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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[1]. 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[2] 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[3]. A quarter and a one-fifth of women without antenatal care had maternal obstetric and medical complications, respectively[3]. 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[3].

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%)[3]. 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'[1]. 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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