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Challenges of material and child health in the developing world

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Abstract

The major challenges of maternal and child health are maternal and child morbidity and mortality in the developing world including Nigeria. These are associated with inappropriate health care-seeking behaviour of mothers. The purpose of this study was to ascertain the pattern of prenatal health care seeking and the social and self efficacy factors that influence their choices in Akinyele L.G.A. Oyo State, Nigeria and to discuss the implication for health education. Women who had delivered a baby in the previous year constituted the population for the study. Systematic sampling was used to cover the eight communities in Akinyeie L.G.A. A questionnaire was developed from focus group discussion (FGD) and pretested. Women of childbearing age were trained as interviewers. A total of 405 women were interviewed. Most 84.9% registered for ANC during the most recent pregnancy. The median age of pregnancy at the time of registration was 20 weeks, 6.0% registered in first trimester, 64.8% in second trimester and the remainder registered in last trimester. Regression analysis shelved that registration at ANC was associated with higher education; higher level of perceived self- efficacy and more positive attitudes towards ANC. Social support was higher for those who registered (20.9) compared to hose who did not (15.8). 193 (47.7%) delivered in the government maternity centers, 73 (18.7%) in private hospitals, 41 (10.19) in government hospitals, 43 (10.6) at home, 33 (8.10%) spiritual homes, 15 (3.7%) with TBAs, 2 (0.5%) in the farm and 5 (1.2%) no response. Education influenced registration for ANC. Most deliveries were attended by skilled personnel.

Keywords: Challenges, Maternal, child Health, Developing World.

Introduction

The major challenges of maternal and child health are maternal and child morbidity and mortality in the developing world including Nigeria. These are associated -with inappropriate health care-seeking behaviour in pregnancy and childbirth.

Health care seeking behaviours are specific actions taken to maintain health or remedy health problems, including health behaviour during pregnancy, household self-treatment of common ailments, reliance on careavailable within a community's indigenous health system or referral for care outside of the community (Moore. 1990).

These concepts have been adapted to the needs' of pregnant women; whose health seeking behaviour

may include both promotive, preventive actions and curative measures.

Pregnant women are usually vulnerable to several health problems which if not promptly managed could lead to maternal morbidity, poor pregnancy outcome, such as loss of the baby and death of the mother. For these reasons pregnant women are expected to seek pre-natal, antenatal care (ANC) so as to maintain good physical, mental, social and emotional health during pregnancy and also for early detection and prompt treatment of high risk condition that would endanger the life of mother and baby (Myles,2000). When health care during pregnancy is not sought in a timely and appropriate manner, maternal mortality may result. Maternal mortality is, on the average, 10 times higher in the developing world than in the developed world. 99% of maternal and under five child deaths occur in Sub-Saharan Africa and South Asia.

Many researchers have identified the value of seeking early care in Pregnancy (Lia-Hoagberg, Lewis & Greenberg, 1990). Specifically, Harrison (1985) reported that maternal mortality was much lower for women wh6 booked to ANC (1.2 per 1,000 deliveries) compared with those who did not (107.1 per 1000 deliveries), In Nigeria 46 of 49 maternal deaths occurred among women during labour and delivers who had not attended ANC (Rossitcr, Chona and Lister *et al.*, 1985; Harrisoo, 1985).

Unfortunately, most women including Nigerian women received no ANC, even in urban areas where medical sen-ices are readily available (Otolorin, 1997). Although a number of studies have been carried out in Nigeria to determine the major causes of maternal morbidity and mortality, little is known about the pregnant women's pattern or health, care seeking behaviour (Otolorin 1997).

The study aimed at documenting the details of prenatal health care seeking behaviour, social and cognitive factors that influence their health care-seeking behavior during pregnancy and make recommendations for health education to enhance appropriate health seeking behavior during pregnancy.

Maternal and Methods

The study focused on the most recent pregnancy experienced by women in Moniya and because of its focus on the ward of Moniya within AkinyeleL.G.A., was a case study of the health care seeking behaviour of women during pregnancy in that ward. To this end only mothers who ha4 delivered their babies within one year were interviewed to ensure better recall and better reflection of current health care-seeking practices in the community.

Systematic sampling was used to cover the eight communities in Moniya in Akinyele LGA. A questionnaire was developed from focus group discussion (FGD) and pretested. Women of child bearing age were trained as interviewers. A total of 405 pregnant women were interviewed. Data gathered through questionnaire were sorted and coded manually by the investigator. Data eatry and analysis was made using EPINFO (Version 6.0). Content and face validity were enhanced through review by researchers.

Results

405 women who had delivered a baby in the year prior to the study were interviewed in the eight villages within Moniya area of Akinyele Local Government Area. Trie ages of respondents ranged between 18 arid 50 years with a mean of 27.

Educational level of respondents ranged from primary (29.1%), junior secondary (14.6%) senior secondary school (33.1%) to post secondary (12.3%) 44 (10.9%) of the respondents had not been educated.

Antenatal Care (ANC)

Some type of ANC registration was reported by 344 (84.9%) of the women. The majority of those or 219 (63.7%) registered at an L.G.A. maternity centre. Sixty-five (18.9%) registered at a private hospital. 28 (8.1%) at a state government hospital and 15 (4.4%) at a mission hospital. Other choices were made by 12 (3.5%) who said they registered with a traditional birth attendants (TEA) and 5 (1.4%) registered at a church.

The average age of the pregnancy at registration for ANC was 4.7 months with a median of 5.0 months. When considering trimester. 20 (6.0%) registered in the first three months of pregnancy, 223 (64.8%) registered in the second trimester and 101 (29.4%) registered in the third trimester. Of those who registered, 297 couid recall how many times they attended ANC meetings.

The average was 6.8. The median was 6.0 times and the range extended from zero to 14 times. Social support for those who actually registered had significantly higher mean score 20.9 points than those who did not 15.9

points.193 (47.7%) delivered in the government maternity centres, 73 (18.7%) in private hospitals, 41 (10.19 %) in government hospitals, 43(10.6%) at home, 33(8.10%) spiritual homes, 15 (3.7%) with TBAs, 2 (0.5%) in the farm and *5 (1.2%) no* response.

Comparison of some variables with registration

Table 1 Comparison of registration ANC and Respondent's level of Education

Registered	**Level of Education**				**Total**
	None(%)		minimum of Primary(%)	Completed Secondary(%)	
No	17 (36.8)		28 (15.8)	16 (8.7)	61
Yes	27 (61.4)		149 (84.2)	168 (91.3)	344
Total	44		177	184	405

This table shows 27 (61.4%) of 44 women with no education registered compared to 149 (84.2%) of 177 with at least primary education and 168 (91,3%) who had finished secondary school. These differences were statistically significant,

Table 2 Perceived Social Support for ANC Registration Compared with Actual registration for last Delivery.

Perceived social support from all sources for specific actions were also calculated and compared with actual performance of these actions. As seen in the tables, mean perceived support for the item "Go for ANC booking around 3 months was 20.2 points. Table 2 shows that those who actually registered has a significantly higher mean score of 20.9 points than those who did not register (15,9).

Registered	**Number**	**Mean Support**	**Median**	**Std. Dev.**		
No	60	15.9	16.0	7.36		
Yes	343	20.9	23.0	5.46		
Difference		-5.0				
ANOVA						
Variation	SS	DF	MS	F Statistic	P. value	t value
Between	1273.079	1	1273.079	38.141	0.0000	6.176
Within	13384.782	401	33.379			
Total	14657.861	402				

Table 3 Self-Efficacy to Register for ANC and whether registered for ANC at last pregnancy.

Table shows that those who did not had a mean score of 2.4 compared to significantly higher score of 3.3 for those who did register.

Register	Number	Mean self efficacy	Media	Std. Dev.
No	61	2.4	3.0	1.324
Yes	340	3.3	4.0	1.181
Difference				

ANOVA Variation	SS	df	MS	F Statistic	P. value	t value
Between		37.610		25.958	0.0000001	5.094
Within	578.100	399	1449			
Total	615.711	400				

Discussion

The findings revealed that registration for antenatal care was a major activity during pregnancy for most women. They considered ANC services useful registered and attended shows their belief in and understanding of the importance of safe mother-hood. Some mothers in developing countries recognized the risks posed to pregnant women and values *of orthodox* care during ANC and delivery periods (Wedderbume, 1990; Abouzahv, 1998).

Most of them registered late which defeats the purpose of ANC wherein early registration is synonymous with earh- detection of pregnancy[7] risks factors and allow for prompt management and timely referral. The positive association between educational level of women and utilization of maternal care services ANC and deliver}' conforms that education empowers women to take right decision on their health. Perceive social support was demonstrated in this study. This confirms similar findings in Jamaica where social support for close friends was said to be a prerequisite to initiating antenatal care among pregnant adolescents (Wedderbume, 1990). Oakley (1999) found that social support had a positive effect or the outcome of labour and delivery in a variety of settings. Self-efficacy was associated with desired ANC registration and delivery and is essential for both initiation and maintaining health seeking behaviour during pregnancy (Bandura, 1982, 1986).

Conclusion

Registration for ANC, an essential health care seeking behaviour was adopted by most women, although registration was late. Education, Social Support and Self-efficacy influenced registration. Increased girl child education, enhance social support and self-efficacy, training and quality of care are essential for improving health care seeking behaviour of women during pregnancy.

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