are within life and death that they will now consent” (Respondents 13, study setting 7)

“Sometimes, the patient refuses treatment, for instance, I had an experience, the patient was counseled for a cesarean section and refuse to consent, and eventually, when she gave the consent, there was no doctor on the ground to carry out the surgery. There was another case where there was a retained placenta and we attempted to remove the placenta manually but she refused and jump off the couch and said she was not ready” (Respondent 5, study setting 3)

“Noncompliance on the part of the patient is a factor, when you tell them this is what you want to do in case of emergency, they will not comply on time until when they are about to die that is when they will comply” (Respondent 17, study setting 9).

“There was an experience I had where an unbooked woman with fetal distress was counselled for cesareansections but she refused vehemently. She did not consent on time until the baby dies” (Respondent 21, study setting 11)

“At times our patients may not even cooperate, some may have low packed cell volume and may need a blood transfusion and they will refuse and tell you they do not want to be transfused” (Respondent 22, study setting 11)

“At times when you want to give any treatment in an emergency, the patients will tell you they do not want, they will not consent on time. There are many times, women will not tell you the truth and will lie about everything you are asking them, this can prevent you from having an accurate assessment to take prompt action “ (Respondent 20, study setting 10)

“Most patients will not consent on time during an emergency, for instance, a woman that indicates an emergency cesarean section refuses to consent on time, and you know, you must not carry out any procedure without the patient consent, so, you keep counseling, so time may be wasted doing that”(Respondent 1, study setting 1)

Discussion

The findings from this study established that there are some organizational challenges midwives are encountering in the use of EmOC. Non-availability of training on emergency obstetric care was one of the organizational factors that did not allow the midwives to upgrade their knowledge and skills in the use of EmOC as they needed to rely on what they were taught in nursing training institutions while they were still undergraduate. The outcome of this study

corroborates the study conducted in Zaria, Nigeria where there was a dearth of EmOC training for maternity workers which influenced their approach to the management of obstetric difficulties that may emerge during pregnancy and childbirth because when healthcare personnel lacks the requisite knowledge and skills to recognize, diagnose, and treat obstetric issues, they are more likely to cause harm, there will still be increased maternal morbidity and mortality (Lam. & Jamilu, 2019b). Emergency obstetric and newborn care training can assist in reducing maternal and child mortality while also improving quality of life (Bergh et al., 2015). More than half of maternal health services that advocated for increased accessibility incorporated the use of EmOC in their training elements, according to evidence (Ameh et al., 2019a; Otolorin et al., 2015). While poor access to EmOC is a concern, if healthcare providers lack expertise and skills in the use of EmOC, there may be difficulties in reducing maternal and neonatal mortality (Namayi et al., 2020).

Inadequate equipment needed for EmOC was also described as a challenge in the use of EmOC as some equipment was not available while some of the equipment that were available were not sufficient and some were malfunctioning. This finding of this study was in line with the finding of a study conducted in Rwanda that found the ability of health workers to change their practice on the Use of EmOC to be disrupted by insufficient equipment and material for use for obstetric emergencies (Uwajeneza et al., 2015). It is worth emphasizing that having access to EmOC requires more than simply the presence of healthcare staff in healthcare facilities; there must also be a sufficient supply of equipment, pharmaceuticals, and other consumables to provide EmOC services (Mkoka et al., 2014). Insufficient midwives and other health practitioners that are directly involved in the care of pregnant women were seen as an organizational factor that hinders the use of EmOC as the workload is much on the little available staff that

is on duty which reduces their efficiency and effectiveness in rendering EmOC services. To reduce maternal mortality the presence of health staff who have been trained to address obstetric crises and complications is required for successful treatment, but if this is not accessible, documenting a success may be a mirage (Okonofua et al., 2019a). The findings of this study further go in line with some studies that identified impediments to the implementation of EmOC as scarcity of skilled health staff or human resources (Lakew et al., 2015; Stal et al., 2015; Wright et al., 2017).

Non-availability of drugs is another organizational factor that influences the use of EmOC as explained by midwives. Some drugs were not available for use, especially at night when the patients will be asked to procure them outside the hospital if there is a need for them. A study conducted in Ghana also identified an insufficient supply of drugs as a factor that can prevent improvement in Emergency obstetric referrals. The midwives in addition identified that there were inadequate basic amenities. Such as the supply of electricity needed to work especially at night which makes the environment not conducive for working and makes it difficult to see clearly which can influence the quality of care rendered to pregnant women in terms of EmOC. The findings from this study also corroborate the outcome of a study conducted in Northern Nigeria that identified other barriers to the use of EmOC including a lack or poor supply of electricity (Kabo et al., 2019; Oguntunde et al., 2021). The non-conducive working environment for midwives has been documented to influence the use of EmOC in Rwanda (Uwajeneza et al., 2015). The patients factors identified from the finding of this study include financial constraints as when there is a need to buy some drugs which are not available for use in case of emergency, some patients may not have money to procure such items which may lead to delay in attending to the pregnant women. A study conducted in Lagos, Nigeria identified high treatment costs as barriers

to EmOC use (Wright et al., 2017). The religious belief of patients in prayers when there is a need for prompt action in an emergency is another challenge of the use of EmOC. The women will prefer going for prayers until complications set in. The findings of this study were in line with the outcome of a study conducted in Zimbabwe where apostolic belief in prayers by women influences the delay of women in taking decisions when there is a complication (Munyaradzi Kenneth et al., 2016). However, a study conducted in Nigeria shows that there is a minimal impact of religion on women's uptake of maternal health services (Al-Mujtaba et al., 2016). The midwives identified the uncooperative attitude of pregnant women when there is a need for Emergency Obstetrics Care. The pregnant women will not consent on time to procedures the midwives and doctor want to carry out until the case becomes complicated, especially in the case of cesarean section.

Recommendations

Based on the findings of this study, it is therefore recommended that there should be periodic training that should be organized on Emergency Obstetric Care for midwives and other healthcare workers that are directly involved in the care of pregnant women. There should be the provision of equipment needed for the utilization of EmOC services while drugs needed for managing obstetrics emergencies should be made available on the ward for emergencies. There is a need for the recruitment of midwives and other staff handling pregnant women for the successful use of EmOC services. Modalities should also be put in place to educate pregnant women on the need to comply with the use of emergency obstetric care when the need arise and not wait until complication set in before they give consent for EmOC services to be rendered for them. A religious leader should be educated on Emergency obstetric care and encourage pregnant women to utilize emergency obstetric care when there is a need for it.

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