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Reasons of home births in the Hausa community in the peri-urban area of Mfou, Cameroon

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Abstract

Introduction: Home births (HBs) have a negative impact on maternal mortality, particularly in rural areas and regions where this practice is widespread. HBs are common in the northern of Cameroon and in communities in other Cameroonian cities where internal migrants from the northern and immigrants from the Central African Republic live. This study aims to describe the reasons for HB among women living in the Hausa neighbourhood of the Mfou health district in centre region of Cameroon.

Materials and methods: This is a descriptive study conducted among mothers residing and giving birth at home in the Hausa neighbourhood of the Mfou health district. With the help of a local guide, a comprehensive list of mothers known to have given birth at home at least once was compiled. The data collected during individual interviews using a questionnaire were entered and analyzed using Epi Info 7 software.

Results: A total of 57 mothers who had already given birth at home at least once were surveyed. The results show that, mothers in the Hausa neighbourhood mostly choose HBs because of the high cost of care in health centers (29.8%) and fear of going there (21%). Many of them feel in good health during home birth but lack confidence in their ability to give birth alone (73.8%). Despite the proximity of health centers (less than 5 km for 87%), 70% have no means of transportation, and nearly half have had a bad experience related to cost or quality of service. The choice of where to give birth is influenced by family and traditions, according to mothers. Mothers are calling for lower healthcare costs, greater respect for patients, and more information about the signs of labor during pregnancy.

Conclusion: Despite the proximity of health centers, economic, social, and cultural barriers lead many mothers in the Hausa neighbourhood to prefer home births, thereby limiting access to safe care. It is crucial to reduce costs of care, improve reception services while taking traditions into account, and raise awareness and improve transportation options to encourage births in health facilities.

1. Introduction

The high number of maternal deaths in certain regions reflects inequalities in access to quality health services and highlights the gap between rich and poor. In Cameroon, significant progress has been made over the past 30 years to provide universal access to sexual and reproductive health and rights for all [1].

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Since 2014, Cameroon has adopted national programs aimed at reducing mortality to a significantly lower rate, with a target of 140 deaths per 100,000 births by 2030. Maternal and child health remains a major challenge in Cameroon despite significant efforts to improve healthcare. In 2023, the maternal mortality ratio was 258 deaths per 100,000 live births. In the same period, the neonatal mortality rate was 25 deaths per 1,000 live births, and under-five mortality in 2024 was 67 deaths per 1,000 live births [2].

According to the World Health Organization (WHO), approximately 260,000 women died during or after pregnancy or childbirth in 2023, and 92% of all maternal deaths occurred in low- and lower-middle-income countries in 2023, most of which could have been prevented. Unlike Eastern European and South Asian countries, which have seen a significant decline in maternal mortality rates of 75% and 71% respectively, in sub-Saharan Africa, the maternal mortality rate remained very high in 2023, but nevertheless declined by 40% between 2000 and 2023 [3].

The main complications responsible for nearly 75% of maternal deaths are severe haemorrhage (mainly after childbirth); infections (usually after childbirth); high blood pressure during pregnancy (pre-eclampsia and eclampsia); complications during childbirth; unsafe abortion, HIV/AIDS, and others such as cerebral malaria, pulmonary embolism, and anaesthetic accidents [3, 4, 5].

Home births (HBs) contribute negatively to maternal mortality, particularly in rural areas and regions where this practice is widespread. Unassisted or poorly assisted HBs limit rapid access to emergency care in the event of complications such as haemorrhage, eclampsia, or infection, thereby increasing the risk of maternal death. This situation is exacerbated in contexts where medical evacuation systems are inadequate [6]. In Cameroon, the groups of women most likely to practice HBs are mainly located in the Far North and East of the country [7]. In some localities in the Far North, for example, where HBs are common, women prefer traditional birth attendants, beyond cultural requirements, because they are not only present throughout the village, but also flexible, as they allow women to defer payment for their medical services [8].

For several years now, there has been a movement of ethnic groups from the Northern and other regions of Cameroon to major cities such as Yaoundé, Douala, and their suburbs. These people are mostly young people looking for work, often accompanied by their wives and children, and they live in newly built neighbourhoods, often forming communities. In addition to these groups, there are immigrants from the Central African Republic and Nigeria. Most of these people live in precarious conditions. In the district of Mfou, in the Centre Region, located about 66 km from the city of Yaoundé, there is a Hausa neighbourhood populated mainly by Hausas from northern Cameroon and neighbouring countries. This study aims to describe the reasons for HB among women living in the Hausa neighbourhood of the Mfou health district in centre region of Cameroon.

2. Materials and methods

2.1. Type of study

This is a descriptive study conducted among mothers residing and giving birth at home in the Hausa neighbourhood of the Mfou health district. The study aims to assess the reasons for HBs among these mothers in this community.

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2.2. Study site and population.

The Hausa neighbourhood is in the Mfou health area, Mfou health district. In 2025, the Mfou health area had a population of 13,143, including 2,958 women of childbearing age and 481 women expected to give birth in the same year [9]. The main ethnic groups found in the municipality of Mfou are the Bene and the Ewondo. In addition to these, the most widely spoken foreign dialects in Mfou include Bamileke, Hausa, Bassa, Eton, Bamoun, and Fulfulde, etc. [10]. Mfou is a town located about 66 km from Yaoundé in Cameroon. The Hausa neighbourhood is a community made up mainly of people from the Northern regions of Cameroon, commonly known as Hausa, but it is not exclusively populated by Hausa people, as the name might suggest.

The target population of our study was women of childbearing age in the Hausa neighbourhood, and the study population was women present in the Hausa neighbourhood who had given birth to at least one child at home in the Hausa neighbourhood since the beginning of their stay in the community.

2.3. Sampling

This was an exhaustive sample of women who had given birth at home since the beginning of their stay in the Hausa neighbourhood in the Mfou health area. Only women who were present when the interviewer visited and who gave their free consent were included in the sample.

To identify mothers in households, we presented our study to the neighbourhood leader, who gave us his approval. With the help of a local guides, a route map of the neighbourhood was drawn up to enable access to all households. Five local guides, who lived in the neighbourhood, were from the same ethnic group as the target population and had a good knowledge of the customs and culture of the community, went door-to-door to identify and recruit women who had given birth at home during their stay in the community. The interviews were conducted by two investigators from the research team. Empty houses and/or those where the mothers were absent were excluded from the sample.

2.4. Data collection tools and processes

We used pre-tested questionnaires to collect data in the field. Interviews were conducted face-to-face in a quiet, secluded location, away from prying eyes, to reassure mothers of confidentiality and allow them to express themselves freely.

2.5. Ethical considerations

This study was approved by the Regional Ethics Committee for Human Health Research at the Center in Yaoundé, Cameroon. Approval No. CEN00980CRERSHC/2025 dated May 2, 2024. Data were collected only from participants who gave their free consent. The collection forms were anonymized to ensure the protection and confidentiality of the participants. The data collected were coded, entered, and stored in an Excel file. Access to the database was password-protected and restricted to those responsible for the study.

2.6. Data analysis

The data entered Excel were cleaned and imported into Epi Info 7.2.6.0 software for

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analysis. Measures of central tendency (mean and standard deviation, median and interquartile range) were used to describe quantitative variables or participant characteristics, while modes were used to describe qualitative variables. Proportions were calculated with a 95% confidence interval (CI).

3. Results

3.1. Demographic data

A total of 57 mothers who had given birth at home at least once were surveyed in the Hausa neighbourhood of Mfou in July 2025. The mothers' ages ranged from 22- to 62-year-olds, with a median age of 33 years and a standard deviation of 11 years. The mothers had given birth between 1 and 9 times, with an average of 2 births. Most mothers were single (38.6%), followed by married women (33.3%), and only one woman was divorced (1.7%). In terms of occupation, most of women were housewives (35.0%), followed by farmers (22.8%) and traders (17.5%). See Table 1 for more details.

Education level	Number	Percent	%IC	
None	7	12.28	5.08	23.68
Primary	23	40.35	27.56	54.18
Secondary	21	36.84	24.45	50.66
Higher	6	10.53	3.96	21.52
Marital status				
Single	22	38.60	26.00	52.43
Cohabiting	13	22.81	12.74	35.84
Divorced	1	1.75	0.04	9.39
Married	19	33.33	21.40	47.06
Widowed	2	3.51	0.43	12.11
Occupation				
Hairdresser	2	3.51	0.43	12.11
Shopkeeper	11	19.30	10.05	31.91
Farmer	13	22.81	12.74	35.84
Student	9	15.79	7.48	27.87
Civil servant	2	3.51	0.43	12.11
Housewife	20	35.09	22.91	48.87

***Table 1**. Distribution of participant demographic data*

3.2. Intrinsic constraints

The main reason given by mothers in the Hausa neighbourhood for choosing HBs was the lack of money to pay for care at the health center, cited by 17 mothers (29.8%, CI 18.4-43.4), followed by 12 (21.0%, CI 11.3-33.8) who cited fear of going to the health center; 10 women surveyed (17.5%, CI 8.7-29.9) described a positive experience with previous HBs and 06 (10.5%, CI 3.9-21.5) mentioned that labor was too short. A minority cited reasons such as personal preference, lack of transportation to the health

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center, and others, with 04 (7.0%, CI 1.9-17.0) for each reason. Other reasons cited by the mothers included: Familiarity and trust in local traditional birth attendants (“At the time, my mother delivered all the women in the village, so I didn't see the point of going to the hospital”); Lack of awareness of labor onset (“I didn't feel the contractions”); Practical or personal preparations that delayed hospital visit (“I wanted to finish my braids before leaving, but the baby didn't wait”); and Cultural or traditional recommendations (“my tradition recommends it”).

Most mothers self-assessed their health as good at the time of the HBs, i.e., 32 (56.1%, CI 42.3-69.2) and 18 (31.5%, CI 19.9-45.2) were unable to self-assess their health status during this period, but 07 (12.2%, CI 5.0-23.6) reported being in poor health at the time of the HBs. Conversely, 42 (73.8%, CI 60.3-84.4) reported not having confidence in their ability to perform HB independently, versus 15 (26.3%, CI 15.5-39.6) who had confidence in themselves. In addition, 41 (71.9%, CI 58.4-83.0) of the mothers reported having attended antenatal consultations (ANC) before the HB, versus 16 (28.0%, CI 19.9-41.5).

3.3. Challenges related to access to health services.

Most mothers also mentioned that the health center was less than 5 km from their household at the time of the HB, i.e., 47 mothers (87.4%, CI 70.0-91.2), versus 10 (17.5%, CI 8.7-29.95) estimating the health center to be between 5-10 km away. A total of 40 mothers (70.1%, CI 56.6-81.5) did not have a means of transportation to get to the health center during the labor, versus 17 (28.8%, CI 18.4-43.4) who did have a means of transportation. Although not in the majority (Table 2), 18 (31.5%, CI 19.1-45.2) mentioned, based on their previous experiences, that they did not receive a warm welcome at health centers. The cost of childbirth care in a health center was not affordable for 28 (49.1%, CI 35.6-62.7) mothers; 26 (45.6%, CI 32.3-59.3) mothers mentioned having had a negative experience at the health center during their last visits.

Distance between health center and household	Number	Percent	%IC	
Between 5 and 10 km	10	17,54	8,75	29,91
Less than 5 km	47	82,46	70,09	91,25
Availability of transportation?				
No	40	70,18	56,60	81,57
Yes	17	29,82	18,43	43,40
Friendly reception at the health center				
I don't know	11	19,30	10,05	31,91
No	18	31,58	19,91	45,24
Yes	28	49,12	35,63	62,71
Affordable cost of care at the health center?				
No	28	49,12	35,63	62,71
Yes	29	50,88	37,29	64,37

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Distance between health center and household	Number	Percent	%IC	
Negative experience at the health center				
No	31	54,39	40,66	67,64
Yes	26	45,61	32,36	59,34
Total	57	100		

***Table 2**. Factors limiting mothers' access to healthcare.*

3.4. Socio-cultural barriers

Among the mothers surveyed, 26 (45.6%, CI 40.6-67.6) acknowledged that their social circle encourages HBs. Only 14 (24.5%, CI 14.1-37.7) mothers acknowledged that community traditions and cultures influence the decision to practice HB. Half of the mothers, or 29 (50.8%, CI 37.2-64.3), stated that the place of delivery is decided by another family member, only 21.0% (CI 11.3-33.8) of mothers decide for themselves, and 28.0% (CI 16.9-41.5) decide with their spouse (Table 3). Most mothers also reported the presence of a midwife or traditional birth attendant in the community, with 38 mothers (66.6%, CI 52.9-78.6) stating this.

Does the entourage encourage the HBs?	Number	Percent	%IC	
No	31	54,39	40,66	67,64
Yes	26	45,61	32,36	59,34
Do traditions influence the HBs?				
No	43	75,44	62,24	85,87
Yes	14	24,56	14,13	37,76
Who decides where the birth will take place?				
Other family members	29	50,88	37,29	64,37
The spouse and mother	16	28,07	16,97	41,54
The mother	12	21,05	11,38	33,89
Is a midwife or traditional birth attendant available in the community?				
No	19	33,33	21,40	47,06
Yes	38	66,67	52,94	78,60
Total	57	100		

***Table 3.** Socio-cultural factors promoting home births.*

3.5. Mothers' proposals for improving access to health services.

Mothers said they would be more attracted to services offering lower-cost care. “Lower the cost of care, stop frustrating us. Not everyone has as much money as they do”, said one

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mother (F8). Mothers also called for more privacy and respect for themselves and their customs/patients in healthcare facilities. This was reflected in statements such as: "The whole healthcare system needs to be changed because we are traumatized by the healthcare staff. It's as if they lack humanity," said F43; "Respect for privacy by allowing only women to attend births," F27; "Respect for the privacy of pregnant women," F7; "Take into account the traditions of all women so that they do not feel frustrated." Mothers also asked to be better informed about the signs of danger and the signs of labor. "Inform women about the signs of labor and the birth plan," F14. Table 4 describes the frequency of mothers' suggestions for improving access to health services for pregnant women.

Suggestions	Frequency	Percent	%IC	
Nothing to say	11	31.43	16.85	49.29
Lower healthcare costs	9	25.71	12.49	43.26
Better inform us about danger signs and signs of labor	7	20.00	8.44	8.44
Respect and confidentiality for patients	5	14.29	4.81	30.26
Take everyone's customs into account	3	8.57	1.80	23.06
Total	**35**	**100.00**		

***Table 4**. Frequency of mothers' suggestions for improving access to health centers.*

4. Discussion

Our study consisted of describing the reasons why mothers gave birth at home in the Hausa neighbourhood of Mfou, in the Mfou health district. Our study population included only mothers who had already given birth at home and resided in the Hausa neighbourhood. The average age of the mothers surveyed was 33, like the results found by Hounkponou N.F.M et al. (2021) in Benin [11]. The mothers' parity ranged from 1 to 9, with an average of 2 births. Other studies had already shown that the lower the parity, the less likely women were to give birth at home [11, 12]. The work of Welffens K et al. (2016) also showed that mothers choosing home birth are multiparous and have better maternal outcomes [13]. In our study, most mothers were single. This could be explained by the fact that single and separated mothers give birth less often in healthcare facilities than married women due to financial difficulties [12]. Similarly, more than half of the mothers had less than a secondary education, exposing them to a higher risk of HB, as shown in the work of Nkurunziza M, (2015); Welffens K. et al., (2016); Hounkponou N.F.M et al., (2021) and Hailu D. et al., (2021) [11, 12, 13, 14]. Most mothers were housewives and therefore unemployed, and the lack of money to pay for care at health centers was one of the main reasons for HB, justifying the financial difficulty in accessing care [12, 15].

Several mothers mentioned fear of giving birth in health centers as a reason for choosing home birth in our study. This could be justified by fear due to medical-obstetric trauma, as shown by Valentin BS et al. (2019) [16]. Our study also showed that several women mentioned that a positive experience with a previous home birth was a reason for giving birth at home. According to Nkurunziza, M. (2015), older mothers, relying on their

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experience of motherhood, are more reluctant to give birth in a health facility. Mothers mentioned that a short labor was one of the reasons for home birth [12]. This could be explained by the fact that mothers often do not have time to reach health centers before giving birth because of a short labor.

Similarly, the work of J.W. Mukadi Wa Mpoy (2025) has shown that the unavailability of transportation is a factor associated with HB [15]; mothers in our study also mentioned that the lack of transportation to the health center contributes to HB. Other studies reveal that multiparous women and grand multiparous women give birth at home because of the rapid duration of labor and because of the experience gained during previous births [17]. The notion of experience gained was also mentioned by several mothers in our study. These positive experiences could also explain the confidence in giving birth at home as reported by some mothers.

Nearly 24.5% of mothers acknowledged that community traditions and cultures influence the decision to give birth at home, confirming the findings of Weldegiorgis SK et al. (2021) that societies where home birth is considered a common practice and the perception of the normality of labor are reasons for choosing home birth [18]. Other studies have also shown that home birth is considered a tradition in certain communities [19].

Our study revealed that, in nearly half of cases, the place of delivery is sometimes decided by family members, consistent with other studies. According to Sarker BK et al. (2016), "often, the mother-in-law forbids her daughter-in-law from going to the hospital because she herself did not go there to give birth. The importance of the opinion of elders, including mothers-in-law, remains a determining factor in decision-making regarding childbirth" [19]. Other members of the community, due to culture and the need to maintain privacy, have been mentioned by other authors. For example, in the study by Toja E et al. (2022), one mother stated, "When I was pregnant, a close member of my community advised me not to go to a health facility to give birth, because it meant exposing my privacy to strangers and they frequently inserted their hands, which is not part of our culture." [20]. This also shows women's lack of autonomy in decision-making regarding childbirth and their dependence on husbands and other family members, as found by Sialubanje C et al. (2015) [21]. More than 66.6% of mothers also mentioned the presence of a midwife or traditional birth attendant in the community. This also contributes to the decision to give birth at home. Other studies have shown that in some communities, many births after attending prenatal care are assisted by traditional birth attendants, experienced women, and relatives. This is because childbirth requires the assistance of a trusted person who is well known in the community [20].

A minority of mothers in our study stated that the couple themselves decided on the place of delivery (21.0% by the mother and 28.0% by the spouse). This confirms the work of Toja E et al. (2022), according to which the personal beliefs of women giving birth have a significant influence on their preference for the place of delivery [20]. One of the recommendations made by the mothers in our study was to ensure privacy and respect for women's customs in healthcare facilities.

Mothers mentioned that they would be more attracted to services offering lower-cost care. This could be justified by the fact that poverty is the most frequently cited reason for preferring home births with a traditional birth attendant in certain communities [19].

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5. Limitations of the study

The descriptive and cross-sectional nature of our study limits the possibility of establishing causal relationships between the factors identified and the choice to give birth at home. Our exhaustive sampling, conducted only among women present at the time of the survey in the Hausa neighbourhood, may introduce selection bias, thus excluding those who were absent or had moved away. The study focused on a single specific community, which limits the generalizability of the results to other ethnic or geographic contexts.

6. Conclusion

Despite the proximity of health centers, economic barriers, lack of trust, negative experiences, and socio-cultural influences lead many mothers in the Hausa neighbourhood to prefer home births. These constraints limit access to safe obstetric care, potentially increasing risks for both mother and child. It is essential to reduce the cost of care and improve the quality of care in health centers, while respecting women's traditions and privacy. In addition, raising awareness of danger signs and prenatal care, as well as facilitating transportation, will help encourage deliveries in health facilities.

Conflicts of interest

The authors have no conflicts of interest.

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