Sexual & Reproductive Healthcare 6 (2015) 119–125

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.srhcjournal.org

Prevalence, reasons and predictors for home births among pregnant women attending antenatal care in Birnin Kudu, North-west Nigeria

Adewale Olufemi Ashimi [a,*], Taiwo Gboluwaga Amole [b]

[a] Department of Obstetrics and Gynaecology, Federal Medical Centre Birnin Kudu, Jigawa State, Nigeria
[b] Department of Community Medicine, Aminu Kano Teaching Hospital, Kano, Nigeria

ARTICLE INFO

Article history:
Received 4 August 2014
Revised 16 December 2014
Accepted 16 January 2015

Keywords:
Home birth
Prevalence
Predictor
Maternal mortality

ABSTRACT

Objective: To determine the prevalence, reasons and predictors for home birth in a rural community.
Method: Descriptive cross sectional study which utilised a pretested interviewer administered semi-structured questionnaire to assess the place of delivery in their last childbirth among 410 pregnant women attending antenatal care in Birnin Kudu, Nigeria. Logistic regression analysis was used to assess the relative effect of determinants.
Result: Prevalence: Of the 410 women, 248 (60.5%) delivered at home in their last childbirth. Self reported reasons: Home birth was opted for because of: lack of transportation 113 (45.6%), onset of labour was at night 104 (41.9 %), preferred birthing position 72 (29.0%), tradition 60 (24.2%), fear of surgery 42 (16.9%) and poor attitude of health workers 32 (12.9%).
Predictors: The odds of giving birth at home was 3.88 times higher in women with informal education (adjusted OR 3.88; 95% CI: 2.51, 6.00) and the odds of giving birth at home was 0.27 for women with less than 5 deliveries compared with women with 5 or more deliveries (adjusted OR 0.27; 95% CI: 0.15, 0.49) after controlling for confounders.
Conclusion: The prevalence of home birth is high in Birnin Kudu and according to our respondents the main reasons for this practice are onset of labour late at night with lack of transportation and a limited choice of birthing positions. Provision of training and retraining of skilled birth attendants to assist women birthing in squatting positions would encourage women to deliver in the hospitals.

Introduction

The death of a woman during pregnancy, childbirth or shortly after delivery has both social and economic implications for her family and the community at large. Disappointingly, 56% of the global maternal deaths in 2010 occurred in Sub-Saharan Africa, and Nigeria accounted for 14% of these deaths [1]. At this estimate, Nigeria's maternal mortality ratio (MMR) is put at 630 with a range of 370–1200/100,000 live births [2]. According to the Nigeria demographic health survey (NDHS) of 2008, the MMR is higher in the northern region compared to the south and also in the rural areas [3]. Although the reasons for this high MMR are multifaceted, and access to and utilisation of emergency obstetric care services in various parts of the country rank high as one of the main causes [3].

Evidence has shown that 40% of all pregnancies will have complications and of those with complications, 15% will have life threatening complications that require emergency obstetric care and a significant proportion occur during or after childbirth. These complications are poorly predicted but can be treated by skilled birth attendants who are able to recognise them, manage or provide appropriate referral, thus making the choice of place of childbirth very important [2].

Childbirths at home are a usual occurrence worldwide and some of the reasons often cited for this practice includes: birthing in the comfort of a familiar environment, a negative previous hospital experience and the preference for a less medicalised and less invasive care in labour which is provided by a midwife [4]. Remarkably the outcome of home births is not significantly different from hospital births as evidenced by studies from the developed countries [5,6]. Generally home birth is planned with a skilled birth attendant; however, in developing countries, majority of home births are not planned or supervised by skilled attendants hence they are often associated with both maternal and foetal complications such as postpartum haemorrhage, retained placenta, puerperal sepsis and neonatal tetanus [3,7]. These complications contribute significantly to the unacceptably high maternal and perinatal morbidity and mortality occurring in developing countries and Nigeria is not an exception. In recent times, the northern region (especially the North-East and North-West) has been under serious security threat from radical Islamic groups, resulting in displacement of people and the loss of lives worsening the existing precarious situation.

* Corresponding author. Department of Obstetrics and Gynaecology, P.M.B. 1022 Birnin Kudu, Jigawa State, Nigeria. Tel: +234 8077424051.
E-mail address: adewaleashimi@yahoo.com (A.O. Ashimi).

http://dx.doi.org/10.1016/j.srhc.2015.01.004
1877-5756/

In a multicountry analysis of demographic and health survey data for developing countries, more than half of the births were reported to be at home in 23 of 48 countries [8]. The prevalence of home births ranged from 43% in Ghana [9] to 90% in Ethiopia [10] and Nepal [11] while an average of three of five births (62%) occurs in Nigeria, with as many as 90% home deliveries in the North-western zone, a region with one of the highest MMR and lowest adult literacy level in the country [3]. It is not surprising that most women who deliver at home are in the lowest wealth quintile, reside in the rural areas, have little no formal education, are multiparous and received little or no antenatal care [3,9,10].

However the emerging trend in recent times is that many pregnant women who attend antenatal care do so for reassurance and to have a card with the health facility in the event that attempts at home birth is unsuccessful [12]. The reasons often cited for this practice includes: the cost of delivery, unfriendly attitude of healthcare workers, lack of options of birthing positions, fear of surgery, lack of privacy, cultural practice and no perceived need for the services [6,9,10,12].

In an attempt to reduce the maternal and the perinatal complications associated with antenatal care without hospital delivery, we sought to know if pregnant women who received antenatal care in government owned health facility deliver in the hospital. The aim of the study was to determine the prevalence, reasons and predictors for home births among women attending antenatal care in this rural community. The findings from this study would assist in planning interventions which would encourage hospital delivery.

Materials and method

Setting

Nigeria, with an estimated population of 169 million inhabitants in 2012, is the most populous country in Africa and the sixth most populous nation in the world, with about 50% of the populace residing in rural areas where accessing healthcare remains a challenge. It is located in western Africa on the gulf of Guinea with a total area of 923,768 km^2, making it the fourteenth largest country in Africa. It is comparable in size to Venezuela and about twice the size of California in the United States of America. It shares border with republic of Benin in the west, Chad and Cameroon in the east and Niger in the north. Nigeria has more than 250 ethnic groups, with the largest groups being Hausa, Yoruba, Igbo and Fulani. The official language is English and the country is divided into 36 states for administrative purposes. These states are grouped into 6 zones for geo-political reasons: North-West, North-East, North-Central, South-West, South-East and South-South. The northern region is mainly occupied by the Hausa and the Fulani and majority are Muslims.

The Nigerian healthcare system is structured into 3 levels with responsibility at the federal, state and local government. The federal government is in-charge of tertiary health centres (university teaching hospitals, specialist hospitals and federal medical centres), the state government manages the secondary health facilities (general hospitals) while the local government deals with the health centres and dispensaries which are under the primary healthcare. The maternity care services at the various levels are organised differently because of the facilities and type of skilled health professional available at each level. At the tertiary level, maternity care services are provided and supervised by Obstetricians and supported by midwives while at the secondary level the services are provided by the midwives and General practitioners. They may be supervised by Obstetrician(s). At the level of health centres, maternity care services are offered by community health workers in conjunction with midwives. The Obstetricians manage both high and low risk patients while the midwives only attend to low risk cases and they refer other cases when identified. The midwives are registered with the Nursing and Midwifery Council of Nigeria. Due to inequalities of health facilities and professionals in the country, many centres do not have the requisite staff to man these facilities, hence the tertiary facilities also provide general services to the community. However it is not a national policy that women should deliver in the hospital; women decide where they want to deliver; however they are encouraged to deliver with skilled birth attendants who are mainly available in health facilities (primary, secondary or tertiary) in Nigeria.

This study was carried out at the antenatal clinics of the Federal Medical Centre and the General Hospital, the two hospitals in Birnin Kudu, Jigawa state (Fig. 1) which is in the North-West geopolitical zone of the country. Birnin Kudu is a town and a local government headquarters in the south of Jigawa state of Nigeria. It has paved roads and is easily accessible to other communities. The common means of public transport in the town includes motorcycles, tricycles and cars which are not readily available at night.

According to population estimates in 2012, Birnin Kudu had a population of 333,757 inhabitants and they are predominantly Muslims. They are mainly Hausa/Fulani by ethnicity. Their major occupation is farming. Birnin Kudu is about 130 km south-east of Kano city, the commercial nerve centre of northern Nigeria.

The Federal Medical Centre is a tertiary health facility. It serves the healthcare needs of the people in the community and also receives referrals from other hospitals in the state and neighbouring northern states like Kano and Bauchi. The hospital is a 250 bedded facility and the obstetrics and Gynaecology department provides antenatal care (ANC) services which are paid for by the clients. These services are provided by 3 resident consultant Obstetricians, 5 medical officers, and 5 midwives.

The General hospital is a secondary health facility and it is funded by the state government. The hospital is a 180 bedded facility and it provides free maternity care services with free drugs to all pregnant women and children under 5. It receives referrals mainly from primary health centres in neighbouring towns and villages in the state. The antenatal clinic is run by 1 medical officer, 2 midwives and 4 community health workers.

Subjects

The study population consisted of pregnant women attending the antenatal clinic of the two hospitals from 20th January to 24th February, 2014. Women who consented to participate in the study and were not critically ill were selected. The participants were assured of confidentiality and that non-participation in the study would not in any way affect the care they would receive. A systematic sampling technique was used to select women who consented to participate in the study. Using the average monthly attendance at the clinic as the sampling frame, the sampling fraction was calculated and subsequently a sampling interval of three was obtained. The first respondent for each day was selected by balloting and picking a number between one and three. Subsequently, every third pregnant woman that registered with the records department was recruited.

Inclusion criteria:

1. Pregnant women attending one of the health facilities and had delivered before.
2. Their last child birth must be 15 months or less at the time of presentation to the antenatal clinic for booking.

Exclusion criteria: Primigravidae and women whose last child birth was more than 15 months at the time of presentation to the antenatal clinic.