

The Discordance between Antenatal Care Attendance and Skilled Birth Attendant at Delivery in the Niger Delta Region of Nigeria.

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Abstract

Background: Maternal mortality is unacceptably high in Nigeria. A skilled attendant at birth has been recognised as the single best measure against maternal mortality. Yet, a large proportion of women register for antenatal care services in the hospital but choose to deliver in unorthodox facilities.

Objective: This study aims to determine the reasons why women book for antenatal care in hospitals but don't deliver there, and where they go for delivery.

Methods: This is a cross sectional study using random sampling technique. Semi-structured questionnaires were administered to participants who had consented to the study and the data was analysed using SPSS Windows version 20.0. Significant level was set at $P < 0.05$

Results: 378 women participated in the study. The mean age was 27.66 years \pm 5.15. Most respondents were Christians and most had at least a post secondary level of education. They booked for antenatal care primarily to access care when ill and to receive immunization and be screened for the Human Immunodeficiency Virus. They did not deliver in the hospital because of sudden onset of labour and because labour occurred in the night, as well the fear of caesarean section and high cost of delivery. Most respondents delivered in church, at traditional birth attendants and at home. Those who claimed to deliver in other hospitals were of the minority. There was a statistically significant association between increasing parity and delivery in unorthodox facilities.

Conclusion: To encourage deliveries with skilled birth attendants, it is necessary to re-emphasize rigorous, comprehensive health education; incorporate trained TBAs in orthodox health care to encourage timely referral, and equip health centre annexes for churches who offer obstetric care. Also there should be improvement in contraception utilisation and implementation of focused antenatal care.

Key Words: Discordance, Skilled birth attendant, Traditional birth attendant, Maternal Mortality

I. Introduction

The problem of maternal mortality continues to plague the developing world, Nigeria inclusive and the year 2015 has come and gone but the target of the millennium development goal 5, to reduce maternal mortality by 75%, has not been met[1,2].

The World Health Organization estimates that approximately 600,000 maternal deaths occur worldwide annually, with 99% of these deaths occurring in the developing world[3]. Nigeria is said to contribute 10% to the annual estimate of maternal mortality[4]. Indeed, recent statistics still make for grim reading: there were 576 maternal deaths per 100,000 live births between 2008-2013[5]. And for every maternal death, there is, apart from high perinatal wastage, the hidden cost of subsequent problems of fertility and damage to reproductive organs[6].

It is estimated that greater than 80% of maternal deaths are due to direct obstetric complications i.e haemorrhage, sepsis, hypertensive disorders, unsafe abortion and obstructed labour[7]. Most of these conditions cannot be predicted but they can be treated with simple readily available means[8]. These complications occur even in normal pregnancies. Indeed, it has been shown that some women who had apparently normal antenatal periods develop these problems in labour and the puerperium and some of them die[9]. Thus even though antenatal care is an acknowledged measure for reduction of maternal mortality and morbidity, this favourable outcome is noticed in patients who receive antenatal care and deliver in orthodox health care facilities where skilled attendance is available[9]. Thus there is a strong association between skilled care at delivery and lower levels of maternal mortality[10]. In 1999, the United Nations General Assembly recommended that countries use the process indicator of skilled attendant at delivery as a benchmark indicator to measure progress towards reducing maternal mortality and morbidity[11].

Yet in Nigeria, there is a disparity between antenatal care attendance and delivery in orthodox facilities[5,12]; and most women prefer to deliver in churches, at home and in traditional birth attendant places.

The aim of this study was to determine why women book for antenatal care in the hospital in the first place, but decide to deliver in unorthodox facilities without a skilled attendant. This information, it is hoped will guide programming and initiate measures that will increase the hospital delivery rate among our booked patients and ultimately lead to a reduction in the maternal mortality and morbidity in our environment.

II. Materials And Methods

This cross sectional study was conducted between February 2015 and May 2015 in three hospitals in Akwa-Ibom State: Iquita General Hospital, Oron; Saint Luke's Hospital, Anua, Uyo; and the University of Uyo Teaching Hospital after approval of the study by the ethical review committee of the University of Uyo Teaching Hospital. The Iquita General Hospital Oron and the Saint Luke's Hospital, Anua are secondary health care facilities and offer comprehensive emergency obstetric care. All the hospitals are situated in thickly urban populations. Akwa Ibom State is in South-South zone in the Niger Delta of Nigeria with a population of approximately four million people.

The study population were pregnant parous women who booked for antenatal care in their last pregnancy but delivered elsewhere. Primigravid patients were excluded from the study. A cross sectional formula of $N = \frac{Z^2pq}{d^2}$ and a P of 31.5% was used to determine sample size, being the proportion of women who refused delivery at a health facility because of high cost in Akwa Ibom State of Nigeria Demographic and Health survey, NDHS 2013)

$$N = 1.96 \times 1.96 \times 0.315 \times 0.685 / 0.0025 = 331.6 = 332.$$

$$\text{Adding 10\% of non response rate} = 10/100 \times 332 = 364.$$

Three hundred and ninety women were selected in the antenatal clinic by simple random sampling after explanation of the nature of the study and assurance of confidentiality of information given. Pretested, semi-structured questionnaires were distributed to consenting women by trained research assistants. The questionnaires had sections on the sociodemographic characteristics of the respondents, their previous place of delivery, reasons for nondelivery in health facilities, the people who decide where the respondents deliver. Three hundred and seventy eight women filled the questionnaires correctly and data analysis was based on these.

Data was analyzed using SPSS for windows version 2.0 (SPSS Inc, Chicago IL, USA) and presented in simple table. Descriptive statistics was done for continuous variables while categorical variables were summarised using frequencies and percentages.

Association between selected variables and place of delivery of respondents was compared using Chi-square. Level of significance was set at 5% ($P < 0.05$)

III. Results

The majority of the respondents were between 20-34 years of age, 303(80.2%) with a mean age of 27.7 years, and were married (96.0%) while 226 (59.8%) were unemployed. Only 12 (3.2%) of the respondents did not have a formal education with 236 (62.4%) having secondary level education. Two hundred and forty two (64.0%) of the respondents were resident in an urban area while 136 (36.0%) were residents in rural communities (TABLE 1).

The type of facility the women delivered in their previous pregnancy is shown in TABLE 2. The church was the most preferred facility for delivery 134(35.4%). One hundred women (26.5%) delivered in a TBA's place while 91 (24.1%) delivered at home

The most common reason given by respondents for not delivering in hospital was that labour started in the night 128(33.9%). Other common reasons included sudden labour 108 (28.6%), fear of caesarean section 70(18.5%), no means of transportation 68(18.0%) and long distance of health facility 66(17.5%) (TABLE 3)

In 124(32.8%) of the cases both patient and her husband decide where delivery will take place. In 124(32.8%) of the cases the patient decides by herself while friends and the pastor are those that decide in 8(2.1%) respectively. (TABLE 4).

In (TABLE 5) selected variables were explored against the place of last delivery. These included residence(urban or rural) education, employment, distance to facility, and parity. Only increasing parity was statistically significant with regard to delivery in unorthodox places.

The reasons the women gave for booking for antenatal care in hospital included to have access to hospital when ill 239(78.6%), to receive immunisation 71(23.4%) and to get screened for HIV 45(14.8%)

IV. Discussion

This study shows that a lot of our women despite booking for antenatal care still prefer to deliver in unorthodox health facilities. This is in agreement with several other studies[5,13,14]. This occurs despite the fact that a skilled birth attendant at delivery has been shown to be essential in reducing maternal mortality and this was not present in such places[15-19]. The majority of the patients were aged between 20 and 34, the peak period of their reproductive life [20].

They were mostly resident in urban areas and the majority had at least a secondary school level of education. This is in contrast to several studies which show a positive relationship between mother's education and urban residence and attendance at antenatal care and supervised delivery[21,22]. However, this study was conducted in thickly urban areas where most of the patients live. Also, some studies in a similar society such as ours, have shown that formal education may not change the faith of a highly educated woman[23,24].

Most of these patients were unemployed. This is in agreement with other studies which show the relationship between financial capability and supervised delivery in health care facility[25,26]. The poorer the patient is the less likely she is to access skilled care. The study showed that most of the women delivered in churches or at traditional birth attendant. This is in agreement with other studies conducted in the Niger Delta Region of Nigeria[27-30]. The role of spiritual churches in antenatal clinic default has been elucidated[31]. This is even so when it has been demonstrated that when women deliver in these churches, the outcome is worse than delivery anywhere else[31]. The reasons adduced for the patronage of these churches include spiritual attack by wicked people, prophetic warning from the church and divine blessings for the babies born in the church[31]. Indeed, it has been found that the need for divine intervention in the labour process may drive these parturients to church [32].

As much as 22% of deliveries in Nigeria are conducted by TBAs even though there is a high incidence of complications in such deliveries[5]. The presence and role of TBAs in rural areas is well-known, especially because here there are inadequate health facilities and skilled attendants[33]. What is less well known is the presence and utilisation of these TBAs in urban areas[34]. This is illustrated in this study and emphasises the strong cultural affinity for these services. Kleinman has demonstrated how the difference between a medical model, considered intrinsically alien, and strong cultural belief systems can impair orthodox health seeking behaviour[35]. TBAs are more culturally attuned to the belief systems of patients and are seen to be more empathetic, as well as cheap. They are therefore heavily patronised. Restricted socio-cultural gender roles for women, may further drive these women to deliver in TBAs.

The common reasons given for not coming to the hospital to deliver include sudden labour/labour at night, fear of caesarean section, no means of transportation, long distance of health facility and high cost. Birth preparedness and complication readiness is the process of planning for normal birth and anticipating the actions needed in an emergency[36]. It is hoped that with the implementation of focused antenatal care, which includes birth preparedness, sudden labour and labour at night will no longer serve as a reason for not delivering in hospitals.

Fear of caesarean sections was another major reason for not delivering in hospitals. This is supported by several studies[37-39]. The reasons given for opposition to caesarean section include denial of womanhood, fear of scorn from other women, and the risk of dying from the procedure. It is therefore necessary to educate the people on the role caesarean section plays as an alternative to hazardous vaginal delivery, and to critically examine caesarean delivery and suggest alternative measures where feasible[30].

Financial constraints and lack of transportation are also major obstacles to accessing skilled attendance at delivery as shown in this study. This agrees with other studies[40,41]. It is therefore essential that pregnant women and their family save money for delivery. However, the issue of transportation may go beyond good roads. Institutional barriers, including financial cost and socio-cultural factors, may limit the advantage of shorter distances[42].

In a majority of instances in this study the husband decides where the woman delivers. This underlines the need to involve the husband personally in every decision about management of the patient.

In table 5, the association between selected variables and place of last child delivery was explored. Only increasing parity was found to be statistically significant for delivery in unorthodox places. Indeed, the latest report from the national demographic and health study shows that birth order, with increasing parity, is inversely associated with the likelihood of a birth being assisted by a health care provider[5].

Thus, it is shown that social, cultural, economic and political, biological considerations modulate the behaviour of pregnant women who seek care. This complex interaction means that even when skilled care is available some women may not seek it, or receive it[22].

V. Conclusion

To reduce the maternal mortality rate, every woman should have a skilled attendant at birth. However a significant proportion of our women continue to deliver in unorthodox places even after booking for antenatal care in hospitals. To discourage women from delivering in unorthodox facilities or make it safer we recommend as follows:

- : Continuous and rigorous health education on the benefits of delivering with a skilled attendant. This education should not only be personal, but also communal.
- : Raising women's status through sustainable poverty alleviation programs as well as eradication of poverty.

- : Reducing the cost of health care generally, and through a national health insurance scheme which extends to the grassroots, not just civil servants.
- : Training and retraining TBAs to recognise signs of difficult labour and encourage them to refer to orthodox care.
- : Setting up of a properly equipped health facility, with government oversight functions, near churches which engage in obstetric practices.
- : Education of the community on the importance and safety of caesarean section as an alternative to hazardous vaginal delivery.
- : Enlightenment to improve on the current contraception utilisation of 2%⁵ to limit family size.
- : Comprehensive implementation of focused antenatal care.

What is known about this topic.

- A skilled birth attendant at birth is necessary to reduce maternal mortality.
- Most women in Nigeria deliver in unorthodox places where skilled birth attendants are lacking.
- Traditional birth attendants are patronised mostly in rural areas where health care facilities are lacking.

What this study adds.

- Traditional birth attendants are heavily patronised in urban areas.
- Increasing parity is associated with delivery in unorthodox places.
- Socio-cultural factors may prevent educated women from accessing health in orthodox facilities.

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Results

Table 1. Sociodemographic Characteristics Of Respondents: N=378

Characteristics	Frequency	Percentage
Religion		
Christians	376	99.5
Islam	2	0.5
Age group		
Less than 20	25	6.6
20-34	303	80.2
35-49	50	13.2
Educational Status		
No formal education	12	3.2
Primary education	74	19.6
Secondary education	236	62.4
Post secondary education	56	14.8
Marital Status		
Married	96.0	96.0
Single	12	3.2
Divorced	1	0.3
Widow	2	0.5
Employment Status		
Employed	152	40.2
Not employed	226	59.8
Residence		
Urban	242	64.0
Rural	136	36.0
Parity		
1	119	31.5
2-4	229	60.6
5 and above	30	7.9

TABLE 2: Previous Place Of Delivery Of Respondents: N: 378.

CHARACTERISTICS	FREQUENCY	PERCENTAGE
Church	134	35.4
TBA	100	26.5
Home	91	24.1
Unknown maternity homes	53	14.0

TABLE 3 : Reasons For Non Delivery In Health Facilities: N:378

REASONS	FREQUENCY	PERCENTAGE
Labour at night	128	33.9
Sudden labour/delivery	108	28.6
Fear of caesarean section	70	18.5
No means of transport	68	18.0
Long distance of health facility	66	17.5
High cost	65	17.2
Staff on strike	50	13.2
Delays at health facility	43	11.4
Previous deliveries not in hospital	38	10.1
Poor staff attitude	34	9.0
Disallowed by family members	28	7.4
Forbidden by the voice of God	27	7.1
Care providers not compassionate	27	7.1
No staff at night	23	6.1
Poor quality of service	20	5.3
Lack of staff	16	4.2
Poor privacy	13	3.4
Secrets not maintained	4	1.1

TABLE 4: WHO DECIDES WHERE WOMEN DELIVER: N: 378.

VARIABLES	FREQUENCY	PERCENTAGE
Both wife and husband	125	33.1
Myself (wife) alone	124	32.8
Others	82	21.7
Wife's mother	26	6.9
Friends	8	2.1
Pastor	8	2.1

TABLE 5: Association Between Selected Factors And Place Of Delivery Of Last Child: N:378

VARIABLES	PLACE OF DELIVERY				TOTAL	TEST OF STATISTICS AND STATISTICAL VALUES
	HOME	TBA	CHURCH	HOSPITAL		
Age group(yrs)						
Less than 20	4 (4.4)	11 (11.0)	10 (7.5)	0 (0.0)	25	X ² 10.581 DF 6 P= 0.086
20-34	74 (81.3)	79 (79.0)	108 (80.6)	42 (79.2)	303	
35-49	13 (14.3)	10 (10.0)	16 (11.9)	11 (20.8)	50	
Residence						
Urban	53 (58.2)	68 (68.0)	81 (60.4)	40 (75.5)	242 (64.0)	X ² 5.767 DF 3 P= 0.124
Rural	38 (41.8)	32 (32.0)	53 (39.6)	13 (24.5)	136 (36.0)	
Employment						
Employed	40 (44.0)	35 (35.4)	54 (41.2)	22 (41.5)	151	X ² 1.589 DF 3 P= 0.659
Unemployed	51 (56.0)	64 (64.6)	77 (58.8)	31 (58.5)	223	
Education						
No formal edu	3 (3.3)	5 (5.0)	4 (3.0)	0 (0.0)	12 (3.2)	X ² 16.026 DF 9 P=0.066
Primary	20 (22.0)	23 (23.0)	28 (20.9)	3 (5.7)	74 (19.6)	
Secondary	59 (64.8)	58 (58.0)	83 (61.9)	36 (67.9)	236 (62.4)	
Post sec.	9 (9.9)	14 (14.0)	19 (14.2)	14 (26.4)	56 (14.8)	
Religion						
Christians	91(100.0)	98 (98.0)	134 (100.)	53 (100.0)	376	X ² 5.590 DF 3 P= 0.214
Islam	0 (0.0)	2 (2.0)	0 (0.0)	0 (0.0)	2	
Distance to Facility						
< 30 minutes	43 (47.3)	59 (59.0)	73 (54.5)	30 (56.6)	205	X ² 2.825 DF 3 P= 0.424
>=30minutes	48 (52.7)	41 (41.0)	61 (45.5)	23 (43.4)	173	
Employment						
Employed	40 (44.0)	35 (35.4)	54 (41.2)	22 (41.5)	151	X ² 1.589 DF 3 P= 0.659
unemployed	51 (56.0)	64 (64.6)	77 (58.8)	31 (58.5)	223	
Parity						
1	35 (38.5)	40 (40.0)	38 (28.4)	6 (11.3)	119	X ² 21.615 DF 6 P= 0.001**
2-4	47 (51.6)	55 (55.0)	82 (61.2)	45 (84.9)	229	
5 and above	9 (9.9)	5 (5.0)	14 (10.4)	2 (3.8)	30	

**Statistically significant p value.