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## Utilisation of skilled birth attendance in Northern Nigeria: A cross-sectional survey



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## ABSTRACT

**Objective:** to determine the level and determinants for utilisation of Skilled Birth Attendance (SBA).

**Methods:** a population-based survey using a structured questionnaire was conducted in Goya and Tundunya political wards of Katsina state from May to June 2012. Four hundred women aged 15–49 years who had delivered a baby within two years prior to the study were asked about birth attendance during antenatal care (ANC), childbirth and postnatal period of their most recent birth. Logistic regression analysis was performed to obtain independent predictors of skilled birth attendance (SBA).

**Findings:** of the 400 women recruited for the study, 145 (36.3%) received antenatal care, 52 (13%) had their births assisted by skilled personnel and 88 (22%) received postnatal care from skilled birth attendants. Of the 52 women who had their births attended by skilled birth attendants only 29 (56%) had their births in a health facility. Maternal education, husband's occupation, presence of complication and previous place of childbirth were found to be statistically significant predictors for SBA utilisation. Barriers to SBA utilisation identified included lack of health care provider, lack of equipment and supplies and poverty. Enablers mentioned included availability of staff, husband's approval and affordable service.

**Conclusion:** women are more likely to utilise SBA with the availability of skilled personnel, strengthening of the health system and intervention to remove user fees for maternal health services. Joint effort should be made by government and community leaders to promote girl's education and to encourage men's involvement in maternal health services.

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## Introduction

Pregnancy and childbirth is a significant period in the lives of women and their relatives. However, pregnancy and childbirth is a potentially risky and fatal experience for millions of women in developing countries (Olopade and Lawoyin, 2010). This is in spite of evidence which shows that motherhood can be safer for all women by following a set of life-saving strategies that can work even in poor resource settings (De Brouwere et al., 1998; World Health Organization (WHO), 2007).

Annually, more than 200 million women become pregnant in the world. Of these, 358,000 die as a result of pregnancy-related complications (WHO, 2010a). About 99% (355,000) of these deaths occur in developing countries where the lifetime risk of women dying due to pregnancy-related complications is 250-fold higher than that in industrialised regions (Lawn et al., 2005; Yanagisawa

et al., 2006; WHO, 2010a). Over 30 million more women suffer long-lasting injury or illness from pregnancy-related causes and complications (De Bernis et al., 2003) and many more suffer from related mental morbidity in developing countries (Hogan et al., 2010). About 80% of these maternal deaths are due to direct obstetric conditions, haemorrhage, puerperal sepsis, pre-eclampsia and eclampsia, obstructed labour and complication of unsafe abortions (WHO, 2011).

Two regions in developing countries, sub-Saharan Africa and South Asia, account for 87% of these maternal deaths (WHO, 2010a). Nigeria, a sub-Saharan Africa country, accounts for 10% of the global maternal deaths (Federal Ministry of Health (FMoH), 2005). Nigeria is characterised by a very high maternal mortality ratio (MMR) of 545 per 100,000 live births (WHO, 2010b), neonatal death rate of 40 per 1000 live births (National Population Commission (NPC), 2009) and a lifetime risk of maternal death of 1 in 18 (WHO, 2007).

When the mother dies, the survival of newborn is also threatened. Globally, about 2.6 million stillbirths occur annually and 1.2 million of these deaths are due to obstructed labour or umbilical cord complications, which are linked to care during

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childbirth (Yakoob et al., 2011). Nearly 40% of the 8 million child deaths each year occur within the first month, with two-third of neonatal deaths occurring within the first week of life and are often due to the lack of or inappropriate care during pregnancy, childbirth and postpartum period (United Nations Population Funds (UNFPA), 2004; WHO, 2010a).

Skilled Birth Attendance (SBA) has been advocated as a critical intervention for improving maternal and child health (WHO, 1999; WHO, 2004). According to a joint statement by WHO, ICM and FIGO, a skilled birth attendant is defined as 'an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in identification, management and referral of complications in women and newborns' (WHO, 2004). SBA is an international strategic option for the achievement of Millennium Development Goal five (MDG 5). Skilled Birth Attendance coverage represents the percentage of all the processes by which pregnant women and their newborns are provided with adequate care during pregnancy, labour, birth and the postnatal period by skilled personnel with an enabling environment irrespective of the place of childbirth, whether at home, health centre or hospital (MacDonagh, 2005).

Studies have shown a correlation between having skilled care during childbirth and declining maternal mortality (Loudon, 1992). Countries like Sweden, Norway, The Netherlands and Denmark achieved remarkably low maternal mortality very quickly due to increase in SBA coverage. In Egypt, 50% reduction in MMR was observed from 1983 to 2000 following doubling of the proportion of childbirth by skilled personnel and ensuring availability of the enabling environment (Graham and Hussein, 2006; Matthews, 2010).

In Nigeria, the coverage of SBA varies across the continuum of care. According to the Nigeria Demographic Health Survey (NDHS), 58% of all pregnant women received ANC at least once, 39% received skilled care during childbirth and 38% received postnatal care within two days after childbirth from a skilled birth attendant (NDHS, 2008). The coverage of SBA also varies by states, with northern states having a lower SBA coverage compared to the southern states (NDHS, 2008).

Various studies have assessed factors that motivate or serve as barriers for utilisation of SBA. Positive predictors for SBA utilisation have been suggested to include education (Babalola and Fatusi, 2009; Kamal, 2009; Butawa et al., 2010; Aremu et al., 2012), maternal age (Elom, 1992; Burgard, 2004; Dairo and Owoyokun, 2011), less parity (Mahfuzar et al., 2008) and presence of obstetric complication. Knowledge of danger signs has been identified as a predictive factor that enhances the utilisation of skilled care during both low-risk birth and emergency obstetric care in complicated cases in poor resource countries (Starrs, 2006). However, distance (Makokha et al., 1994; Moore et al., 2011; Awoyemi et al., 2011), rural area (Rahman et al., 2008; Oladapo and Osiberu, 2009; Okaro and Iyoke, 2010) and cost (Thaddeus and Maine, 1994; Babalola and Fatusi, 2009; Gabrysch and Campbell, 2009) have been identified as factors shown to have negative association with SBA utilisation.

In Nigeria, studies that explore the barriers and enablers for utilisation of SBA for continuum of care from women's perspective are rare (Babalola and Fatusi, 2009; Dairo and Owoyokun, 2011). A population-based survey compared the utilisation of SBA in three northern states – Katsina, Yobe and Zamfara (Doctor et al., 2011). The findings showed a high rate of home births using unskilled birth attendants in the three states: Katsina state (82.3%) compared to 95% and 87.2% in Zamfara and Yobe states, respectively. There is however the possibility of a recall bias as participants were women with at least one

childbirth five years prior to the study (Doctor et al., 2011). Although this study assessed the levels of utilisation of SBA, factors contributing to the utilisation or non-utilisation after childbirth were not explored.

Hence, to formulate strategies that promote SBA utilisation for continuum of care, there is an urgent need for information on the barriers and enablers for SBA utilisation, especially in the northern states where maternal and neonatal mortalities are high. Specifically, this study determines the level of utilisation of SBA in rural Nigeria, the knowledge of women on danger signs and explored the enablers and barriers for SBA utilisation.

## Methods

### *Study area and population*

This study was conducted in Funtua Local Government Area (LGA) of Katsina state in Northern Nigeria. Funtua is located in the southern part of Katsina state with an estimated population of 225,571 in which 106,868 were women of reproductive age (Katsina State Government, 2012). Funtua has 11 political wards and the predominant tribes are Hausa and Fulani. Majority are Muslims and the major occupations are farming and animal rearing. Katsina state literacy rate is 27.5%; male 34.5%, female 20.1% (National Bureau of Statistics, 2010; Katsina State Government, 2012).

Funtua LGA has one referral hospital and 11 primary health centres. Maternal health services are provided mainly at the primary health care level by skilled personnel, with complicated cases referred to the referral hospital. Within the communities, there are unskilled personnel who assist women during childbirth.

The study population included women of reproductive age (15–49 years) who had given birth in the last two years preceding the study. We excluded women who refused to freely give consent for participation, relocated to the area in the last two years before the study and women who had their childbirth more than two years prior to the study.

### *Sample size and sampling*

Sample size was calculated using Epicalc 2000. The prevalence of SBA utilisation of 58% was used (NDHS, 2008), alpha error level was set at 5%, power of 80% and addition of 5% for non-response. Substituting the values, a minimum sample size of 416 was obtained and this was rounded to 420 women.

A multistage sampling technique was used to select the study population. The multistage sampling involved three stages. At stage one, a rural LGA (Funtua) was purposively selected. At stage two, we randomly (balloting) selected two political wards (Tundunya and Goya) out of the 11 political wards in Funtua whereas at stage three, using systematic sampling we selected 400 women of reproductive age from Tundunya and Goya. Sample size for each ward was obtained by using probability proportional to size. About 190 women were recruited in Tundunya and 230 women from the Goya political ward.

### *Data collection instrument*

Questionnaire for the study was developed in English and translated into Hausa, the local language of the study setting. This was then back translated to English to check for consistency and avoid loss of meaning. The questionnaire consisted of both closed and open-ended questions on the following: socio-demographic information; antenatal care history; knowledge of danger signs during pregnancy; past obstetrics history; place of childbirth and

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