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Factors Militating Against the Attainment of Millennium Development Goals (MDG4) In Bayelsa State.

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Abstract: *The Millennium Development Goals (MDGs) are 8 international development goals that came out of the Millennium Summit of the United Nations in 2000. These goals were voluntarily adopted by 189 nations in an attempt to comprehensively address global poverty, hunger, maternal and child mortality, communicable disease, education, gender inequality, environmental sustainability, and a global partnership for development.The study aimedat exploring the factors that militate against achieving the millenniumdevelopment goals (MDG4) in Bayelsa State.Transcendental phenomenological research design was adopted, using non-probability sampling technique and purposive sampling methods to obtain data from 15 participants. Validity and reliability was based on criteria for trustworthiness in a qualitative research. Instrument for data collection was semi-structured in-depth interview guide and tape recorder, with an in-depth face-to-face interview that lasted between 10-45minutes per participant. Data were analyzed using Colaizzi's seven steps of data analysis. Result shows thatmajority of the women were below the ages of 36years. Demographic data equally presents 60% of the women in business, 26.6% full housewives, and 6.7% Artisan, and Civil Servant respectively. In addition 20% had Tertiary education, 46.7% had SSCE, and 33.3% hadFSLC. Moreso, 93.3% had delivery at home (40% by nurses and 6.7% by midwife) and 6.7% in the church. It was also revealed that most women stay 3 to 4 monthsat least before booking for antenatal care and on average had attended up to 4 times before their delivery. Factors militating against MDG4 were previous experiences of the women, availability of TBA's in the family, religion, fear of caesarian sections,and level of education. Findings revealed interplay of family and personal factors as major militating factors against millennium development goal attainment in Bayelsa state.*

Keywords: *personal, family factor and MDG*

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I. Introduction

The Millennium Development Goals (MDGs) are 8 international development goals that came out of the Millennium Summit of the United Nations in 2000[30] These goals were voluntarily adopted by 189 nations in an attempt to comprehensively address global poverty, hunger, maternal and child mortality, communicable disease, education, gender inequality, environmental sustainability, and a global partnership for development. Maternal and child mortality is widely regarded as one of the best measures for the overall health and socioeconomic status of a country[33,35]. The fourth MDG (MDG4) aimed to reduce the under-five child mortality rate by two-thirds.The Millennium Declaration set out development aims that the world would strive to meet by 2015[30].Which include a set of health-related aspirations, known as the Millennium Development Goals (MDGs).They have focused the global community's attention and funding on specific health-related issues. Thus, MDG4 set out to reduce by two-thirds the death rate of children aged <5 years ('under-five mortality rate'-U5MR), between 1990 and 2015.

Child birth safety includes both labour and delivery; ie, it refers to the entire process as the baby makes its way from the womb down the birth canal to the outside world[6]. Although, vaginal delivery is the most common and safest type of childbirth, when necessary in certain circumstances, forceps (instruments resembling large spoons) may be used to cup the baby's head and help guide the baby through the birth canal. Vacuum delivery is another way to assist delivery and is similar to forceps delivery. In vacuum delivery, a plastic cup is applied to the baby's head by suction and the health care provider gently pulls the baby through the birth canal. However, vaginal delivery may not always be possible, hence caesarean delivery (C-section) may be necessary for the safety of the mother and baby, especially if one of these complications is present such as big baby, transverse or oblique lie and breech presentation where there will be difficulties for the baby to pass through the pelvis or there is foetal distress. Most often, the need for a caesarean delivery is not determined until after labour

begins. Once a woman has had a caesarean delivery, future deliveries may be done by caesarean section. That's because surgery done on the uterus increases the risk of it rupturing during a future vaginal delivery[13]. The birth environment has a profound effect on how labour progresses and on how women remember their birth experiences and that the place of birth should provide a distraction-free, comfortable, supportive and reassuring environment for mothers and their families. Women need to remain confident, have freedom to respond to their contractions in any way that works for them and have continuous emotional, psychological, and physical support throughout labour[15].

The present paper aims to identify and describe factors that militate against the attainment of Millennium Developmental Goal (MDG4), in Bayelsa State. It is necessary to reflect on the challenges pertinent to attaining this outcome to guarantee the most effective and sustainable interventions developed for the Sustainable Developmental Goals (SDGs) 2030.

In line with the above,21st century was marked by a global commitment to meet the MDG outcomes in 2015. This was a promising endeavour to benefit populations at large as countries were provided with indicators serving as a compass to give strategic direction to service delivery, and that enabled countries to prioritize their goals[17].Organizations such as the African Union Commission, the United Nations Economic Commission for Africa, and the African Development Bank were applauded for their response to ensure that Africa addressed the factors that might militate to attaining the MDGs[17].Over the past 5 years, the MDG implementations have shown eminent improvements towards attaining some of the MDG outcomes. However, it is also clear that some countries, including Nigeria, still face challenges in achieving the targeted outcomes.[17,18,19]

Consequently, there has been least progress regarding this element of the Under-5years Mortality Rate (U5MR): the proportion of U5MR accounted for in the neonatal period had risen from 37% in 1990 to 42% in 2010[14]. Between 1990 and 2010 the U5MR fell by just 35%,[31] but this rate of decline is accelerating. In 2010 approximately 7.7 million children died before their fifth birthday[25]. Some regions (such as North Africa) have been successful at reaching their MDG4 targets, but the U5MR in Sub-Saharan Africa and Oceania had only fallen by 30% by 2010[31]. Almost all regions have seen slower declines in their neonatal mortality rate than U5MR[31].Studies have shown that annually there are approximately 2.1 million neonatal deaths[25]. One million of these deaths occur as a consequence of premature birth[14]. Although there has been substantial progress towards MDG4, with 31 countries on target to reach their goals, 23 countries in Sub-Saharan Africa are unlikely to achieve MDG4 targets before 2040[16]. Where countries have progressed rapidly, the common theme is a governmental commitment to make the required improvements.

For example, the global under-five mortality rate has declined by more than half since 1990, from 12.7 million to about 6 million in 2015[9]. However, progress has been uneven, with some countries achieving many goals while others achieved very few, if any, of the established targets. Tracking of progress under the MDGs has also been impeded by gaps, discrepancies, and reporting delays in data[7]. The United Nations Millennium Development Goals Task Force Reports on Child Health and Maternal Health declared that one of the largest barriers to providing interventions and achieving MDGs was the lack of properly trained healthcare providers distributed across the globe[9]. The WHO estimates that healthcare systems comprised of fewer than 23 healthcare workers per 10,000 population are unable to properly deliver necessary health services to a given region[36]. Several studies from across the world have suggested that an increase in physician or skilled healthcare worker density can produce a significant reduction in maternal and child mortality rates[21,28].

2015 marked a significant milestone on a critically important journey, but reminds us of how far we have gone as a country. Even in low-income countries that have achieved MDG4, one child in 12 dies before the age of 5 years, compared with one in 147 in high-income countries[32]

More so, the worldwide mortality rate of children younger than 5years has fallen by 53% between 1990 and 2015, a reduction resulting in 6·7 million fewer children dying in 2015 than in 1990, despite the overall increase in population. This reduction has mostly occurred since 2000; the rate of decreasing mortality is 2-3-times greater after 2000 than in the decade before. This spectacular global improvement, which says a lot for the value of setting goals, nevertheless fails to reach the 67% reduction prescribed in MDG4. However, of 195 countries with available data, 62 (32%) have individually achieved the two-thirds-reduction goal: 12 of these being low-income countries, ten of them in sub-Saharan Africa[4].

Currently, Bayelsa State has adopted the National Development Plan (NDP) 2030 vision that incorporates the SDGs as new interventions. It is therefore crucial to examine previous MDG reports to evaluate the challenges experienced during the programme implementation. Evaluating these reports will assist in recommending strategies to facilitate attaining the SDGs 2030 within the NDP. Additionally, the information will assist in monitoring and evaluating programmes for the SDGs 2030.

II. Methodology

A transcendental (descriptive) phenomenological research design was adopted. The transcendental is used to describe the peoples lived experiences, while the phenomenological is used to investigate subjective phenomena[29].

The study was carried out in Bayelsa State, made up of 3 senatorial zones (East, West and Central). However, the study was conducted in the Central Senatorial District, using the following health centre's - Family Support Programme (FSP) Clinic Yenagoa, Comprehensive Health Centre Agudama-Epie (CHCA) and General Hospital Amassoma (GHA). These facilities are situated in the state capital Yenagoa, having 28 villages with 8-Health Centre's, while the Amassoma health centre is located in Amassoma community, which is the only motorable community among the 5 villages in Ogboin Clan having 2-Health Centre's. These facilities were consideredbecause of convenience, accessibility and availability of personnel which has contributed to the increase patronage.

The target population comprised of all women who have attended antenatal care during pregnancy, but delivered their babies at home, TBA's homes, Churches or other faith based centres other than health facility they booked.

A sample size of 15 women was used. This is in accordance with recommendations from Spezaile& Carpenter[29] that in descriptive phenomenological approach, a sample size of 10 to 15 are adequate provided participants are able to provide rich description of the phenomenon.Sorting out the real participants was done by asking three pertinent questions: The booking status, regular attendance and place of delivery. Only those who booked, attended clinics but delivered outside the health facility were eligible for the study.

Data saturation was ensured when the researcher observed that in each facility, from participant 4 to participant 5, no new information was elicited.A semi-structured researcher's developed interview guide was used, which guided the in-depth interview that helps to prepare for data collection using face-to-face interviews[22].

Face and content validity was done in line with qualitative research, expressed through credibility and transferability and reliability was expressed in two ways,dependability and conformability. This procedure helps the participants to ascertain if their answers to any questions need to be ratified, and ensures that the researcher has not misinterpreted the data[24.] Using the Individual In-depth Interview guide,data was generated using interview notes and a digital audio tape recorder and participants were encouraged to talk freely and to tell stories using their own words. Each interview lasted a maximum of 45 minutes.

The data was analyzed using Colaizzi's seven steps of data analysis method[26]. Polit and Beck[24] point out that Colaizzi's data analysis method is the only phenomenological analysis that calls for the validation of results by returning to study participants.

III. Results

Table 1: Socio-demographic characteristics

n=15

Variables	Frequency (*f*)	Percentage (%)
Age		
16 – 20	3	20.0
21 – 25	9	60.0
26 – 30	1	6.7
36 – 40	2	13.3
Occupation		
House Wife	4	26.6
Business	9	60.0
Artisan	1	6.7
Civil Servant	1	6.7
Educational Status		
FSLC	5	33.3
SSCE	7	46.7
Tertiary	3	20.0
Place of Delivery		
Home	14	93.3
Church	1	6.7
Delivered by		
TBA	8	53.3
Midwife	1	6.7
Nurse	6	40.0
No of Months Before Booking		
3 – 4	8	53.3
5 – 6	1	6.7
7 – 8	6	40.0
No of Times Attended ANC Before Delivery		

1 – 3	8	53.7
4 – 6	7	46.3

The study result shows that only 2, among the women ware up to the ages of 36years and above. While, 9 (60%) of the women are engaged in business, 4 (26.6%) are full housewives, and 1(6.7%) Artisan, with 1(6.7%) Civil Servant. In addition, only 3 (20%) of these women have obtain Tertiary education, 7 (46.7%) had SSCE, and 5 (33.3%) have FSLC. More so, 14 (93.3%) of the women had delivered their babies at home and just 1 (6.7%) had delivered in the church. On the other hand, 8 (53.3%) of the women were delivered at home by a TBA, while 6 (40%) by nurses at home and 1 (6.7%) by a midwife. It also revealed that most mothers stay 3 to 4 months at least before booking for antenatal care and on average had attended up to 4 times before their delivery.

Table 2: Personal factors that informed decision to deliver outside the health facility of booking.

Major themes	Significant statement	Meaning
Theme I [personal factors]	*I gave birth to my first daughter…. So I just decided to go there because I like that native way....*	Respondent prefers to deliver at the TBA because of her previous experience with the place.
	The TBAs are very caring during delivery than those in the hospital.... they really took time to care for you…they even pet you most times.	The preference of the TBA here is because of the way she was handled by the TBA.
	I will never go to the hospital to deliver because of the scissors they normally use and some other fear they create in me in the hospital like operation	Fear of sharp objects and recommendations for CS are the reasons why some of the respondents prefer TBA than their facility of booking.
	.....Absent of workers in the health facility, most times you will go there to get treated you will meet locked down facility.	Health worker not being available at the health facility also de-motivates the pregnant women from using the health facilities during delivery.
	The TBA is more caring during delivery to the pregnant woman. In the hospital the nurse use to shout, hay shot up...dontshout…dont make niose…do this, do that...but the TBA people usually pet you...sorry o baby will soon come...hence, I prefer them to hospital".	The issue of quality of care by TBA's is emphasized by respondents as a factor for delivering outside the facility of booking to hospital.

Personal factors that informed decision to deliver outside the health facility of booking *(previous experience, fear of Caesarean Section and unavailability of health workers)*

Previous Experiences

People's past experiences with the TBA's tend to influence future use. Women in particular openly talked and gossiped about their past experiences with the TBA's. These include their interaction with care providers and their perceived quality of services.

Fear of Caesarean Section (CS)

Some of the participants complained bitterly for fear of sharp objects and recommendations for Caesarean Section.

Unavailability of health workers

Some participants expressed concern on the non-availability of health workers in the facilities mostly when a woman is in labour and gets to the facility only to meet no one on ground.

Table 3: Family factors that informed decision to deliver outside the health facility of booking.

Major themes	Significant statement	Meaning
Theme II [Family factors]	*The reason why I delivered in the church is because I was having problem in my marriage and I heard a voice in my sleep that I should go there and deliver my baby.*	The respondent delivered outside the facility of booking as a result of misunderstanding in her marriage, so the only place she can find peace to deliver is the church.
	I told them to take me to the hospital, but they said I shouldn't worry, I will deliver safely and will be alright...it was my mother in-law that delivered me,…she is a TBA.	Against the wishes of the respondent, she was delivered at home by her mother in-law who is a TBA.

Religious Belief	*My friends, and my father in-law refused taking me to the hospital because my husband is not around, so I was convinced to deliver at home by a TBA.*	Preference of family for TBA over facility of booking reflects why she delivered at the TBA place.
	The only reason is that God spoke to me to deliver at the church.	
	As a Christian we listen to God. My pregnancy was more than 9months and the delivery took time. If is hospital they would have operated me. After the deliver, I saw why God directed me to there.	The respondent claims to hear the voice of God instructing her to deliver at the church. The participant claims God revealed that she should deliver at church.

Family factors that informed decision to deliver outside the health facility of booking *(Religious affiliation, Preference of family/friends, Presence of TBA in the family)*

Religious affiliation

There is this claim by women who have tied their reason of delivering outside (churches) to directives from God. This religious believe prevented some women from visiting the health facility and using a SBA during delivery.

Preference of family/friends

Women's lack of autonomy in decision making also affected hospital delivery because their husband or head of household decide whether they should access health care or not. Indeed, some families prevented women from going to the health facility. A participant said:

Presence of TBA in the family

Central to participants' narratives was the perception of a strong shift toward community (TBA's) endorsement of the biomedical model of pregnancy and delivery care.

IV. Discussion of Findings

Socio-demographic characteristics

From the study, 14 (93.3%) of the mothers had delivered at home, but 6 (40.0%) of the participants still prefer to be delivered by nurses. This statistics revealed that even at home, most of the mothers still prefer to be delivered by a trained skilled nurse. This however shows that mothers still pose a lot of confidence on the knowledge and skill of the trained nurses in handling delivery. In addition, the study showed that only 3 (20%) of these women have obtain tertiary education. Knowledge they say is power. This is in line with Ikeako& Iloabachie[12]that the low level of education also contributes to out-of-hospital delivery. In support,Gabrysch, Cousens, Cox & Campbell[11], also identified poor education and marital status as individual factors contributing to out-of-hospital delivery.More so, well documented socio-demographic data by Simkhada, Teijlingen, Porter, Kadel, Stephen & Sharma et al[27],indicate that women with low levels of education are less likely to access antenatal services, even if they are provided. While Ali, Osman, Abbaker& Adam[1], added that having husband with a low level of education have been identified as barriers.A participant had narrated that she prefer to deliver at home because during the antenatal clinic they have received all the necessary treatment and also been assured that they (mother and baby) are fine. This for sure could make mothers feel more comfortable to deliver at home since is perceived to be less expensive and where they feel even if they don't have the complete money can always pay later. Unlike the hospital, were you must pay before you leave. This again has proven that high cost of hospital delivery has been a contributing factor for out-of-health facility delivery. Data presented here are consistent with other studies indicating the costs associated with Health Care Facility deliveries are very real deterrent for women[20]. Interestingly, this study also proved that mothers do attend antenatal care service at least 4 times before delivery. This is in line with National Health Scheme[23] and the World Health Organization[34] recommendations of a minimum of 4 antenatal attendances before delivery.

The findings further showed that facility delivery is limited because the women are living on past experiences. This is evident in this study as most of the respondents expressed their willingness to deliver at home by the TBA's whom they say is more concerned and caring for the pregnant woman especially during delivery. Most of the participants narrates that with the TBA's they are more comfortable to express their feeling and pain. Also, stating that the TBA's even share their pains with them by way of petting, telling them sorry and even strengthens them by assuring them of safe delivery no matter what. But in health facility, they (the care givers) show little or no concern about your feelings and even shout on you, embarrass you when you complain of the pain and make you feel you are disturbing them. These experiences will in no doubt affect the

autonomy and freedom of expression of the pregnant women using the health facility for delivery. This reduced autonomy identified as a contributing factor to out-of-health facility delivery has been reported[8] thatrestricted autonomy for women has been identified as a factor underpinning inability to make personal decisions about health service use. This factor is one of the underlying elements relating to lack of accessing health care facility even during emergency in labour.Also, it was argued that socio-cultural beliefs have hampered women's ability to access services in many low and middle income countries including Nigeria[10]. That the word"Kunya", meaning "shame" play an extremely important role in Hausa childbirth particularly in the first pregnancy were the newly pregnant girl is not to draw attention to her state, and all mention of the pregnancy should be avoided in conversation and action. In this case, older women stand ready to scold her should her behavior deviate from the expected norm. This social pressure to remain modest may well prevent her from asking questions about seeing antenatal care or to deliver in hospital when labour begins.

It is interesting to note that some of the participants avoid health facility delivery because of the fear of operation-caesarean section (CS). Based on the findings, respondents revealed that the TBA will do everything possible to ensure that the woman gives birth per vagina irrespective of the delay. However, in the health facility when delivery is delayed the woman is referred immediately for hospital and booked for operation (CS) in the quest to save both mother and baby. This option of CS to secure the life of both mother and baby on the other hand is seen as disturbance/hindrance to mothers. Thus, serve as deterrent for mothers to utilize health facility for delivery. This finding is in agreement with other studies[5] which posited that fear of possible caesarean section is a major factor for out-of-hospital delivery. It is therefore possible to state that the mother of the case presented may have opted to be delivered by a TBA to avoid possible delivery by caesarean section.

This study revealed that decision to deliver out-of-health facility is also influenced by religious believes. A participant *(thm-II, CHCA-4)* said family pressures of not having a child coupled with miscarriage almost cost her are marriage. She had claimed that she heard the voice of God telling her to deliver in church, which she did and that is why she had this baby today. The issue of religious believes influencing place of delivery was also proved in a study[5]were respondents cited fear of spiritual attack by wicked people and prophetic warning in church as their major reasons other than hospital delivery. A qualitative study in sub-Saharan Africa find outthat cultural beliefs about pregnancy, childbirth and spiritual beliefs also contribute to the determination of delivery location[2].

Also the study shows that awareness on the importance of hospital delivery contributed to their reasons for booking for antenatal services and even makes efforts to attend (*see*...Table-1) but factors such as passed experiences and stories from family members and friends have contributed in discouraging women from hospital delivery. In this study, participant narrated that family members and friends do play a major role in influencing their decision on place to deliver their baby especially when the woman is financially dependent. Data presented here are consistent with other studies[2]adding that educational attainments as well asrelatives and friendssignificantly influence the respondent choice of place of delivery. [3]Choudhury & Ahmed(2011), also conducted a study in sub-Saharan Africa which shows thatfamilyinvolvement in decision making during child birth has great influence on place of delivery.

From the study, it shows that some respondent would deliver their baby at home not because they wish to but simply because either their mother, mother in-law or a family member is a TBA who rather prefer she deliver at home than going to the hospital. However, majority based their reason on the fact that they do receive better attention and care during labour from the TBA's. In addition, the presence of a TBA in the family could be of advantage to the pregnant mother since it will save her the stress of moving to hospital as well as cost of transportation. A research carried out by[2] still reveals that most of these home deliveries are attended by Traditional Birth Attendant (TBA), relatives or women themselves in the home.

V. Conclusion

MDG4 has served to highlight the issue of child health globally, and, despite a slow start, progress towards achieving the goal has recently accelerated. Much evidence for effective, affordable interventions that prevent neonatal and childhood deaths already exists. The task now is to ensure that these are implemented consistently and evenly, within and between countries.

Our outcome variables were informed by the specified UN Development Goals. For MDG4, the key indicators specified are the under-five mortality rate per country MDG4.1

Hence, the need to suggest burgeoning support for health care facility delivery by both pregnant women in central senatorial district and their communities. This support is particularly important given the influential nature of community and family members in health seeking behavior in Bayelsa State. While a palpable shift in support for health care facility delivery will mark a critical step toward increasing rates of health care facility delivery. However, the perspective provided here suggests major barriers persist. Unaddressed, these barriers may severely hinder achievement of MD4 in the state. Thus, programmers, researchers and stake-holders will do well to actively address these barriers.

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