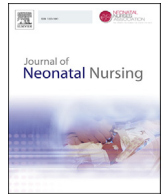




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## Original Article

## Knowledge levels, treatment preferences and neonatal health problems in southwest Nigeria

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## ABSTRACT

**Background:** Knowledge of nursing mothers residing in urban and rural areas about various danger signs during neonatal period and factors influencing care and treatment preferences for newborn were not given necessary considerations in the existing studies. This study sought to examine the pattern of behaviour of nursing mothers and identify factors influencing care and treatment preferences for newborns in rural and urban environment.

**Methods:** The research employed a descriptive cross-sectional design. Utilizing a multistage sample design, data was obtained from 349 nursing mothers with children 0–6 months in selected rural and urban areas of Ife-Ijesha zone. Data obtained were analysed at univariate, bivariate and multivariate levels.

**Results:** High proportions of nursing mothers in both areas had poor knowledge of neonatal danger signs and were unaware of the importance of immediate care of newborn. Apart from the age of nursing mothers residing in the urban areas, respondents' background and knowledge of neonatal health problems did not predict treatment preferences for newborns in both areas ( $p > 0.05$ ). A higher proportion of nursing mothers in the urban area (62.8%) compared with their counterparts in the rural area (45.7%) noted signs suggestive of neonatal health problems on their neonates. Early bathing was the norm in both areas, with majority of nursing mothers (urban 69.2% versus rural 66.7%) bathing the index child immediately after birth.

**Conclusions:** The study highlights the importance of Behavior Change Communication (BCC) strategy for improving newborn health and survival in both rural and urban areas.

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## Introduction

The level of the World neonatal mortality rate has remained unchanged for the past five decades (Lawn et al., 2005). Notably, 25–45% of the World neonatal deaths occur in the first 24 h after birth and about three-fourths occur during the early neonatal period (Kumar et al., 2008). Globally, progress towards reducing neonatal death has been slow and neonatal deaths now account for a greater proportion of child deaths. It has also been noted that

issues of neonatal morbidity and mortality fall into relative obscurity due to lack of accurate data and a misconception that neonatal care requires a high cost in many developing countries (Murray, 1997).

Sub-Saharan Africa has the highest rate of neonatal mortality in the world and showing the slowest progress in reducing newborn deaths, especially deaths in the first week of life. As pointed out by Lawn et al. (2006), each year, at least 1.16 million African babies die in the first 28 days of life and 850,000 of these babies do not live past the week they are born. Thirty-eight percent of babies in sub-Saharan Africa die of infections, mainly after the first week of life (Lawn et al., 2000). The majority of these deaths are products of low birth weight (LBW) babies while many are due to preterm.

Unfortunately, in many developing countries including Nigeria, health care during and after childbirth is inadequate and non-existent

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in some area (Puri et al., 2008). Home births are very common without taking into consideration the importance of first days of life, as the most critical moment for newborn survival. In this region, nearly half of all mothers and newborns do not receive skilled care during and immediately after birth (WHO, 2012). Up to two-thirds of newborn deaths could be prevented if known and effective health measures are provided at birth and during the first week of life. WHO (2012) report, indicates that only 13% of women in developing countries receive postnatal care in the first 24 h. In addition, most mothers who give birth in health facilities could not return for postnatal care because of financial, social or other barriers (WHO, 2012). Poor maternal education, multi-parity, and low socioeconomic status are some of the predictors of home deliveries (Ogunniyi et al., 2000).

Since care and nurturing of the newborns are the primary responsibilities of the mothers, their behaviour in seeking healthcare services either, as a preventive or curative treatment is an important factor in determining child survivorship. Such seeking behaviour most times does not take place unless the mother recognises signs and symptoms of illness, waits and observes the condition, interprets the possible severity of the conditions before taking an action to seek care (Hill et al., 2003).

In Nigeria, mortality during the first 28 days of life accounts for two-thirds of deaths in children less than one year of age, and nearly four-tenths of all deaths in children less than five years of age (WHO, 1994; Stoll, 1997). A more recent report shows that as the mortality statistics in Nigeria is falling, the percentage of deaths that occur in the first month of life is increasing (Save the Children Nigeria, 2011). The report further indicate that, every year 241,000 babies die in the first month of life in Nigeria making it the African country with the highest newborn death toll. This high incidence of neonatal mortality calls for an increased focus on reducing newborn deaths, the vast majority of which are avoidable. In a study conducted by Onayade et al. (2006) to determine neonatal mortality, neonatal tetanus, lack of skilled attendance at delivery, deliveries at missions and homes and low socioeconomic status of mothers were positively associated with neonatal death.

## Materials and methods

The study was conducted in Ife-Ijesha zone otherwise known as Osun East Senatorial District, Osun State, Nigeria. Osun State is situated in the Southwestern part of Nigeria, with Osogbo as the state capital. Osun State is divided into three Federal Senatorial Districts of which Osun East Senatorial District is one of them. Osun East Senatorial District is the largest of the three Senatorial Divisions in terms of landmass, with a population of over 1.2 million people (NPC, 2007).

There are ten Local Government Area in Ife-Ijesha zone including Atakunmosa East, Atakunmosa West, Ife Central, Ife East, Ife North, Ife South, Ilesha East, Ilesha West, Obokun and Oriade. The dominant language in this region is Yoruba with three major dialects of Ife, Ijesha and Oyo. Few of these Local Government Areas are metropolitan in nature with major cities surrounded by many adjoining and accessible villages. Preliminary investigation revealed that Oriade, Atakunmosa East, Atakunmosa West, Ife North and Ife South Local Government Area are predominantly rural while Ilesha West, Ilesha East, Obokun, Ife Central and Ife East Local Government Area are predominantly urban based on 2006 census.

The residents of the area are predominantly Yoruba and practice three major religions - Christianity, Islam and traditional religion. The dominant occupation and economic activities of the people centre on farming, agro allied productions, trading, artisanship, teaching and cottage industries. The district is also blessed with mineral deposits like gold, talc and feldspar. In the rural area,

majority of inhabitants are farmers while in the urban settings, they are mostly traders, artisans and civil servants. Despite the infra-structural advancement that had been witnessed over time in the zone and its implications in terms of modern lifestyles, people in the zone still attach considerable importance to the traditional values of the Yoruba culture.

This study which employed a descriptive cross-sectional design was carried out among nursing mothers with children (0–6) months old in the selected households within the rural and urban area covered by the study. A multistage sampling method was employed with local government area in the zone forming the primary sampling units. The first stage involved the use of stratified random sampling technique to select two urban and two rural local governments each from the list of LGAs in the zone. The selected LGAs include Atakunmosa West, Ife North, Ilesha East and Ife Central. At the second stage, the list of all political wards delineated by INEC was adopted and constituted the sampling frame. Twenty-five percent of political wards in each LGA were selected using simple random sampling technique. In the third stage, systematic sampling of the households was done by picking every 25th and 17th eligible households in urban and rural area respectively. The starting point was a household that produced an eligible respondent. In a situation where a household did not produce an eligible respondent, the household that immediately followed was visited, and in a household where there were more than one eligible respondents, a paper toss of “yes” and “no” was used to pick eligible respondent.

The sample size was determined using the formula for calculating sample size for the comparison of two independent proportions.

$$N/\text{group} = 2 \left( Z_{\alpha} + Z_{\beta} \right)^2 \times p(1 - p)P_0 - P_1$$

$N/\text{group}$  = minimum sample size per rural and urban area

$p_0$  = estimate of true proportion of mothers that applied potentially dangerous substances to the umbilical cord in rural area which is 9.3% as documented by a study carried out in rural area of Borno State, North - Eastern Nigeria (Ambe et al., 2009).  
 $p_1$  = estimate of true proportion of mothers that applied potentially dangerous substances to the umbilical cord in urban area which is 3.3% as documented by a study carried out in urban area of Kano State, Northern Nigeria (Mukhtar et al., 2011).  
 $p_0 - p_1$  = the difference between the proportions of mothers that applied potentially dangerous substances to the umbilical cord in rural and urban area.

$Z_{\alpha}$ , the standard normal deviate corresponding to the probability  $\alpha$  (i.e. the probability of making a type 1 error at 5%) = 1.96  
 $Z_{\beta}$ , standard normal deviate corresponding to the probability  $\beta$  (i.e. the probability of making a type 2 error = 5% and Power  $(1 - \beta) = 95\%$ ) = 1.64

$p$  = Arithmetic average of the two proportions ( $p_0$  and  $p_1$ ) which is calculated as  $(9.3 + 3.3/2) = 6.3$

Therefore,  $N/\text{group} = \frac{2(1.96 + 1.64)^2 \times 6.3(1 - 6.3)}{9.3 - 3.3} N/\text{group} = 144.24$ .

For the purpose of getting a good representation of the sample and to make up for non-response, a total of 180 respondents were interviewed per rural and urban area using 20% allowance.

Both quantitative and qualitative techniques were employed for the study. While questionnaire was employed in tapping information for the major thrust of the research objectives, focus group discussions (FGDs) were used to complement the quantitative information. Out of the 360 nursing mothers approached for interviews using semi-structured questionnaire, 349 (96.94%) responded and completed the questionnaire. In total, one hundred and eighty (180) questionnaires were administered and completed

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