

**FACTORS INFLUENCING LOW USE OF MOTHER AND CHILD HOSPITAL,
AKURE FOR DELIVERY SERVICES AMONG WOMEN WHO REGISTERED AT
THE
ANTE-NATAL CLINIC**

BY

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DEDICATION

This project is dedicated to my best companion and friend, my comforter, counsellor, guide, and advocate- the HOLY SPIRIT, and to my husband for his love and the confidence he has in me.

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ABSTRACT

A significant period in the lives of women and their relatives is pregnancy and childbirth. Skilled Birth Attendants (SBA) offer significant interventions that improve maternal and child health consequently reducing mortality. However, despite provision of appropriate modern equipment, skilled health personnel, and free health services put in place by the Government of Ondo State at the Mother and Child Hospital (MCH) Akure, pregnant women who registered at the MCH still failed to deliver there. Alternatively, they preferred the services rendered by unskilled staff in missions, Traditional Birth Attendants (TBAs), and Homes. While previous studies have largely focused on the utilisation of skilled and unskilled birth attendants for delivery, this study was exclusively aimed at investigating the factors preventing women who registered at the MCH, Akure from delivering their babies in the facility.

Lwanga and Lemeshow sample size formula was used to determine the sample size of 417 with p at 40% based on the 2013 Nigeria Demographic and Health Survey estimate. A purposive sampling technique was used to select 417 consenting women who had registered at the MCH but failed to deliver there and the women were assessed through contact tracing. A descriptive cross-sectional survey was conducted among 417 respondents who had registered at the MCH to determine factors that prevented them from delivering in the facility. For qualitative information an In-Depth Interview (IDI) was conducted among 3 consenting respondents (health worker, one mother who had used a Mission, and another a TBA facility). Thematic approach was used to analyse the IDI data. Quantitative data was collected from the 417 respondents using a questionnaire that was administered by me and six (6) trained field assistants. Each respondent was given an interviewer-administered pre-coded questionnaire to obtain information on respondents' socio-demographic characteristics, information received by registered pregnant women on importance of using Health Facility (HF) for delivery, perceptions and experiences of respondents, and health service-related factors that prevented them from using the HF at delivery. Quantitative data were analysed using, descriptive statistics and Chi-square test at $p < 0.05$ level of significance.

Respondents' age was 31.7 ± 6.4 years. (80.7%) believe that MCH promotes foetal and maternal wellbeing. The chosen place of next delivery was Mission Home (51.6%), MCH

(30.5%), TBAs Home (14.1%) and respondent's Home (3.8%). There was significant association between parity, educational attainment and utilization of MCH. Factors preventing the use of MCH for delivery included: lack of privacy in wards (72.2%), waiting period (68.8%), unfriendly attitude of health workers (64.0%), disrespect for mothers (60.0%) and overcrowded delivery ward (56.6%).

The main factors for low use of MCH for delivery were lack of privacy in wards and unfriendly attitude of health workers. Therefore, the government and management should train MCH staff on work ethics and behavior through regular workshops, monitoring and supervision and updating infrastructural facilities. Disseminating workshop should be carried out for the government and relevant stakeholders.

Keywords: Delivery services, Mother and child hospital, Low utilisation, Skilled birth attendants

Word count: 478

CERTIFICATION

I certify that this research work was carried out by OLORUNTOBA Jacinta Astosime in the Health Promotion and Education Department, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria under my supervision.

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LIST OF ABBREVIATIONS

ANC	-	Antenatal Care/Clinic
EMOC	-	Emergency Obstetric Care
FANC	-	Focused Antenatal Care
HE	-	Health Education
HF	-	Health Facility
IDI	-	In-Depth Interview
KAP	-	Knowledge, Attitude and Practice
MCH	-	Mother and Child Hospital
MDG	-	Millennium Development Goals
NDHS	-	National Demographic Health Survey
UNEPA	-	United Nations Population Fund
NPC	-	National Population Commission
SBA	-	Skilled Birth Attendant
TBA	-	Traditional Birth Attendant
UNICEF	-	United Nations Children Endowment Fund
USAID	-	United States Agency for International Development
WHO	-	World Health Organization

CHAPTER ONE

INTRODUCTION

Background of the study

Globally, several initiatives have been taken to reduce maternal deaths and improve maternal health. This initiative include: provision of Ante-Natal Care (ANC), skilled assistance for normal deliveries, appropriate referral for women with obstetric complications, postnatal care, family planning and other reproductive health services. Maternal health was reinforced in the United Nations Millennium Summit of 2000, when it was included as one of the Millennium Development Goal (MDG) (United Kingdom, 2000). The goal, which has the aim to improve maternal health, includes two targets: reduce maternal mortality ratio by three quarters between 1990 and 2015 and achieve universal access to reproductive health by 2015.

Proportion of births attended by skilled birth attendants (SBAs) and coverage of ANC are the two main indicators to measure these targets (United Nations, 2011). The presence of a SBA at delivery, either at home or at a health facility has been strongly emphasized throughout the international initiatives on maternal health. ANC (care during pregnancy) is the key entry point for a pregnant woman to receive a wide range of preventive interventions and information which foster their health, well-being and survival, and that of their infants (UNICEF, 2008).).Annually, more than 200 million women become pregnant in the world, of these, 385,000 die as a result of pregnancy-related complications (World Health Organisation [WHO], 2010). About 80% of these maternal deaths' are due to direct obstetric conditions; haemorrhage, puerperal sepsis, pre-eclampsia and eclampsia, obstructed labour and complications of unsafe abortions (WHO, 2011).

In developing countries like Nigeria, increasing the percentage of births delivered in health facilities is an important factor in reducing deaths arising from complications of pregnancy. The expectation is that if a complication arises during delivery, a skilled health worker can manage the complication or refer the mother to the next level of care (NDHS, 2013). A significant period in the lives of women and their relatives is pregnancy and childbirth. However, pregnancy and childbirth is potentially risky and fatal experience for millions of women in developing countries (Olopade and Lawovin, 2010).

According to the final report of Nigeria Demographic and Health Survey of 2013, the prevalence of maternal mortality in Nigeria was 576 per 100,000 live births. This ratio is not significantly different from the ratio reported in the 2008 NDHS which was 545 per 100,000 live births. The estimate of infant mortality rate in 2013 NDHS was 69 deaths per 1,000 live births. Proper care during pregnancy and delivery is important for the health of both mother and the baby. ANC from trained provider is important in order to monitor the pregnancy and reduce morbidity and mortality risk for the mother and child during delivery (National Population Commission (NPC) [Nigeria] and ICF Macro, 2013).

Maternal mortality clusters around the time of birth, and the most common reasons for mortality are haemorrhages, infections and hypertensive disorders that require medical interventions. It has therefore been argued that the strategy of skilled attendance in an enabling environment is the single most effective approach for preventing maternal death. The strategy of skilled attendance in an enabling environment entails that health workers with midwifery skills are present at birth; have the ability to handle or refer in cases of emergency; and have sufficient and appropriate equipment (Lerberg, Sundby, Jammeh and Fretheim, 2014). The services of Skilled Birth Attendants (SBAs) include Ante-Natal Care (ANC), delivery and Post-Natal Care (PNC). Such services are critically important for reducing maternal and neonatal mortality because they provide timely delivery of obstetric and newborn care when life threatening complications arise. 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).

Statement of the problem

With current Maternal Mortality Ratio (MMR) of 576 per 100,000 live births (NDHS, 2013), translating that for every 1,000 live births in Nigeria, approximately six women died during pregnancy, during childbirth, or within two months of childbirth, thus, ranking Nigeria among the countries with the highest maternal mortality rates in the world.

Delivery in health facilities in Ondo State is still challenging as higher number of women attend antenatal clinic but about half of them deliver without the assistance of skilled health professional. According to the final report of NDHS, 2013 the percentage of pregnant women who delivered at the health facility in Ondo state was 56.2% and this percentage is still the least among the south-west states. However, there are several unexplained factors influencing

the low use of delivery services in Mother and Child Hospital (MCH), Akure where services offered before and after delivery are free and modern equipment needed for safe delivery, and skilled birth attendants are available. The facility at the MCH among other things is a unique cost effective digitalised drug procurement system that has practically eradicated the ‘*out of stock syndrome*’, the bane of many free health schemes across the country. The mother and child hospital has equipment including electronic force monitoring birthing and airway management simulators for life like practical demonstrations and applications on emergency care.

In year 2010, the Ondo State Government, Nigeria put in place the Safe Motherhood (‘Abiye’) Initiative, establishing two MCHs in the State that offer free health care services in State and General hospitals in every Local Government Areas (LGAs) in the State. According to records by September 4, 2011, pregnant women numbering 12,963 had been registered and attended to. Of this number, 6,952 safe deliveries had been conducted in MCH, Akure. From confidential report of research carried out in 2012 in the State, 9 out of 10 pregnant women that die during childbirth failed to visit skilled maternal attendants, indicating that many women that go for ante-natal care do not go for delivery at the hospital. Review of records in the hospital (2011) confirmed this despite availability of skilled health personnel, adequate facilities and free health services.

Justification

Understanding the factors that hinder delivery in health facilities are particularly important in order to narrow the existing gaps among regions and improve quality of health service delivered to pregnant mothers to reduce maternal morbidity, mortality and disabilities that are related to pregnancy and childbirth. Low delivery in health facilities is as a result of many factors which lead to high morbidity and maternal mortality, therefore proper interventions must be taken to increase delivery in health facilities. The persisting low utilisation of health facilities for delivery services in Ondo State compared to other States in the south-west region of Nigeria is a great concern. This necessitated the need to find out factors that have to be considered significant to improve delivery in health facilities in this region, particularly in Mother and Child Hospital, Akure and Ondo where services offered are free.

The comprehension of the factors that influences low use of health facility for delivery will contribute to the identifying of problems and the design of appropriate intervention programmes aimed at addressing the gap identified for the improvement in quality of life of pregnant women and ultimately achieving the Millennium Development Goals (MDG) 5 as this represent the hallmark of this research endeavours. Many studies have examined the use of skilled and unskilled birth attendants, but rarely show factors influencing the low use of health facilities offering free delivery services. This is the case with MCH Akure. This study aimed at using empirical data to describe specific factors influencing the low use of MCH Akure. The purpose of this study is therefore to identify the reasons why pregnant mothers who register at the ANC do not deliver in the hospital.

Findings from this study could have implications for programme strategy to better address the delivery needs of women in the community, identify points of intervention to improve the use of safe motherhood services in the area studied and similar communities. The findings will also appreciably advance knowledge in the field of public health, contribute something new, add practical value and lead to the development of other investigations.

Study Hypothesis

The following were the Null hypotheses of the study:

1. There would be no significant association between the non-demographic factors (attitude of health workers, waiting time, etc.) contributing to low utilisation of MCH, Akure as a place of delivery and the knowledge of registered pregnant mothers on the importance and benefits of the health facility for delivery services.
2. There would be no significant association between demographic factors and low utilisation of MCH Akure as a place of delivery by registered pregnant mothers.

Research Question

This study answered the following research questions:

1. What educational information is given by health facility staff to registered pregnant women on the benefits and importance of utilizing the health facility for delivery at the Mother and Child Hospital, Akure?
2. What are the experiences and perceptions of respondents that account for low use of the health facility for delivery?

3. What are the health service-related factors contributing to low utilisation of the health facility for delivery?

Broad Objective

The broad objective of the study was to investigate the factors influencing low use of Mother and Child Hospital, Akure among pregnant women who registered at the antenatal clinic.

Specific Objectives

The specific objectives were to:

1. Assess the information received by registered pregnant women in Mother and Child Hospital, Akure on the benefits and importance of utilizing the health facility for delivery.
2. Assess the experiences and perceptions of respondents that contribute to low use of the health facility
3. Describe the health service-related factors contributing to low utilisation of the health facility for delivery.

CHAPTER TWO

LITERATURE REVIEW

Improving maternal health is one of the eight Millennium Development Goals (MDGs) (goal 5) adopted by the international community in 2000. Under MDG- 5, countries made commitment to reducing maternal mortality by three-quarter between 1990 and 2015. Since 1990, maternal deaths worldwide have dropped by 47% (WHO, 2012). According to the final report of Nigeria Demographic and Health Survey (NDHS) 2013, the prevalence of maternal mortality in Nigeria was 576 deaths per 100,000 births and prevalence of infant mortality rate was 69 deaths per 1,000 live births in 2013.

Globally, maternal mortality remains a major public health concern more than twenty years after the international Safe Motherhood Initiative was launched. Each year, 358,000 women die worldwide from pregnancy-related causes, nearly all in Sub-Saharan Africa and Asia, and many women die from obstetric complications (WHO, 2010).

Maternal Health

A health care system aiming to reduce pregnancy-related morbidity and mortality must focus on maternal and newborn health. Reproductive health care, the care a woman receives before and during pregnancy, at the time of delivery, and soon after delivery, is important for the survival and well-being of the mother and her child. It encompasses the health care dimensions of family planning and prenatal, natal, and postnatal care with the aim of reducing maternal morbidity and mortality (Franny, 2013).

While motherhood is often a positive and fulfilling experience, for too many women during the experience, it is associated with suffering, ill-health and even death (WHO, 2010).

Live birth is the complete expulsion or extraction from its mother of a product of conception irrespective of the duration of the pregnancy, which after such separation, breathes or shows any other evidence of life. For example, beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles – whether or not the umbilical cord has been cut or the placenta is attached. Each product or such a birth is considered live born (WHO, 2004).

Maternal Morbidity is defined as chronic and persistent ill-health occurring as a consequence of complications of pregnancy and childbirth.

Maternal Death

Maternal death as defined by WHO is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy. From any cause related or aggravated by the pregnancy or its management but not from accidental or incidental causes.

The Maternal Mortality Rate (MMR) is the annual number of female deaths per 100,000 live birth from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental cause). The MMR includes death during pregnancy, childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year (Nigeria Demographic and Health Survey, 2013).

Causes of maternal mortality

The WHO facts sheet: maternal mortality updated August 2013, described the major causes of maternal morbidity and mortality as; haemorrhage infection, high blood pressure, unsafe abortion, and obstructed labour. Two contributing factors have been consistently identified: a lack of knowledge about when to access health care services and difficulties with transportation, which deals with delays in reaching health care facilities. In reducing infant and maternal mortality rates by 2015, MDG 4&5 are directly related. However, the results of analysis of trends in 2008 revealed that goals 4&5 were not likely to be achieved by 2015.

Universal Health Coverage (UHC)

Universal Health Coverage (UHC) is the goal that all people can obtain the prevention and treatment of health services they need without suffering financial hardship when paying for them (World Health Organization, 2010). Supported by growing evidence (Moreno-Serra, and Smith, 2012), proponents argue that UHC can improve population health and promote economic development by lifting the barriers created by unequal access to quality health care services. To deliver on this promise, UHC efforts must be designed, implemented, and measured appropriately. The connection between UHC and the women's health agenda, recommending policy measures that can help to ensure that adoption of UHC, as part of the

post-2015 framework and implementation of UHC in national health systems, will directly contribute to improving women's health.

The Skilled Birth Attendant

The term 'skilled Birth Attendant' refers exclusively to people with midwifery skills (for example, doctors, midwives, and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric complications. They must be able to recognize the onset of complications, perform essential interventions, start treatment, and supervise the referral of mother and baby for interventions that are beyond their competence or not possible in the particular setting (UNFPA,2011).

The World Health Organisation defines a skilled attendant 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 the identification, management and referral of complications in women and newborns"(WHO, 2005). History and research have shown that, although all women and babies need pregnancy care, care in childbirth is most important for the survival of pregnant women and their babies since timely treatment of complications is critical. Traditional birth attendants, who are not formally trained, do not meet the definition of skilled birth attendants.

Coverage of Skilled Birth Attendants in Nigeria

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). Improving women's SBA utilisation rate during childbirth is an important component of the Millennium Development Goals (MDGs) (The Millennium Development Goals Report 2011). The World Health Organization (WHO) established international targets for SBA-assisted births (that is: 80% by 2005, 85% by 2010, and 90% by 2015).

Skilled Birth Attendant services

The services of skilled birth attendants (SBAs) include antenatal care (ANC) as well as delivery and postnatal care. Such services are critically important for reducing maternal and neonatal mortality because they provide timely delivery of obstetric and newborn care when life-threatening complications arise. Globally, the maternal mortality ratio (MMR) decreased from 400 maternal deaths per 100,000 live births in 1990 to 210 in 2010. Low-income countries account for 99% (284,000) of all maternal deaths worldwide and a majority of deaths occur in sub-Saharan Africa (162,000) and Southern Asia (83,000). (WHO, 2012). Skilled Birth Attendants (SBA) working together within an enabling environment constitutes Skilled Birth Attendance. The enabling environment includes equipment, drugs and a referral pathway. (Adegoke, Hofman, Kongnyuy and van den Broek, 2011). There is a correlation between an increased proportion of births attended by SBA and a reduced maternal mortality ratio as shown by a number of studies (Adegoke, and van den Broek, 2009).

Skilled Birth Attendance and how it can be measured

Skilled Birth Attendance is the process by which a woman is provided with adequate care during labour, delivery and the early postpartum period. Skilled attendance at all births is considered to be the single most critical intervention for ensuring safe motherhood, because it hastens the timely delivery of emergency obstetric and newborn care when life-threatening complications arise. Skilled attendance denotes not only the presence of midwives and others with midwifery skills (MOMS) but also the enabling environment they need in order to perform capably. It also implies access to a more comprehensive level of obstetric care in case of complications requiring surgery or blood transfusions. Skilled birth attendance is measured by the presence of a skilled birth attendant at delivery which is important in averting maternal and neonatal morbidity and mortality. (UNFPA 2011) Historical as well as contemporary evidence from many countries, most notably China, Cuba, Egypt, Jordan, Malaysia, Sri Lanka, Thailand and Tunisia, indicate that skilled midwives functioning in or very close to the community can have a drastic impact on reduction of maternal and neonatal mortality. This is why the proportion of births attended by a skilled health provider is one of the two indicators for measuring progress toward the fifth Millennium Development Goal, improving maternal health. (UNFPA, 2011)

Complications are mostly unpredictable but treatable

A potentially fatal condition complicates up to 15 percent of all births. Although many of these complications are unpredictable, almost all are treatable. Skilled attendants are trained to recognize problems early, when the situation can still be controlled, to intervene and manage the complication, or to stabilize the condition and refer the patient to a higher level of care, if needed. Skilled attendance is also vital to protecting the health of newborns: the majority of perinatal deaths occur during labour and delivery or within the first 48 hours after delivery. Yet in the developing world, only about 58 per cent of all deliveries are reported as attended by skilled health providers. In some countries, the figure is closer to 10-12 per cent. And in many of those cases, the woman does not have access to life-saving emergency care should something go wrong (UNFPA, 2011).

Maternal mortality is unacceptably high. About 800 women die from pregnancy- or childbirth-related complications around the world every day. Almost all of these deaths occurred in low-resource settings, and most could have been prevented. The highest incidence of maternal and perinatal mortality occurs around the time of birth with the majority of deaths occurring within the first 24 hours after birth. This is why WHO advocates for "skilled care at every birth". Skilled care before, during and after childbirth can save the lives of women and newborns babies (WHO, 2014). Ensuring quality maternity care services can save the lives of women and newborns. In addition to the appropriate skills, these health professionals should be motivated and located in the right place at the right time, they need to be supported by appropriate policies, essential supplies including medicines and operating under appropriate regulatory frameworks.

What still remains are the challenges which relate to the shortage of health workforce, education and practice. WHO has developed tools and frameworks to support interventions in response to these Challenges, Globally and locally; studies have identified delivery assistance as a vitally important factor associated with positive improvements in maternal mortality rates (Bhutta, Chopra, Axelson, and Berman, 2010). The SBA has a critical role of making pregnancy safer. Based on the analysis of MMR in 181 countries, Hogan and Foreman concluded that between 1990 and 2008, the increase in the proportion of women who gave birth with a skilled attendant was a main explanatory factor in the decline in global MMR. Countries such as India with large declines in MMR over the same period also experienced a concomitant increase in the proportion of deliveries made by skilled attendants. (Hogan and

Forman, 2010). During the same period, sub-Saharan Africa recorded the smallest magnitude of decline in MMR. (Limwattananon, Tangcharoensathien, and Sirilak, 2011).

Most (94%) of the health facilities (HF) that studied in Nasarawa State did not provide standard EmOC services to women. (Nyango, Mutahir, Laabes, Kigbu, and Buba, 2010) In another review of delivery practices at secondary health facilities in Nigeria, basic EmOC services (vaginal examination, fetal heart monitoring, and blood pressure measurement) were given to less than two-thirds of the 309 subjects, and less than adequate quality persisted well into the labor stage of delivery. (Osungbade, Oginni, Olumide, and Owoaje, 2010).

A study of 152 Health Workers (HW) (doctors, nurses, midwives, and Community Health Extension Workers (CHEWS) from 22 health facilities in five cities of two States in Nigeria found that 91% of the HW had poor knowledge of EmOC concepts, and 60% did not counsel clients on complications readiness. Only two-thirds of them adhered to the recommended EmOC standard of practice. (Ijadunola, Ijadunola, Esimai, and Abiona, 2010). Given these facility-level deficiencies, women reportedly discerned no comparative advantage in delivery at PHCs over deliveries by TBA at home. This may explain why many women still opt for TBA delivery despite the established life-threatening limitations of TBA, notably their weak judgment. (Okoli, Abdullahi, Pate, Abubakar, and Aniebue, 2012), (Eze, Ibekwe, 2010) (Olusanya, Inem, and Abosede, 2011).

The health of a mother impacts the family and even the entire community. Her ability and access to receive necessary healthcare largely determines health outcomes for herself and her baby. Most maternal deaths, stillbirths and neonatal deaths are preventable. Access to Skilled Birth Attendance during childbirth and in the immediate post natal period and access to Emergency Obstetric Care (EmOC) in case of obstetric complications are considered to be effective interventions to reduce the number of global maternal and newborn deaths. (Scott and Ronsmans 2009).

The World Health Organisation defines health as the enjoyment of the highest attainable standard of health and is one of the fundamental rights of every human being. It has been found that healthier nations, or those with a greater life expectancy and lower infant mortality, see greater economic growth and prosperity. The argument has also been made the other way that economic growth contributes to healthier nations. It's not just the overall availability of

resources that improves health, but the access by the public to those resources. Health only improves during economic prosperity if there is a shift in resource allocation towards health and education, equitable distribution of income, and extensive employment programs to decrease the unemployment rate. UNICEF found that healthy children need healthy mothers.

Positive predictors for SBA utilisation in health facility

Positive predictors for SBA utilisation have been suggested to include education (Babalola and Fatusi, 2009) and maternal age (Dairo and Owoyokun, 2011). However, distance (Oladapo and Osiberu, 2009) and cost (Babalola and Fatusi, 2009; (Gabrysch and Campbell, 2009) have been identified as factors shown to have negative association with SBA utilisation. In a recent study, the effects of socio-economic and gender factors on the utilisation of facility delivery in Nigeria was examined. The study found that factors such as women's age, education, higher wealth quintile, urban residence, employment status, and ethnicity were associated with higher odds of using facility delivery. The study also found a strong and independent effect of gender, indexed by autonomy in decision-making and the possession of more modern attitudes regarding a wife's ability to control her sexuality on the odds of using facility delivery (Singh, Bloom, Haney, Olorunsaiye, and Brodish. 2012).

Factors affecting the use of health facility for delivery services

Several studies have been conducted worldwide on the factors affecting delivery in health facilities and some factors were observed. The issues of risk and vulnerability, such as lack of money, lack of transport, sudden onset of labour, short labour, staff attitudes, lack of privacy, geographical location, perception of poor quality of health services, tradition, cultures and the pattern of decision-making power within the household were perceived as key determinants of the place of delivery (Magoma, 2010,).

The reasons why many women in Nigeria continue to use any of these unsafe delivery approaches was reviewed. The review identified supply and demand side factors as pivotal in the utilisation of delivery attendance. In the case of unskilled attendance, the supply side factors include generalized health systems weakness, indexed by lack of infrastructure (like poor or no supply of electricity) and equipment (such as ambulances); perennial stock out of obstetric care commodities; sub-standard Emergency Obstetric Care (EmOC) and poor compliance with standard of practices; inadequate health worker size, mix, capacity,

motivation; weak referral linkages and feedback mechanisms (Erim, Kolapo, and Resch, 2012).

Factors on demand side in maternal health care include cost of services, prohibitive local customs; husbands/significant others that are not supportive of use of formal services; unwillingness by some women to see a male health care provider; limited knowledge of available services by others. (Doctor and Dahiru, 2010) and poor socio-economic status, and the persistence of gender norms that are adversarial to women's health (Eze, and Ibekwe, 2010). Some access related issues include high user-fees, limited health facilities within reasonable commuting distance, and poor HW attitudes, including their lack of respect in care-giving. Furthermore, the fear of stigma and loss of privacy were additional reasons many pregnant women living with HIV/AIDS (PLWHAs) do not use skilled birth attendance in Nigeria (Enwereji, and Enwereji, 2010;Iyaniwura, and Yusuf, 2009; Ezeanochie, Olagbuji, Agholor, and Okonofua, 2010).

Health service-related factors such as unreliable transport is also a barrier to access skilled delivery in rural areas, failure to plan in advance for transport cause higher number of women to deliver in their homes even if they had planned to deliver in health facilities (Magoma 2010).

Importance of ante-natal care and delivery in health facility

Antenatal care is the care given to women during pregnancy that provides an important opportunity for discussion between a pregnant woman and a health care provider about health behaviour during pregnancy, recognizing complications that may arise during pregnancy, and delivery plans that will meet the needs of the individual woman. Antenatal care refers to the regular medical and nursing care recommended for women during pregnancy. Also, it is a type of preventive care with the goal of providing regular checkups that allow doctors or midwives to prevent, detect as well as treat potential health problems that may arise in a pregnant woman (WHO 2005).

The major objective of antenatal care is to ensure optimal health outcomes for the mother and her baby. Ante-natal care from a trained provider is important to monitor the pregnancy and reduce morbidity risks for the mother and child during pregnancy and delivery. Antenatal care provided by a skilled health worker enables (1) early detection of complications and prompt

treatment (such as, detection and treatment of sexually transmitted infections), (2) prevention of diseases through immunisation and micronutrient supplementation, (3) birth preparedness and complication readiness, and (4) health promotion and disease prevention through health messages and counseling for pregnant women. It is during ANC visits that the expected date of delivery is typically determined. The mother is usually expected to deliver any moment from 38-42 weeks of gestation. Errors in estimating the expected date of delivery could lead to the baby being delivered supposedly unexpectedly. Assistance during childbirth is an important variable influencing the birth outcome and the mother's and infant's health. The skills and performance of the person providing assistance during delivery determine whether complications are properly managed and hygienic practices are observed (NDHS.2013).

High-quality antenatal care (ANC) has been shown to promote maternal and fetal wellbeing (Ochako, Fotso, Ikamari, and Khasakhala, 2011). The proportion of women receiving skilled care during delivery is used as a progress indicator for reducing maternal mortality, since direct measurement of maternal mortality is difficult (Nikiema, Kameli, Capon, Sondo, Martin-Prevel, 2010). The majority of maternal deaths occur during labor, delivery, and the immediate postpartum period (Wanjira, Mwangi, Mathenge, Mbugua, and Ng'ang'a, 2011). Because most maternal deaths occur due to preventable obstetric complications, most could be prevented if women had access to high-quality maternal health care, including antenatal care, skilled assistance at delivery, and postnatal care (Chou, Inoue, Mathers, Oestergaard, Say, Mills, Suzuki, and Wilmoth, 2010,).

Antenatal clinic attendance and delivery in health facility

Antenatal care (ANC) from a trained provider is important in order to monitor the pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy and delivery. About three-fifths of mothers (61 percent) reported consulting a skilled health provider—a doctor, nurse, midwife, or auxiliary midwife—at least once for antenatal care for the most recent birth in the five-year period before the survey (NDHS, 2013).

Insufficient counseling during antenatal visit is another factor for low delivery in health facility, minimal time used by health workers for counseling pregnant mothers during antenatal clinic is the missed opportunity to educate women on the importance of health facilities delivery. Also information that all pregnancy carry risk and labour complications are unpredictable, are not communicated during antenatal clinic visit. In some places provider do

not inform pregnant mothers the meaning of expected date of delivery, when the labour pain start early before that date they end up delivering in their homes even if they were interested to deliver in health facility. Majority of women who visited antenatal clinic had low awareness about the danger signs of obstetric complications. These lack of adequate information about danger signs and complication related to delivery are the factors for low delivery in health facilities (Pembe, 2010; Magoma, 2010) Pregnant mothers are encouraged to attend antenatal clinic at least four visit according to WHO recommendations as they received more information on the status of their pregnancy which in turn informs their decisions on the place to deliver.

Coverage of Antenatal care (ANC)

Antenatal care coverage is an indicator of access and use of health care during pregnancy; it is defined as percentage of women who used antenatal care provided by skilled health personnel for reasons related to pregnancy at least once during pregnancy as a percentage of live births in a given time period. Antenatal care (ANC) from a trained provider is important in order to monitor the pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy and delivery. About three-fifths of mothers (61 percent) reported consulting a skilled health provider—a doctor, nurse, midwife, or auxiliary midwife—at least once for antenatal care for the most recent birth in the five-year period before the survey. The differentials in antenatal care coverage are large. Coverage is highest for births to women 20-34 years old (63 percent), and much higher in urban areas (86 percent) than rural areas (47 percent) (WHO, 2014).

Across geopolitical zones, the proportion of mothers reporting that they received antenatal care from a skilled provider is markedly lower in the North West (41 percent) followed by the North East (49 percent). Women in the South East (91 percent) and South West (90 percent) are most likely to have received antenatal care from a skilled provider. Among the states, the percentage of mothers who received antenatal care from a skilled provider ranges from a high of 98 percent in Osun to a low of 17 percent in Sokoto. Percentages of women receiving antenatal care from a skilled provider are also relatively low in Zamfara (22 percent), Katsina (23 percent), and Kebbi (24 percent). As the mother's educational level rises, so does the likelihood that she has seen a skilled provider for care during pregnancy. Antenatal care utilisation is highest among women with more than secondary education (97 percent) and lowest among women with no education (36 percent). The proportion of mothers receiving

antenatal care from a skilled health provider increased from 58 percent in 2003 to 61 percent in 2013.

ANC offers an important opportunity for healthcare providers to inform women about the advantages of delivering their babies with the help of an SBA. Moreover, ANC teaches pregnant women about the danger signs of pregnancy, enabling them to recognize early symptoms and go to a health facility as soon as possible. For women with normal pregnancies, WHO recommends a minimum of four ANC visits, ideally at 16, 24–28, 32, and 36 weeks (Minimum package of antenatal care services defined.)

In low-income countries, about 68% of mothers complete at least one ANC visit and almost 60% complete four or more visits (Stanton, Blanc, Croft, and Choi, 2009). Medical checkups and screening tests help keep a pregnant woman and the foetus healthy during pregnancy. This is called prenatal care. It also involves education and counseling about how to handle different aspects of your pregnancy. During a pregnant woman's visit to the clinic, the doctor or the midwife may discuss many issues, such as healthy eating and physical activity, screening tests, and what to expect during labor and delivery.

ANC in practice

To ensure optimal health outcomes for the mother and her baby is the major objective of ANC. ANC from a trained provider is important to monitor the pregnancy and reduce morbidity risks for the mother and child during pregnancy and delivery.

Officially the ANC clinics open at 8am and close at 3.30pm. Health workers encourage pregnant women to arrive early in the morning. While ANC return visits tend to take a few minutes and only consist of abdominal examinations, blood pressure measurements, and the administration of Sulphadoxine-Pyrimethamine (SP) and other drugs, pregnant women's first ANC visits are time-intensive. They are organized along the five components of service provision stipulated by the FANC guidelines: 1) history taking, 2) physical examination, 3) laboratory examinations, 4) drug administration and immunization and 5) health education, provides an overview of the services delivered to pregnant women in comparison with the requirements of the national FANC guidelines (Gross, Schellenberg, Kessy, Pfeiffer, and Obrist, 2011).

Prenatal checkups

During pregnancy, regular checkups are very important. This consistent care can help keep the pregnant woman and the baby healthy, detect problems if they occur, and prevent problems during delivery. Typically, routine checkups occur:

- Once each month for four weeks through 28
- Twice a month for weeks 28 through 36
- Weekly for weeks 36 to birth
- Women with high-risk pregnancies need to see their doctors more often.

At first visit, the doctor will perform a full physical exam, take blood sample for laboratory tests, and calculate the Expected Date of Delivery (EDD). The doctor might also do a breast exam, a pelvic exam to check the uterus (womb), and a cervical exam, including a Pap test. During this first visit, the doctor will ask lots of questions about lifestyle, relationships, and health habits. It is important that a patient be honest with the doctor.

After the first visit, most prenatal visits will include:

- Checking blood pressure and weight
- Checking the baby's heart rate
- Measuring the abdomen to check the growth of the baby
- Routine tests will be done throughout the period of pregnancy, such as tests to look for anemia, tests to measure risk of gestational diabetes, and tests to look for harmful infections. It is important a patient partner with the doctor to manage her care, Keep all her appointments, ask questions and read to educate herself about this exciting time.

Monitoring of baby's activity

After 28 weeks, a pregnant woman needs to keep track of the baby's movement. This will help her notice if the baby is moving less than normal, which could be a sign that the baby is in distress and needs a doctor's care. An easy way to do this is the "count-to-10" approach which is daily. Count baby's movements in the evening — the time of day when the fetus tends to be most active. Most women count 10 movements within about 20 minutes. But it is rare for a woman to count less than 10 movements within two hours at times when the baby is active. The doctor is called if less than 10 movements within two hours is counted or if the baby is moving less than normal. If the baby is not moving at all, the doctor is called right away.

Prenatal care and tests

Tests are used during pregnancy to check the woman and her baby's health. At her first prenatal visit, the doctor will use tests to check for a number of things, such as:

- Blood type and Rh factor
- Anemia
- Infections, such as toxoplasmosis and sexually transmitted infections (STIs), including Hepatitis B, Syphilis, Chlamydia, and HIV
- Signs that the woman is immune to rubella (German measles) and chicken pox

Throughout pregnancy, the doctor or midwife may suggest a number of other tests, too. Some tests are suggested for all women, such as screenings for gestational diabetes, Down syndrome, and HIV. Other tests might be offered based on the woman's: age, personal or family health history, ethnic background, results of routine tests. Some tests are screening tests, they detect risks for or signs of possible health problems in the woman or baby. Based on screening test results, the doctor might suggest diagnostic tests. Diagnostic tests confirm or rule out health problems in the woman or her baby (Gross et al, 2011).

The potential of antenatal care for reducing maternal morbidity and improving new-born survival and health has been widely acknowledged (Nikiema, Beninguisse, and Haggerty, 2009). The antenatal period provides excellent opportunities to reach pregnant women with prophylactic medication, vaccinations, diagnosis and treatment of infectious diseases, as well as with health education programs. Proven effective antenatal interventions include serologic screening for syphilis, provision of malaria prevention, anti-tetanus immunization and prevention of mother-to-child-transmission of HIV. Provision of advice during antenatal care about potential pregnancy complications and danger signs, and information on how to seek medical care, are viewed as key strategies to reduce delay in seeking skilled care. Moreover, a positive association between the level of care obtained during ANC and skilled delivery care has been reported.

The FANC model emphasizes goal-oriented and women-centred care by skilled providers. Activities of the new model include; the early detection of danger signs and referral; therapeutic interventions known to be beneficial; and alerting pregnant women to emergencies and instructing them on appropriate responses. In fact, one of the main goals of the new model is to strengthen the information component through individual health education and

counselling. However, quality assessments of antenatal care services provided to pregnant women raised questions about health workers' performance: practice often diverges from the standards required in the guidelines. Although inadequate health workers' performance has been widely described, determinants of poor performance are not fully understood.

In many studies national guidelines serve as a "gold standard" to assess observed health workers' performance during patient consultations. However, recent qualitative studies emphasize the importance of comprehending the complex context in which guidelines are put into practice (Mathole and Walker and Gilson) for example, assessed the implementation of policy changes in Zimbabwe and South Africa and illustrated health workers' difficulties in handling the changes due to resource shortages and poor policy implementation. They showed that health workers developed informal practices in order to cope with the high demand for their services and the difficult working situation. Two studies from Tanzania and the UK illustrated how peer pressure, perceived patients' preferences and team support lead clinicians to take decisions based on constructed "mind lines" that are the result of day-to-day practice rather than evidence-based knowledge.

Place of Delivery and Outcome

Increasing the percentage of births delivered in health facilities is an important factor in reducing deaths arising from complications of pregnancy. The expectation is that if a complication arises during delivery, a skilled health worker can manage the complication or refer the mother to the next level of care (NDHS.2013).

Delivery outcomes are modulated by the type of delivery attendance utilized. (Lawoyin, Onadeko, Asekun-Olarimoye. 2010) The likelihood of neonates to die with skilled delivery assistance was contrasted and other scenarios: neonates were five times more likely to die if they had no attendance at birth, three times more likely to die if their births were attended by Traditional Birth Attendants (TBA), and four times more likely to die if they were delivered outside the health facility. A matched case control study of 56 infants with Permanent Congenital and Early Hearing Loss (PCEHL) and 280 normal hearing controls also found that infants delivered with unskilled attendance were four times more likely to develop PCEHL than their peers who were delivered with skilled attendance (Esimai, and Abiona. 2010).

These findings are consistent with the results of a 10-year autopsy review in a referral hospital in Cross Rivers State, which showed that 43% of the maternal deaths occurred at the TBA centres and most were associated with preventable causes (Erim, Kolapo, and Resch 2012).

The limited use of skilled birth attendance (SBA) has been documented in Nigeria. Of the 1,875 women who enrolled in a community-based program to improve delivery outcomes in Zaria, Nigeria, 95% of them who delivered at home, only 7% were attended by a skilled attendant (Prata, Ejembi, Fraser, Shittu, and Minkler. 2012). In a survey of 6,882 married women in northern Nigeria, only 26% of the women surveyed had received any antenatal care, 13% delivered in a facility attended by skilled birth attendant, and 86% gave birth at home under unskilled care. (Doctor HV, Findley, Ager, Cometto, and Afenyadu, 2012) In a cross-sectional survey of health facilities in Shagamu Local Government Area in SW Nigeria, it was found that 67% of the 300 women studied delivered at home, and the majority utilized unskilled attendants. In the study, 86% of all home deliveries used unhygienic surfaces, and most utilized unclean kitchen equipment (such as knives, scissors) for cord cutting, with higher risk of infection for both mother and child (Prata, Ejembi, Fraser, Shittu, and Minkler, 2012).

CONCEPTUAL FRAMEWORK OF THE STUDY

Framework for the Analysis of Healthcare Utilisation

The conceptual framework of the use of delivery care services used in this study was based on Andersen's Behavioral Model of Health Services Use. This model has been widely used to understand the factors that determine an individual's use of health care services (United Nations Children's Fund, 2012). According to Anderson and Newman (2005), utilisation of health services can be regarded as a type of individual behaviour. Andersen's Health Behavioural Model (2005) assumes that certain characteristics contribute to, or determine an individual's use of health services. He divided these characteristics into three categories, and proposed that utilisation of health services is dependent on: 1) Predisposing characteristics; 2) Enabling characteristics; and 3) Need- based characteristics.

Predisposing Characteristics

Predisposing factors are the combination of demographic characteristics, social structure, and health beliefs. Demographic characteristics are the tendency of the individual to use services which include: age, gender, family size, number of previous pregnancies and marital status. Social structure such as education, occupation and religion or ethnicity measures the coping

ability of the individual with the problem and availability of the resources. Health beliefs are the knowledge about health and health care system; for example, attitudes towards disease and medical care.

It is postulated that some people are more likely to use services than others and this likelihood can be predicted by individual characteristics. People that possess certain characteristics have been found to be more disposed towards health services use, even though these characteristics are not directly responsible for the utilisation. These characteristics include demographic factors, such as age, sex, parity, and so on; social structural factors, which is a reflection of the individuals social standing or status and is measured by characteristic such as educational attainment and occupation of the head of the family; and attitudinal-belief factors, where individuals who have stronger faith in the efficacy of treatment are more inclined towards healthcare utilisation (Rebhan, Anderson and Newman, 2005).

Enabling Characteristics

Certain resources need to be available to an individual in order to actualize health services utilisation even in the presence of predisposing factors. These resources are defined as enabling as they make health services available to the individual and are found both at the family and community levels. Family resources include income (economic status), health insurance coverage and location of residence (Rebhan, Anderson and Newman, 2005). Family income is an important enabling factor as it determines the amount of funds available to an individual to cover healthcare and related costs, such as: physician consultation, drugs, transportation costs, and so on. Resources at the community level include the number of health facilities and health personnel available for use to an individual. A greater number of health facilities and personnel reduce the unpleasantness of queuing-up for limited services and might be used more frequently by individuals. Community level resources also include the nature of the area where an individual resides that is region of the country or whether residence is in the urban/rural area. This is because local norms and values influence an individual's behaviour towards the practice of medicine (Anderson and Newman, 2005). Enabling factors are factors that make the individual able to obtain health care services, such as income, health insurance, travel, waiting time, and availability of the health care providers. Need factors – which are considered to be the most immediate cause of health service use – are the perception of one's own health status and expectation of benefit from the treatment (Andersen, 1995).

Need-Based Characteristics

Measures of this characteristic include perceived needs, that is, the perception of illness and its severity or the probability of an illness occurring; and needs as evaluated by a health professional (Anderson and Newman, 2005). A woman's need for care may be influenced by past experiences in pregnancy and childbirth or personal preferences. Thus, perceived need serves as a stimulus for the use of health services. Perceived illness can be measured by the number of disability days, and symptoms experienced by the individual during a specified time frame (Anderson and Newman, 2005)

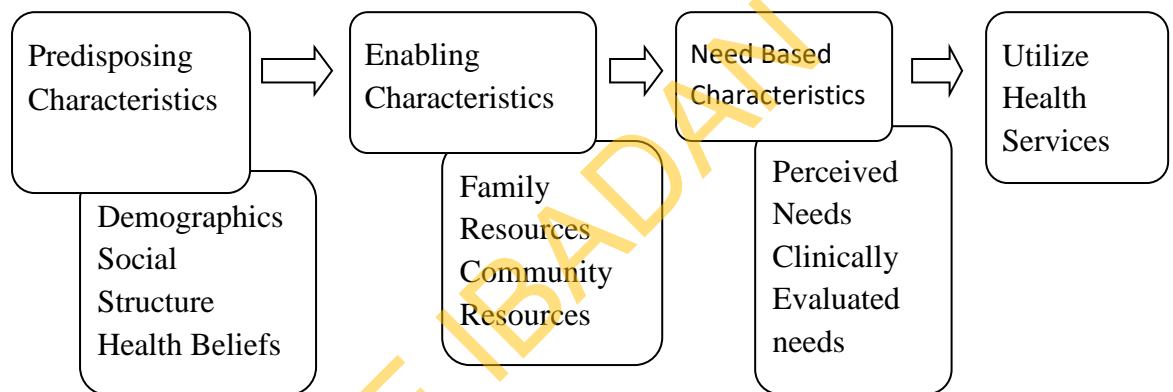


Figure 2.1: Andersen's behavioral model of use of health services (adopted from Andersen, 1995)

Application of the Andersen's behavioral model of use of health services

Andersen behavioural model analyses differences in health services utilisation from a socio-demographic perspective. This tallies with the objectives of this study; hence, the study was conducted based on Anderson's model. The Andersen Model is a conceptual model aimed at demonstrating the factors that lead to the use of health services. (Andersen, 1995). Hence, it was applied to the use of delivery service in MCH Akure. The characteristics that contribute to, or determine pregnant women's use of delivery service in health facility is divided into three categories: Predisposing, Enabling, and Need-based characteristics. These factors determine the utilisation of delivery service.

The predisposing factors were operationalised by questions in section ‘A’ of the questionnaire which collected information on the socio-demographic and economic characteristics of the women. Enabling factors were assessed by questions in section ‘D’ of the questionnaire which assessed the health services related factors influencing the low use of the facility. The Need based characteristics were assessed by questions in section ‘B’ which assessed the quality of the services provided at the health facility which can influence the utilisation of the health facility by pregnant women.

The goal of this model is to ensure that all the factors needed to encourage utilisation of the health facility are provided. Threat of complications during pregnancy and delivery if seen as low, as few believe they are susceptible may influence pregnant women from using the facility. But benefits seen in attending ANC like, free Immunization, drugs, laboratory test, and delivery services, coupled with the intervention of improved health promotion and education especially during ANC will increase the likelihood of utilising MCH for delivery service from moderate to high.

The above can be illustrated in the framework below:

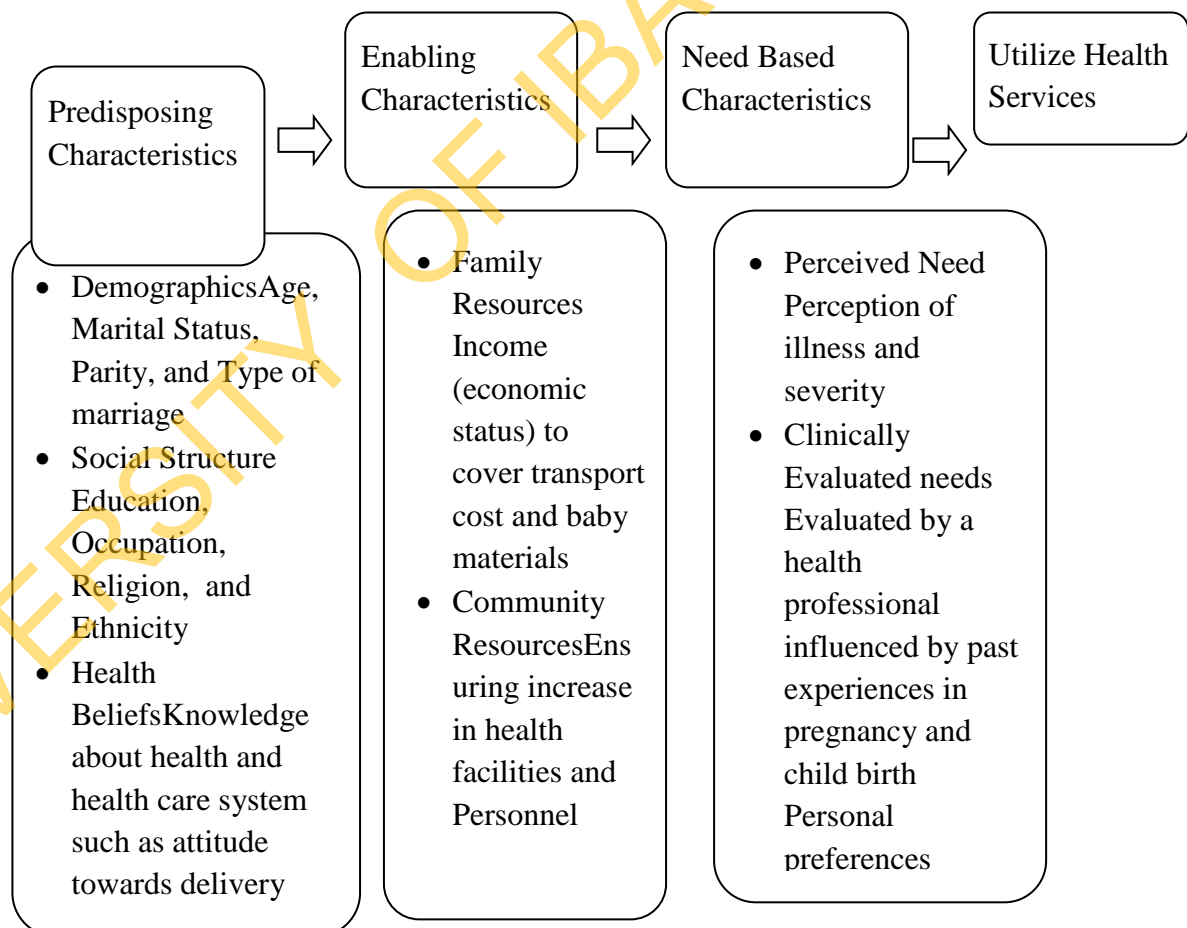


Figure 2.2: Andersen’s behavioral model of use of health services (adopted from Andersen, 1995)

CHAPTER THREE

METHODOLOGY

Research Design

The research design was the descriptive cross-sectional survey designed to investigate the factors influencing low use of Mother and Child Hospital, Akure for delivery services by women who register at the ANC.

Population of the Study

The population of the study comprise mothers aged 15-49years who registered within 18 months (March 2013-August 2014) at the Ante-Natal Clinic (ANC) in Mother and Child Hospital (MCH), Akure, Ondo State but did not deliver there. Recruitment was done by the researcher and 6(six) field assistants. The interviewing field assistants were trained to conduct and administer the questionnaires for two days.

Inclusion criteria

All mothers who registered at the ANC but did not deliver in the hospital and mothers that consent to be participants by signing consent form.

Exclusion criteria

Mothers who did not register at the clinic and mothers who did not consent by signing the consent form.

Study Site

Ondo State is one of the 36 states in Nigeria, was created on 3 February 1976, by the then Federal Military Government of Nigeria. It was carved out of the former Western region. Akure is the state capital, and there are eighteen Local Government Areas in the state. The state shares boundary with Kogi, Osun, Kwara, and Ekiti states. The total area covered by Ondo state is 15,500 km² (6,000 sq m) with a total population of 3,440,000 (2006 census). Akure is a city in south-western Nigeria and is the largest city and capital of Ondo State. The city has a population of approximately 387,087. The people are of the Yoruba ethnic group.

Ethnic composition, Languages, Culture and the Arts. The people of Ondo state are Yoruba (except those from owo, Ijaw settlement in the littoral part of the state) and the most known ethnic sub- groups are the Akure, Akoko, Ondo, Ijaw, Ikale, Ilaje and Owo. Generally the people have similar customs, traditions and language although there are some variations most observable with the ijaw. In the field of arts and culture, Ondo State is among the richest in the federation in the variety and quality of its traditional sculpture. The people are lovers of arts, music (such as Obitun dancers) with sayings and poetry. The ivory carvings, bronze works and wood carvings from Owo are Yoruba's culture. Ondo indigenes are found in various services and especially in education and civil services. They are hardworking people with the slogan, "Ise logun ise" and they are peace loving people.

The Mother and Child Hospital, where the study was carried out is situated at Oke- Aro in Akure. The model hospital is a brainchild of the governor of the state. The government of Ondo state designed the facility to promote preventive, restorative and rehabilitative healthcare to the women and children of Ondo state. The facility offers free health care services with skilled birth attendants. The facility at the Mother and Child hospital is amongst other things, a unique and cost effective digitalised drug procurement system that has practically eradicated out of stock syndrome, the bane of many free health schemes across the country. The mother and child hospital has equipment including electronic force monitoring birthing and airway management simulators for life like practical demonstrations and applications on emergency care.

Sample Size

Determination of sample size

The sample size (n) was determined by using Lwanga and Lemeshow (1991) sample size formula:

$$n = \frac{Z^2 p(1-p)}{d^2}$$

Where n=minimum sample size required

Z= confidence limit of survey at 95% (1.96)

P= Proportion of birth in Ondo state outside health facility was 43.8%, approximately 44% (NDHS 2013 final report).

d=absolute deviation from true value (degree of accuracy) = 5%

$$n = \frac{1.96^2 \times 0.44 \times 0.56}{0.05^2} = 378.6, \text{ approximate} = 379$$

A non-response rate of 10% of 379 = 37.9, approximately 38

Therefore, 38 was added to the sample size calculated to make the sample size 417

Sampling procedure

Subjects were selected using purposive sampling.

Purposive sampling involves the selection of sample of individuals with a particular purpose in mind. The purpose in this study was to determine the reasons why women who register at the ANC do not deliver in MCH Akure. This study was carried out using the records in ANC of women who registered between January 2013 and August 2014 and did not deliver in the clinic. The sample size that was selected was 417 for the quantitative data and 3 for the qualitative data. Each unit was located through address and phone number from the register.

Instrument for data collection

Quantitative data

A semi-structured questionnaire was used to collect information on the following:

1. Socio-demographic parameters of the respondents.
2. The information received by registered pregnant women in Mother and Child Hospital, Akure on the importance of utilizing the health facility for delivery.
3. The experiences and perceptions of respondents that influences the low use of the health facility
4. The health service-related factors contributing to the low utilisation of the health facility for delivery.

The questionnaire used for the study ensured clarity of language, singleness of purpose, correct grammar, and was relevant to the objective of the study. It was also developed in English and translated in Yoruba, the local language of the study setting. This was then translated to English to check for consistency and avoid loss of meaning. The questionnaire consists of both closed and open-ended questions on the purpose of the study.

Qualitative data

Three In-Depth Interviews (IDI) were conducted among a health care worker, a respondent who gave birth at the mission home and a respondent who gave birth at the traditional birth attendant's home using IDI guide which focused on the objectives of the study. A guide with important theme was prepared and used.

The research technique used was the In-Depth Interview (IDI) using interview guide because it allows person to person discussion, lead to increased insight into people's thoughts, feelings, and behavior on reasons why women register at the Ante-Natal Clinic but do not deliver at the hospital. The interview was unstructured since it allows the respondent to talk at length about the topic of interest. Flexible interview approach was used with the aim to ask questions that explain the reasons underlying the use of Mother and Child Hospital, Akure for ANC, and not for delivery services.

Pre-testing of instrument

Ten (10) percent of the total sampling size was pre-tested. The pre-testing of the instrument was done at Mother and Child Hospital Ondo which has similar characteristics as that of the study area. Permission was obtained from the hospital's administration, to allow the record officer release the records of women who attended ANC and those who delivered at the facility to be able to get the required sample (42). Pre-testing of the data collection tools was done with a team of field assistants who eventually collected data for the study. Pretesting was done two weeks prior to actual data collection to allow for final adjustments and modifications to the main questionnaire as well as training. After pretesting the field assistants were retrained on some aspects of the questionnaire and how to administer it. Some questions were reformulated to get consistent responses when asked by different field assistant.

Validity of instruments

For the validity of instrument the following were considered: adequate training of field assistants on the research procedures and instrument for data collection; the instrument was interpreted in Yoruba language for adequate understanding; proper review of literatures pertinent to my study was done to add value to the validity of the instrument; the instrument was applied based on the formulated objectives to adequately validate the instrument. Since validity is practical, the instrument was subjected to peer review for critic, and critical critiquing was done by my project supervisor before and after it was pre-tested at MCH,

Ondo. The forms of validity were protected to ensure accuracy; construct, internal, external, and conclusion validity.

Reliability of instrument

The following actions were taken to test and ensure the reliability of the instrument; the questionnaire was pre-tested at Mother and child Hospital (MCH), Ondo since it has similar characteristics to the selected one; the responses were coded, entered, and analysed using the SPSS software; the consistency, accuracy and precision of the instrument was ensured and it was confirmed when it measured what it was supposed to measure.

Method of Data Collection

The data collection process utilized the service of interpreters in Yoruba language in investigating the factors affecting the use of MCH Akure, for delivery services.

Recruitment and training of field assistants

Six field assistants who are familiar with the study setting, literate with tertiary education, have had previous experiences in data collection, and fluent in local language were recruited and trained for two days prior to fieldwork. The training was focused on the purpose of the study, Interpersonal communication skill, data collection tool, interviewing technique, eligibility criteria and ethical principles.

Variables

The variables were selected based on Andersen's Behavioral Model of health services use. The author distinguished three sets of characteristics related to skilled birth attendance, namely: Predisposing factors (socio-demographic factors which include: age, gender, parity, marital status, education, occupation, religion, ethnicity and knowledge.), Enabling factors (as family income, adequate health facilities, waiting time, and availability of health personnel), Need based factors (past experiences in pregnancy and childbirth and individual perceptions).

Independent variables

The independent variables in this study are the socio-demographic characteristics which are: mother's age, religion, educational level, marital status, parity, and head of household, women occupation and husband occupation.

Dependent variables

The independent variables utilized were the place of delivery, ante-natal care, skilled birth attendance, family income, individual perceptions and so on.

Data Entry and Analysis

Method of analysis for the quantitative instrument

A semi-structured questionnaire was used to elicit information respondents' socio-demographic factors and the objectives of the study. They are to assess the information received by registered pregnant women in Mother and Child Hospital, Akure on the benefits and importance of utilizing the health facility for delivery; assess the experiences and perceptions of respondents that contribute to low use of the health facility; describe the health service-related factors contributing to low utilisation of the health facility for delivery.

All copies of the questionnaire were checked for consistency and completeness of information and the open-ended responses in Yoruba were translated to English for easy data entry and analysis. Each questionnaire was pre-coded and serial number was assigned to each question for easy identification, and for correct data entry or correction of errors, and analysis. A coding guide was developed to facilitate data coding, and entering of each question into the computer for analysis. Responses from open-ended questions were first categorised into themes and coded into categorical responses. Data were entered into the needed software which was the Statistical Package for the Social Sciences (SPSS) version 20.0. Univariate analysis was done to clean and correct the data (Data cleaning). SPSS was used to determine the frequencies and proportions of the general characteristics of the study population. Chi-square and cross-tabulation was used to show the relationship between the covariates and the dependable variables. Multivariate analysis was done using appropriate descriptive statistical measures such as: mean, median, mode, to describe the findings - calculation of proportions, frequency distribution tables and their percentages and inferential statistics (Chi-square test). P-value of 0.05 or less was considered significant. Chi-Square were used to test for hypotheses.

Method of Analysis for Qualitative Instrument

In-Depth Interviews (IDI) were conducted among a health care worker, a respondent who gave birth at the mission home and a respondent who gave birth at the traditional birth attendant's home. An unstructured IDI guide with important theme which focused on the objectives of the study was prepared and used.

All copies of the IDI Guide were checked for consistency and completeness. The IDI data was recorded in audio tape and was listened to over and over. Data was transcribed and organized. Analysis was done using thematic approach. Themes were identified and responses from open-ended questions were first categorised into themes and coded into categorical responses. Themes were developed and testing of theory against data was done. Report writing was effected and results discussed

Limitation of the Study

This study was carried out by combining both qualitative and quantitative methods of data collection which facilitated reliability of data and strengthening of the findings. Despite the strengths, this study also had limitations.

Purposive sampling was utilized and all units within the period of November 2013- August 2014 (10 months) were used to get available respondents in the bid to achieve the required sample (417).As data collection process went on, it was realised that women registered at the ante-natal clinic using wrong addresses of places of residence, and phone numbers, hence the period was extended backwards to march 2013-August2014 (18 months) to get the required sample.

A field assistant was embarrassed on political ground, accused of support for the government mentioning their grievances. The purpose of the study was explained and issues were amicably resolved.

Ethical consideration

Before the commencement of data collection, the research protocol was reviewed and approved by the Ethical Review Committee (ERC) of the Ministry of health, Ondo State. (Appendix VI), and due permission was obtained from the Chief Medical Director of MCH, Akure before the commencement of the study.

After explaining the nature of the study, its rationale, and the extent of participant involvement for adequate understanding enumerators sought written informed consent from every participant. (Appendix IV).This was filled before the administration of the questionnaire. Informed consent and interviews were conducted with due respect to providing privacy and helping respondents feel secure in expressing their answers.

Confidentiality is central to trust. Names of the respondents were not required in the questionnaire so that all information provided were kept confidential. Study participants' welfare was paramount. Due consideration was given to all other ethical issues.

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CHAPTER FOUR

RESULTS

4.1 Respondents' Socio-demographic characteristics

The socio demographic characteristics of the respondents are presented in Table 4.1. All the 417 respondents were women. The ages of respondents ranged from 16 – 52 years with a mean age of 31.7 ± 6.4 years. The highest education attainment was secondary school (40.3), tertiary (35.7), primary (16.7) and few (7.7) had no formal education. Most (73.4%) respondents were Christians and majority of the respondents were Married (87.5%). On a monthly basis, 46.8% do not receive salaries compared to 53.2% who do receive monthly income. Cash spending decision was made mostly by both respondents and their partner (63.1%), followed by partner only (29.5%) and self (7.4%). Fifty six percent of respondents house hold heads do not receive monthly salary.

Table 4.1a: Respondents' Socio-demographic characteristics

N=417

Characteristics	Frequency	Frequency (%)
Religion		
Christianity	306	73.4
Islam	100	24.0
Traditional	11	2.6
Marital Status		
Single	17	4.1
Currently Married	365	87.5
Widowed	6	1.4
Divorced	14	3.4
Separated	15	3.6
Type of Marriage (n= 386)		
Monogamy	295	76.4
Polygamy	91	23.6
Parity in two Categories		
Less than or equal to 2	234	56.1
3 or more	183	43.9
Parity: Mean = 2 ± 1.3 , Min = 1, Max = 8		
Age in three categories		
16-19years	7	1.7
20-24years	42	10.1
25and above	368	88.2
Age: Mean = 31.7 ± 6.4 years, Min = 16, Max = 52		
Education		
No formal education	32	7.7
Primary	68	16.3
Secondary	168	40.3
Tertiary	149	35.7

Table4.1b: Respondents' Socio-demographic characteristics

Characteristics	Frequency	Frequency (%)
Unemployed	118	28.3
Employed but not for cash	77	18.5
Employed for cash payment	222	53.2
Employment in two categories		
Do not receive Monthly income	195	46.8
Receive Monthly income	222	53.2
Head of House Hold Employment		
Unemployed	53	12.7
Employed but not for cash	182	43.6
Employed for cash payment	182	43.6
Head of House Hold Employment in two categories		
Do not receive Monthly income	235	56.4
Receive Monthly income	182	43.6
Cash Spending Decision Maker		
Woman	31	7.4
Husband/Partner	123	29.5
Both	263	63.1

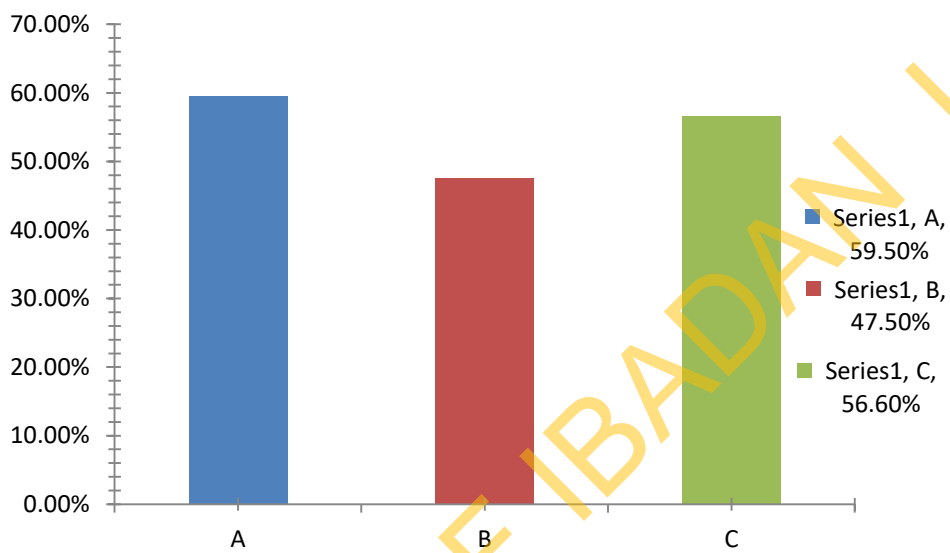


Figure 4.1: Respondents' age group: A= 16 -19 years, B= 20- 24 years, C= 25 and above years

Mean age = 31.7 ± 6.4 years, Min = 16, Max = 52 Min=17, Max = 31

4.2 The Information Received by Registered Pregnant Women in Mother and Child Hospital, Akure on the Importance of Utilising the Health Facility for Delivery.

Qualitative Data

In the in-depth interview from the two pregnant women who attended ANC but decided to give birth in mission homes and in TBAs' home revealed that most of what the pregnant women receive as information included education on cleanliness, nutrition, and how to take proper care of their babies. Their typical responses include the following:

- *“Firstly, whenever we are pregnant and we visit the hospital, they do start with cleanliness, how we are going to eat, get immunisation and how to check the child daily”*
The woman who gave birth in Mission home further listed the importance of attending antenatal clinic. Below were quotes from her comment:
- *“There are a lot of advantages in attending hospital, these include”*
- *“Blood examination”*
- *“Immunization”*
- *“Blood pressure”*
- *“Most of these things are what we do not get in the mission homes”*

The interview with one of the health worker from Mother and Child Hospital corroborated what the two women who gave birth outside the health facility said about the information women receive at the health facility when they come for ANC. In her words:

- *“About safe delivery, we tell them that they and their babies will be safe. We also tell them what they need to know about delivery and expected day of delivery.”*

Quantitative Data

The proportion of respondents with good and poor knowledge scores relating to the importance of giving birth in a health facility are shown on figure 4.2.1 About two-third of the respondents (67%) had good knowledge of the importance of giving birth in a health facility. Respondents had a mean knowledge score of 5.7 ± 1.4 (see figure 4.2.1 for details).

Table 4.2.1 and table 4.2.2 presents results relating to the information received by registered pregnant women in Mother and Child Hospital on the Importance of Utilizing the Health Facility for Delivery. Many (86.3%) indicated that health providers at Mother and Child

Hospital have the required professional skill to handle antenatal care, delivery, and postnatal care. Many (77.2%) disclosed that they have been attended to before by Skilled Birth Attendance. When asked about the place they would like to have their next delivery, Mission Homes (51.6%) top the list followed by Health facility (30.5%) before TBAs' (14.1%) and Home (3.8%). (See Figure 4.2.2 below).

Table 4.2.3 presents the proportion of future place of delivery (inside or outside health facility) by some selected social demographic characteristics. These selected demographic characteristics are: religion, education, gainful employment and respondents' age at last birthday. All (100%) the respondents who practiced traditional belief indicated that they would have their next birth outside the health facility, and majority of Muslim respondents (85.0%) favoured outside health facility as their next place of delivery while 63.4% of Christian favoured outside health facility as their next place of delivery. Overall, there was a significant relationship between respondents' religion and their choice of future birth delivery (See table 4.2.3 for details). The proportion of those who would have their next delivery outside the health facility increase with decrease in educational attainment from respondents with no formal education (90.6%), Primary Education (89.7%), Secondary education (64.3%) to respondents with tertiary educational (61.7%) attainment. There was a significant difference between respondents' highest educational attainments and their choice of future birth delivery. Majority (70.1%) of those who did not have a gainful employment indicated to have their future birth delivery at the Mother and Child Hospital Akure compared to others (29.9) who prefer to have it in TBAs' home, home or Mission Houses. Overall, there was no a significant relationship between respondents' employment status and their choice of future birth delivery (See table 4.2.3 for details).

Table 4.2.1: Perception of staff skills and types of Information staff give to Registered Pregnant Women in Mother and Child Hospital, Akure on the Benefits of Utilising the Health Facility for Delivery.

N= 409

Characteristics	Yes (%)	No (%)	Don't Know (%)	Total
Do the health providers at Mother and Child Hospital have the required professional skill to handle antenatal care, delivery, and postnatal care?	360(86.3)	22 (5.3)	35 (8.4)	417
Have you undergone any examination by any of the SBAs?	322(77.2)	91(21.8)	4(1.0)	
Are you aware of the numerous benefits of Skilled Birth Attendance, such as; normal pregnancy and delivery, safe delivery and healthy baby, good health of mother, and short hospital stay?	303(72.7)	29 (7.0)	85 (20.4)	
ANC and Delivery in health facility promotes maternal and fetal wellbeing?	330(80.7)	15 (3.7)	64 (15.6)	417
Confirm pregnancy and expected date of delivery?	310(75.8)	82(20.0)	17 (4.2)	409
Prevention of disease, early detection of complication and treatment	362(88.5)	27 (6.6)	20(4.4)	409
Advise and counsel on reproductive health, breastfeeding, tobacco and alcohol use	388(94.9)	11(2.7)	10(2.4)	409

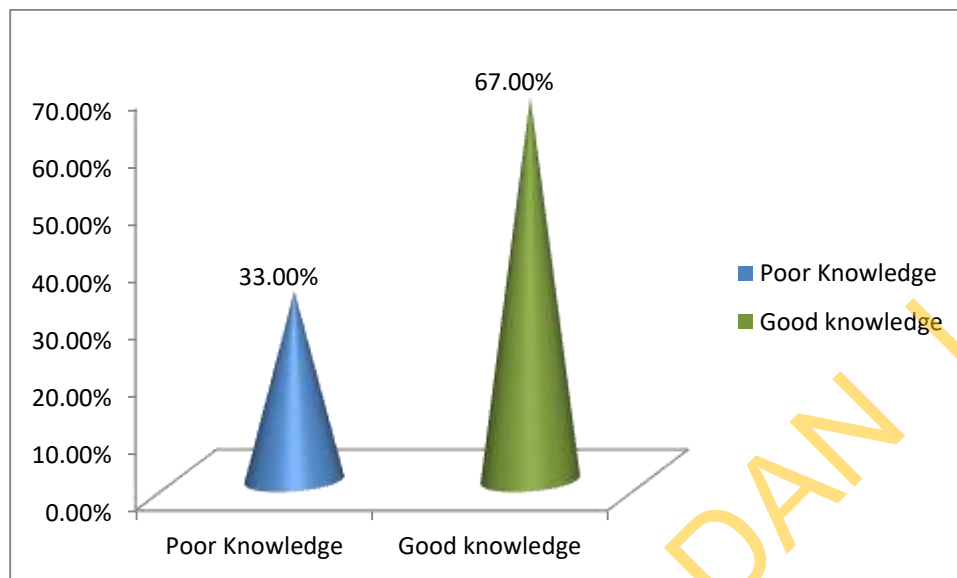


Fig 4.2: Knowledge of respondents about the importance of giving birth in Health Facility

***Key**

Knowledge scores of <6 and ≥ 6 were rated as poor and good, respectively

Good knowledge (6-7) = 274

Poor Knowledge (0- 5 points) = 135

* Note: Mean knowledge score = 5.7 ± 1.4

Table 4.2.2: Types of Places chosen by Registered Pregnant Women in Mother and Child Hospital, Akure for their next delivery

Characteristics	Frequency	Frequency (%)
Place chosen for next delivery		
Mission Home	215	51.6
TBAs' home	59	14.1
Your Home	16	3.8
Health Facility	127	30.5
Place chosen for next delivery		
Outside health facility	290	69.5
Health facility	127	30.5
*Multiple option		
If you think places outside Health Facility (Mission, TBA, Home) is better, why?		
Staff is always available	132	21.7%
No need of transport	66	10.9%
there is privacy	153	25.2%
there is respect for mothers	137	22.5%
Prayer	64	10.5%
it is reliable to safe lives	7	1.2%
am use to it	4	.7%
staff show love and care	44	7.2%
close to my house	1	.2%
If you think health facility is better than outside places why? *Multiple option		
Clean	91	24.1%
Save mothers life	102	27.0%
No retain Placenta	80	21.2%
Save child life	102	27.0%
Close distance to house	1	.3%
it is free	2	.5%

Hypothesis

The following are the Null hypotheses of the study:

- There would be no significant association between demographic factors (education, age, marital status, religion.) and low utilisation of MCH, Akure as a place of delivery by registered pregnant mothers.
- There would be no significant association between the non-demographic factors (attitude of health workers, quality of service, waiting time, etc.) contributing to low utilisation of MCH, Akure as a place of delivery and the knowledge of registered pregnant mothers on the importance and benefits of the health facility for delivery services

Table 4.2.3 presents the proportion of future place of delivery (inside or outside health facility) by some selected social demographic characteristics. These selected demographic characteristics are: religion, education, gainful employment and respondents' age at last birthday. All (100%) the respondents who practiced traditional belief indicated that they would have their next birth outside the health facility, and majority of Muslim respondents (85.0%) favoured outside health facility as their next place of delivery while 63.4% of Christian favoured outside health facility as their next place of delivery. Overall, there was a significant relationship between respondents' religion and their choice of future birth delivery (See table 4.2.3 for details). Therefore, we reject the null hypothesis $p=0.00$ ($p < 0.05$).

The proportion of those who would have their next delivery outside the health facility increase with decrease in educational attainment from respondents with no formal education (90.6%), Primary Education (89.7%), Secondary education (64.3%) to respondents with tertiary educational (61.7%) attainment. There was a significant difference between respondents' highest educational attainments and their choice of future birth delivery. Therefore, we reject the null hypothesis $p=0.00$ ($p < 0.05$)

Majority (70.1%) of those who did not have a gainful employment indicated to have their future birth delivery at the Mother and Child Hospital Akure compared to others (29.9) who prefer to have it in TBAs' home, home or Mission Houses. Overall, there was no significant relationship between respondents' employment status and their choice of future birth delivery (See table 4.2.3 for details). We therefore fail to reject the null hypothesis. $p= 0.06$ ($p > 0.05$)

4.2.3 Demographic Characteristics of Registered Pregnant Women by the selected places of next delivery

	Variables	Outside health Facility N (N %)	Inside Health Facility N (N %)	Total	
Religion	Christianity	194 (63.4)	112 (36.6)	306	$X^2=21.6,$ $P=0.00,$ $P< 0.05$
	Islam	85(85.0)	15(15.0)%	100	
	Traditional	11(100.0)	0(0.0)	11	
Education	No formal Education	29 (90.6)	3(9.4)	32	$X^2=26.2,$ $P=0.00,$ $P< 0.05$
	Primary	61(89.7)	7(10.3)	68	
	Secondary	108(64.3)	60(37.7)	168	
	Tertiary	92(61.7)	57(38.3)	149	
Gainfully Employed	Not gainfully employed	133(68.2)	157 (70.7)	195	$X^2=0.3,$ $P=0.6,$ $P> 0.05$
	Gainfully employed	62 (31.8)	65 (29.3)	222	
Age	16-19years	2 (28.6)	5(71.4)	7	$X^2=5.9,$ $P=0.052,$ $P> 0.05$
	20-24years	31(73.8)	11(26.3)	42	
	25and above	257 (69.8)	111(30.2)	368	

Table 4.2.4 presents knowledge of importance of health facility by non-demographic factors contributing to low utilisation of health facility for delivery. These factors include Attitude of health workers, waiting time/ delay in admission, shortage of staff and quality of service (errors in estimating EDD).

Large proportion of the respondents (70.3%) who indicated that attitude of health workers prevent them from utilizing the health facility who had good knowledge of the importance of using the health facility for delivery. Overall, there is no relationship between health workers attitude as a factor that causes low utilisation of health facility and knowledge of respondents about the importance of using health facility as a place of delivery. (See table 4.4.3 details) Therefore, we fail to reject the null hypothesis $p= 0.3$ ($p> 0.05$). More than a two- third (68.7%) of the respondents who indicated that waiting time or delay in admission prevent them from using the health facility for delivery had good knowledge of the importance of using the health facility compared to 31.3% who had poor knowledge of the importance of using the health facility. Overall, there is no relationship between respondent's delay as a factor contributing to low utilisation and knowledge of respondents about the importance of using health facility as a place of delivery. Therefore, we fail to reject the null hypothesis $p= 0.3$ ($p> 0.05$) Less than a quarter (20.9%) of the respondents who indicated that shortage of staff is a barrier to low utilisation had poor knowledge of the importance of using the health facility. There is no relationship between shortage of staff as a factor contributing to low utilisation and knowledge of respondents about the importance of using health facility as a place of delivery. Therefore, we fail to reject the null hypothesis. $p= 0.07$ ($p > 0.05$)

Table 4.2.4: Knowledge of Importance of health facility by Factors contributing to Low Utilisation of health facility for Delivery

Factors contributing to the low Utilisation of the Health Facility for delivery	Variables	Yes N (N %)	No N (N %)	Total	
Attitude of health workers	Poor Knowledge	77 (29.7)	40 (35.1)	117	$X^2=1.06,$ $P=0.3,$ $P> 0.05$
	Good Knowledge	182(70.3)	74(64.9)	256	
Waiting time/ Delay in Admission	Poor Knowledge	76(31.3)	27(26.0)	103	$X^2=0.96,$ $P=0.3,$ $P> 0.05$
	Good Knowledge	167(68.7)	77(74.0)	244	
Shortage of Staff	Poor Knowledge	18(20.9)	46(31.9)	64	$X^2=3.2,$ $P=0.07,$ $P> 0.05$
	Good Knowledge	68(79.1)	98(68.1)	166	
Quality of service(Errors in estimating EDD)	Poor Knowledge	76(31.3)	27(26.0)	103	$X^2=1.4,$ $P=0.2,$ $P> 0.05$
	Good Knowledge	167(68.7)	77(74.0)	244	

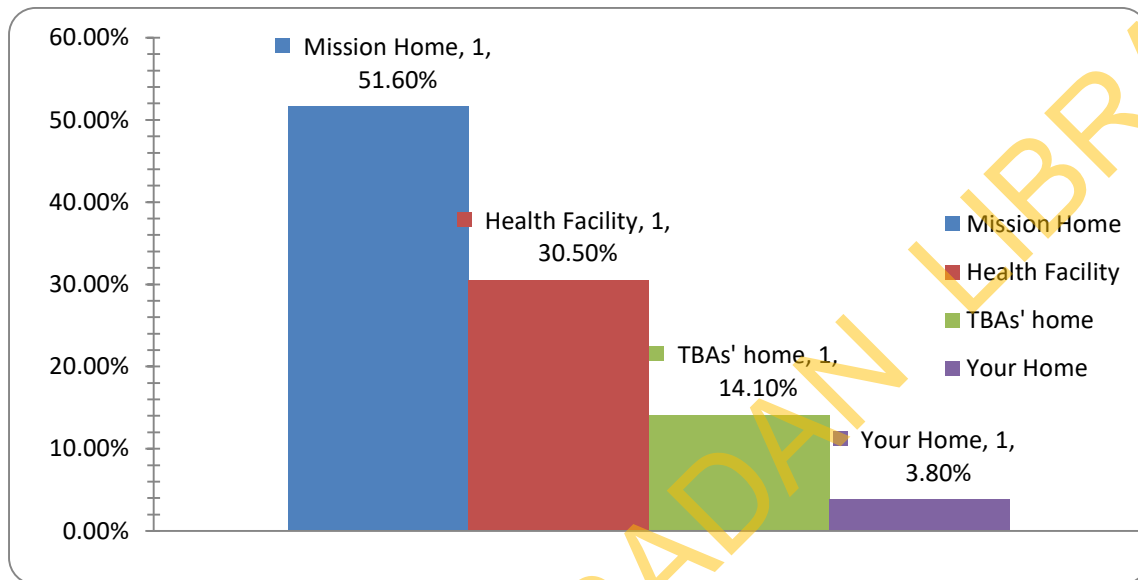


Figure 4.2.2a Place chosen for next delivery

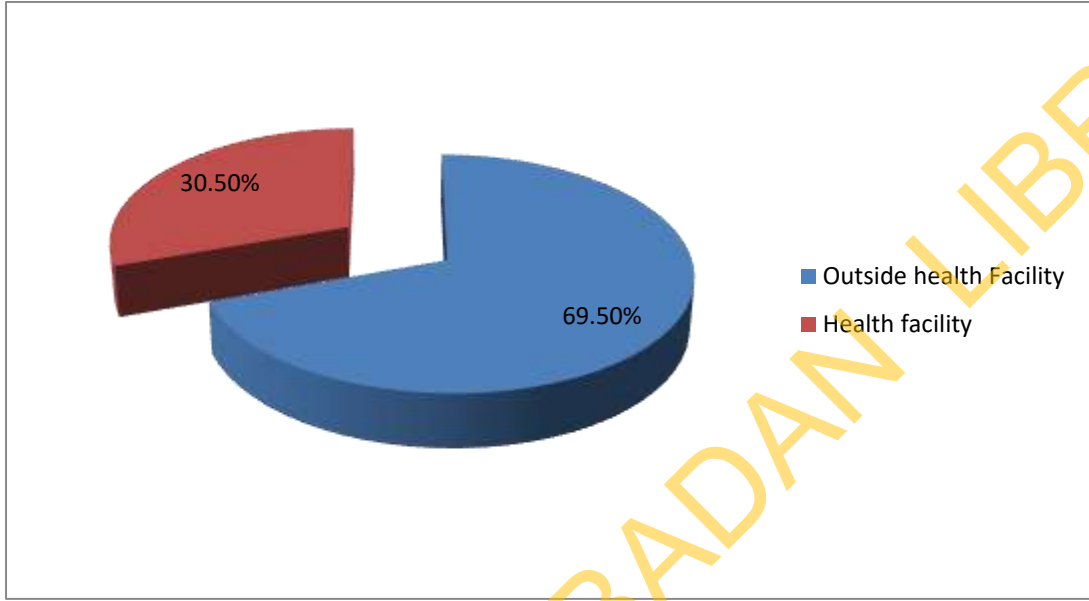


Figure 4.2.2b Place chosen for next delivery in two categories

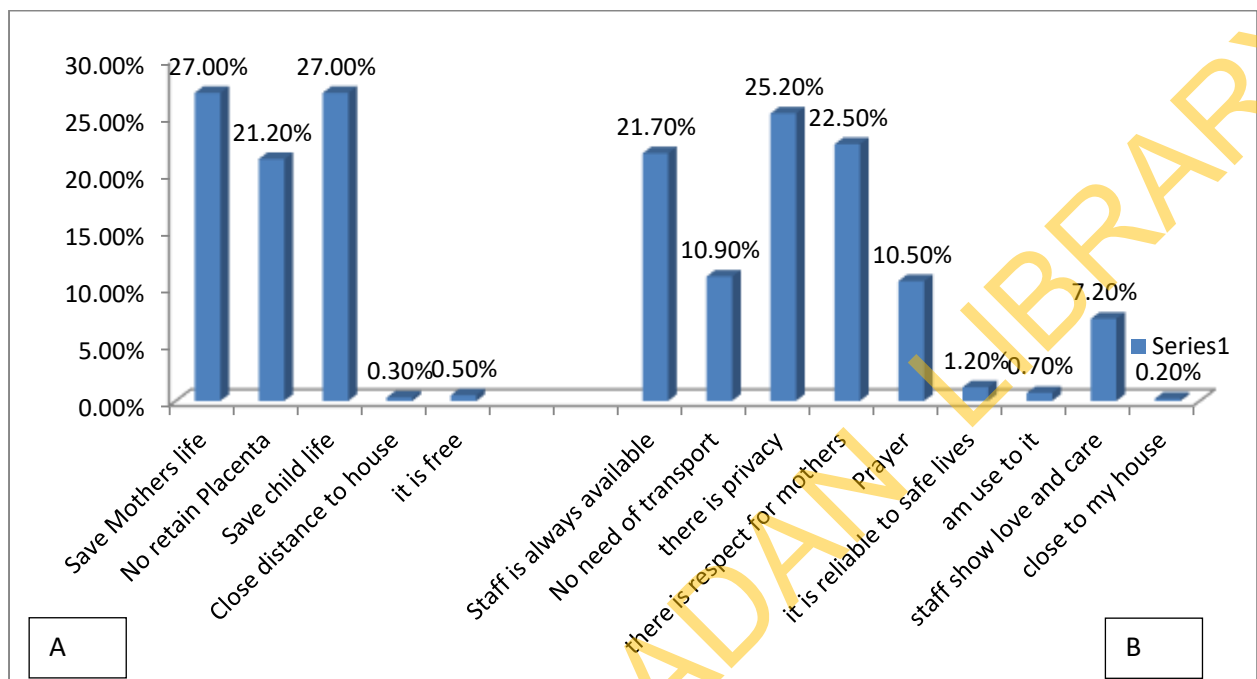


Figure 4.2.3A: Reasons for accepting that health facility is better; B: Reasons for accepting that outside health facility is better

4.4 Perceptions and Experiences of Respondents that Influences the Low Use of the Health Facility

Table 4.3 presents respondents' perceptions and experience relating to low use of Mother and Child health facility. More than half (53.9%) of the respondents agreed that as no of children increased, utilisation reduced in Mother and Care Health facility. More than a quarter (33.0%) of the respondents averred that women's socio-economic status influences delivery in health facility. About 16% strongly agreed that it is not necessary to deliver in the health facilities, while 38.6% agreed that it is not necessary to deliver in the health facilities, 12.0% disagree with the statement and 11.2% of the respondents strongly disagreed with the statement. Similarly, very few (6.7%) and few (11.3%) respondents disagreed and strongly disagreed that Mission Home delivery is safer. The perception that limited resources (money for transport, money to buy baby materials) affects delivery in MCH was affirmed by very few (7.6%) and few (22.5%) of the respondents who agreed and strongly agreed with the statement respectively.

The view of 52.1.1% of the respondents was that traditional birth attendant (TBA/'Agbebi') are helpful and show respect/sympathy as 52.1% agreed with the statement. Similarly, 48.9% and 27.9% agreed and strongly agreed that TBA/ 'Agbebi' provide confidentiality.

Table 4.3a: Perceptions and Experiences of Respondents that Influences the Low Use of the Health Facility

Characteristics	Strongly Agree (%)	Agree (%)	Undecided (%)	Strongly Disagree (%)	Disagree (%)	Total
As no of children increased utilisation reduced	33 (8.1)	220(53.9)	100 (24.5)	18 (4.4)	37 (9.1)	408
Women's socio-economic status influences delivery in health facility	84 (20.5)	135(33.0)	36(8.8)	82(20.0)	72(17.6)	409
Perceive it is not necessary to deliver in the health facility	67 (16.4)	158(38.6)	89(21.8)	49.0(12.0)	46(11.2)	409
Stayed for a long time before attention	106(26.1)	164(40.4)	22(5.4)	39(9.6)	75(18.5)	406
Maternal perception of not wanting to show off pregnancy	31(7.6)	81(19.9)	75(18.4)	81(19.9)	139(34.2)	407
Sudden onset and onset at night	43(10.5)	134(32.8)	89(21.8)	35(8.6)	108(26.4)	409
Mission Home delivery is safer	160(39.4)	123(30.3)	50(12.3)	27(6.7)	46(11.3)	406
Limited resources (money for transport, money to buy baby materials) affects delivery in MCH	26 (6.4)	92 (22.5)	50 (12.2)	70 (17.1)	171 (41.8)	409
Missing attention support and care	51(12.5)	110(27.0)	121(29.7)	33(8.1)	110(22.8)	408
Experienced physical and verbal abuse	83(20.3)	194(47.4)	31(7.6)	38(9.3)	63(15.4)	409

Table 4.3b: Perceptions and Experiences of Respondents that Influences the Low Use of the Health Facility

Characteristics	Strongly Agree (%)	Agree (%)	Undecided (%)	Strongly Disagree (%)	Disagree (%)	Total
Delay in carrying out laboratory investigation	60(14.4)	77(18.5)	64(15.3)	54(12.9)	154(36.9)	409
Left alone to push during delivery	57(13.9)	157(38.4)	25(6.1)	48(11.7)	122(29.8)	409
Assistance during birth outside health facility	120(29.3)	197(48.2)	42(10.3)	11(2.7)	39(9.5)	409
TBA/ 'Agbebi' provide confidentiality	114(27.9)	200(48.9)	46(11.2)	9(2.2)	40(9.8)	409
TBA/'Agbebi' are helpful and show respect/sympathy	123(30.1)	213(52.1)	38(9.3)	4(1.0)	31(7.6)	409
Previous uneventful delivery at health facility	49(12)	172(42.1)	115(28.1)	19(4.6)	54(13.2)	409
Traditional beliefs/socio-cultural barriers, such as: adherence to traditional birthing practices and belief that pregnancy is a test of endurance	117(29.1)	169(42.0)	52(12.9)	33(8.2)	31(7.7)	402

4.5 Health Service-Related Factors Contributing to the Low Utilisation of the Health Facility for Delivery Service.

Qualitative Data

In the in-depth interview from the pregnant women who attended ANC but decided to give birth in mission home and TBAs home revealed that one of the factor that prevent women from giving birth at the hospital was shortage of health workers. She also revealed that most of what the pregnant women considered as factors which made to give birth in mission home include prayer, care and support, availability of staff all the time and good attitude of health worker and good relationship with health worker. Her typical responses included:

- *“There is no time that we visit the mission that we don’t meet them”*
- *“They treat us like family members”*
- *“They come to pay us visit at home”*
- *“We call them sometimes on phone to tell them how we are feeling”*
- *“They pray for us. They give us water and we use it to pray”*
- *“Crowd in the hospital are too much. At times, we might want to see the doctor and they will not attend to us for a week or two weeks”*
- *“If they employ more workers, there will time wherever we visit the hospital. There won’t be a situation whereby there will be much crowd and they will tell us to come back the next day”*

The woman who gave birth in TBA emphasized the need to use “Agbo.” She said in hospitals, “Agbo” is not allowed but they allow them to use it in TBA homes. Both respondents pointed bad attitude of health worker as one of the main reasons while women do not like to give birth in the hospitals

Quantitative Data

Table 4.4 presents health service-related factors contributing to the low utilisation of the health facility for delivery service. The proportion of respondents who agreed with the factors were presented. Lack of privacy in wards (72.2%) topped the list followed by Hospital staff slow to respond to patient’s needs (68.2%) and Lack of support from somebody known to you during delivery (68%). More than half of the respondents (59.5%) agreed that Delay in admission to health facility once mothers report in labour contributed to low utilisation of health facility for delivery. Similarly, more than half of the respondents (56.6%) indicated that

inadequate bed space for patients, equipment, and materials contributed to low utilisation of health facility for delivery. Few of the respondents (20.0%) reported that Shortage of staff (nurses, and doctors) was a factor to consider for low utilisation of health facility for delivery. About 62% of the respondents disagreed that fear of being tested for HIV is a contributing factor to low health facility utilisation for delivery. (See figure 4.5.1).

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Table 4.4: Health Service-Related Factors Contributing to the Low Utilisation of the Health Facility for Delivery Service.

Characteristics	Frequency	Frequency (%)
Delay in admission to health facility once mothers report in labour	244	59.5
Refusal of the presence and support from somebody known to you during delivery	198	47.5
Inadequate bed space for patients, equipment, and materials	236	56.6
Shortage of staff (nurses, and doctors)	86	20.6
Believe that hospital equipment is dangerous	115	27.6
Believe that hospital is a place for complicated delivery	164	39.3
Ignorance of the complications of unskilled attendance	124	29.8
Seeking permission to deliver at the facility	185	44.4
Fear of being tested for HIV	117	28.1
Hospital do not allow women to deliver in their preferred way (such as squatting)	273	65.5
Hospital staff slow to respond to patient's needs	286	68.8
Fear of being verbally abused and beaten by maternity nurses	249	60.0
Fear of being attended to by male staff	145	34.9
Lack of support from somebody known to you during delivery	283	68.0
Fear of caesarean delivery(operation)	260	62.5
Bad reception and unfriendly attitude of health workers	267	64.0
Lack of privacy in the wards	301	72.2
Errors in estimating the EDD which could lead to the baby being delivered supposedly unexpected	262	62.8
Poor assess to hospital (bad roads and few transport vehicles)	173	41.7

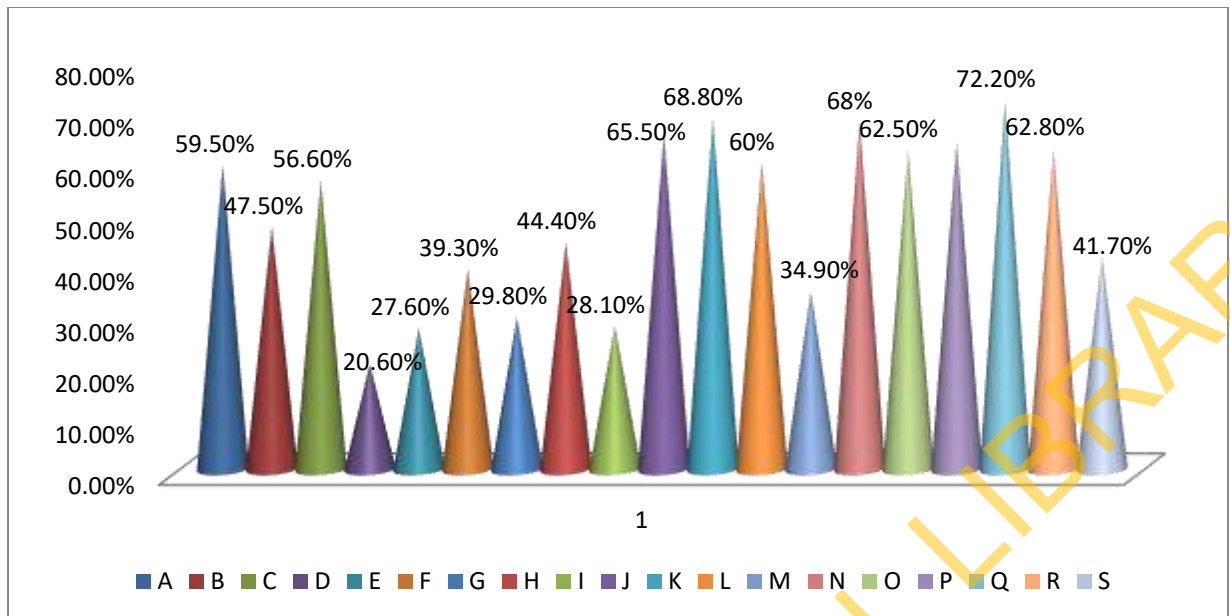


Figure 4.4: Factors contributing to Low Utilisation of health facility for Delivery

Key:

A: Delay in admission to health facility once mothers report in labour

B: Refusal of the presence and support from somebody known to you during delivery

C: Inadequate bed space for patients, equipment, and materials

D: Shortage of staff (nurses, and doctors)

E: Believe that hospital equipment is dangerous

F: Believe that hospital is a place for complicated delivery

G: Ignorance of the complications of unskilled attendance

H: Seeking permission to deliver at the facility

I: Fear of being tested for HIV

J: Hospital do not allow women to deliver in their preferred way (such as squatting)

K: Hospital staff slow to respond to patient's needs

L: Fear of being verbally abused and beaten by maternity nurses

M: Fear of being attended to by male staff

N: Lack of support from somebody known to you during delivery

O: Fear of caesarean delivery (operation)

P: Bad reception and unfriendly attitude of health workers

Q: Lack of privacy in the wards

R: Errors in estimating the EDD which could lead to the baby being delivered supposedly unexpected

S: Poor access to hospital (bad roads and few transport vehicles)

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

The combination of both quantitative and qualitative methods complemented each other, and this enhanced validity and reliability of the findings.

Socio-demographic characteristics and related information of respondent

The ages of respondents ranged from 16 – 52 years with a mean age of 31.7 years. This implies that target population consists of women in their reproductive age (15- 49 years) (WHO factsheet 2010). Secondary school (40.3%) was the most common highest education attainment. This is similar to a previous study conducted in Nigeria by National Population Commission in 2008 where 35.7% of the respondents (women) in the survey had secondary school education.

The Information Received By Registered Pregnant Women in Mother and Child Hospital, Akure on the Importance of Utilizing the Health Facility for Delivery.

According to National Population Commission, the major objective of antenatal care is to ensure optimal health outcomes for the mother and her baby. Ante-natal care from a trained provider is important to monitor the pregnancy and reduce morbidity risks for the mother and child during pregnancy and delivery. Antenatal care provided by a skilled health worker enables: 1) early detection of complications and prompt treatment (e.g., detection and treatment of sexually transmitted infections); 2) prevention of diseases through immunisation and micronutrient supplementation; 3) birth preparedness and complication readiness; and 4) health promotion and disease prevention through health messages and counseling of pregnant women (National Population Commission, 2008). Our findings showed that majority of the respondents were in agreement that being attended to during delivery is important and has a lot of advantages as large percentage (72.7%) are aware of the numerous benefits of Skilled Birth Attendance, such as; normal pregnancy and delivery, safe delivery and healthy baby, and good health of mother. This was corroborated with what was gotten from the in-depth interview.

Increasing the percentage of births delivered in health facilities is an important factor in reducing deaths arising from the complications of pregnancy. The expectation is that if a

complication arises during delivery, a skilled health worker can manage the complication or refer the mother to the next level of care, in our study, majority (77.2%) of the respondents indicated that they have been attended to by skilled birth attendant before, and this was higher than the proportion revealed by the National population commission in 2013 where about three-fifths of mothers (61%) reported consulting a skilled health provider—a doctor, nurse, midwife, or auxiliary midwife—at least once for antenatal care for the most recent birth in the five-year period before the survey (National Population Commission, 2013). This could have resulted from the fact that many women are now aware of the importance of attending ANC and the fact that the literacy level of women generally has been raised.

According to the final report of NDHS, 2013 the percentage of pregnant women who delivered at the health facility in Ondo state was 56.2% and this percentage is still the least among the south-west states. When asked about their chosen place of delivery for their next pregnancy, our study revealed that Mission Homes (51.6%) top the list followed by Health facility (30.5%) before TBAs' (14.1%) and Home (3.8%). This is similar to earlier reports that many women still opt for TBA delivery despite the established life-threatening limitations of TBA, notably their weak judgment. (Okoli, Abdullahi, Pate, Abubakar, and Aniebue, 2012), (Eze, Ibekwe, 2010) (Olusanya, Inem, and Abosede, 2011).

Our study also revealed that there is a relationship between respondents' wealth quintile and their choice of future birth delivery. Majority (70.1%) of those who did not have a gainful employment indicated to have their future birth delivery at the Mother and Child Hospital Akure compared to others (29.9) who prefer to have it in TBAs' home, home or Mission Houses. This was in direct opposite to what National Population Commission reported in their survey that the proportion of births occurring in a health facility increases steadily with increasing wealth quintile, from 7 percent of births in the lowest wealth quintile to 80 percent among those in the highest quintile (National Population Commission, 2008). This disparity is probably due to the fact that Mother and Child Hospital services in Akure is Free and therefore, women have no need to pay for services rendered during deliveries in this hospital.

In this study, women having their first baby are more likely than other women to deliver in a health facility as the proportion of women with first birth (35.3%) who delivered in health facility was higher than that of women who had more than one child (28.5%). This was in accordance with what National population Commission reported in 2008.

Perceptions and Experiences of Respondents that Influences the Low Use of the Health Facility

In this study, more than half (53.9%) of the respondents agree that as no of children increased utilisation reduced in Mother and Care Health facility. This can be due to self efficacy of the respondents that they have had firsthand experience already in child bearing, as a result, they believed in themselves to be able to give birth on their own. This was supported from evidence in this study that showed that women who had just had their first birth, who gave birth in health facility (35%) were more than those who have had more than one experience in child bearing (23.5%).

Several studies have been conducted worldwide on the factors affecting delivery in health facilities and some factors were observed. The issues of risk and vulnerability, such as lack of money, lack of transport, sudden onset of labour, short labour, staff attitudes, lack of privacy, geographical location, perception of poor quality of health services, tradition, cultures and the pattern of decision-making power within the household were perceived as key determinants of the place of delivery(Magoma, 2010.)

In this study, the perception that limited resources (money for transport, money to buy baby materials) affect delivery in MCH was affirmed by very few (7.6%) and few (22.5%) of the respondents who agreed and strongly agreed with the statement respectively. This can be due to the fact that Mother and Child facility is free. Some respondents still emphasized the use of, “Agbo” being not allowed but they allowed in hospital as one of the reasons why they prefer to give birth in mission homes and TBAs.

The reasons why many women in Nigeria continue to use any of these unsafe delivery approaches was reviewed. The review identified supply and demand side factors as pivotal in the utilisation of delivery attendance. In the case of unskilled attendance, the supply side factors include generalized health systems weakness, indexed by lack of infrastructure (like poor or no supply of electricity) and equipment (such as ambulances); perennial stock out of obstetric care commodities; sub-standard Emergency Obstetric Care (EmOC) and poor compliance with standard of practices; inadequate health worker size, mix, capacity, motivation; weak referral linkages and feedback mechanisms (Erim, Kolapo, and Resch, 2012).

Health Service-Related Factors Contributing to the Low Utilisation of the Health Facility for Delivery Service

In this study, respondents were asked to indicate the factors that prevented them from giving birth in Mother and Child Hospital Akure. Lack of privacy in wards (72.2%) topped the list followed by Hospital staff slow to respond to patient's needs (68.2%) and Lack of support from somebody known to you during delivery (68%). The least factor that was considered by the respondents was shortage of staff (20.6%). This was in disparity to what was reported by an earlier study that According to Okoli, Abdullahi, Pate, Abubakar and Aniebue, in study of 152 Health Workers (HW) (doctors, nurses, midwives, and Community Health Extension Workers (CHEWS) from 22 health facilities in five cities of two States in Nigeria which found that 91% of the HW had poor knowledge of EmOC concepts, and 60% did not counsel clients on complications readiness. Only two-thirds of them adhered to the recommended EmOC standard of practice. (Ijadunola, Ijadunola, Esimai, and Abiona, 2010).

In this report, Okoli et al reported that given these facility-level deficiencies, women reportedly discerned no comparative advantage in delivery at PHCs over deliveries by TBA at home. This may explain why many women still opt for TBA delivery despite the established life-threatening limitations of TBA, notably their weak judgment. (Okoli, Abdullahi, Pate, Abubakar, and Aniebue, 2012), (Eze, Ibekwe, 2010) (Olusanya, Inem, and Abosedo, 2011). Though our study revealed that privacy in wards, and bad altitude of health workers are the major reasons why people decide to opt for outside health facilities. This disparity may be due to error in perception of these women who believed that health workers are trained and therefore have the adequate information and knowledge to carry out their activities in the delivery rooms since both study are different based on the type of respondents that were interviewed.

Implication of findings for Health Education

The findings of this study have reiterated the fact that pregnant women do not make optimum use of the MCH delivery services despite the free delivery services provided by the facility. The major reasons adduced for this was lack of privacy in the delivery wards and negative attitude (unfriendliness) of health staff. Hence, it is important to develop effective strategies to improve patronage of the facility by pregnant women. The implementation of multiple strategies such as advocacy to relevant government agencies for provision of more infrastructure to make the facility more enticing to pregnant women; as well as organisation of

in-service training for staff of the facility to improve their attitude towards pregnant women attending the facility.

Health Education (HE) is a combination of learning experiences designed to facilitate voluntary adaptation of behavior conducive to health. Knowledge, Attitude and Practice (KAP) principle is the basic principle on which health education is founded. Health Education can be used to reinforce and change the KAP of pregnant women through effective communication of factual information on importance and use of ANC and delivery services (provided at the MCH) to pregnant women and the community at large, with the aim of encouraging them to make use of the Facility for their delivery needs.

Health Education can also be used to bridge the gap between health information and risk-free health practices within the context of use of delivery services provided at the MCH. This could be in the form of a well-designed public enlightenment programme to address the problem of low risk-perception of the complications or dangers of delivering outside health facility.

Findings of this study could be used as a training needs assessment for the design and development of on-the-job training curriculum for health workers to address the issue of negative attitude (unfriendliness) to pregnant women and their relatives. The management of health facilities has crucial roles to play in maintaining health behavior and work ethics. A strategic principle that can be employed is planning, implementation and evaluation relating to interventions in the health facility. It behooves on health education practitioners to know how best to organize health education activities to ensure improved delivery services in health facilities which will consequently improve use of health facilities by pregnant women for delivery.

Conclusion

The research explored the information received by registered pregnant women in Mother and Child Hospital, Akure on the importance of utilizing the health facility for delivery, the experiences and perceptions of respondents that influences the low use of the health facility and describe the health service-related factors contributing to the low utilisation of the health facility for delivery. Many of the respondents reported that attending health facility is beneficial and important both to the unborn child and the mother.

Delivery in health facilities in Ondo state is still challenging as higher number of women attend antenatal clinic but about half of them deliver without the assistance of skilled health professional. This research has confirmed that more are still willing to deliver outside the health facility despite the free services rendered at the Mother and Child hospital.

Many of the respondents still believed in giving birth outside the health facility due to some factors such as lack of privacy and bad attitude of health workers. Some respondents still emphasized the use of, “Agbo” being not allowed in hospital as one of the reasons why they prefer to give birth in mission homes and TBAs.

Recommendations

The discussions held support the need for a constructive, collaborative approach to promoting change. Recommended interventions that target knowledge and behavioral changes (information) are:

Health education in Antenatal Clinics (ANC) and in the communities

Women need education on the importance of giving birth in health facility. This can be done through public enlightenment as a strategy in health promotion. Since the ANC is the first contact with the women, it is necessary for the midwives to seize the opportunity and spend more time than is currently done on each patient to give appropriate counseling, health education and discussion of plans for delivery. This will not only provide knowledge, but also provide trust. Maternal health services need to continuously sensitize the community so that the number of pregnant mother delivered in health facility increased to attain the National target.

Social network with community groups

Social network or links with community groups closer to homes should be effected to provide conduits for more regular information, advice and support to all family members The community needs to be better informed about the true benefits of hospital deliveries.

Raise awareness on danger signs of pregnancy, labour and delivery

Both the community and ANC clinics should be targeted for health education on dangers signs of pregnancy, labour and after delivery to reach as many people as possible. If the women know and are continually reminded about the danger signs that are leading causes of maternal mortality and morbidity, they will report early to health facilities and ensure delivery service

usage. It should target both men and women especially those who are involved in making decision. Community need to understand that women can survive pregnancy and that the hindrance on their paths can and should be removed as a community obligation. Active community participation in such education, including that of men as leaders and as partners, is required.

Relationship of health care providers and the women

To ensure the continual use of health facilities for delivery by women, action is needed to improve providers' attitudes towards the women and their relatives. The women should be treated with respect, understanding and dignity. Midwives should reorient their caring practices to more culturally, appropriate and evidenced- based maternity care.

Management

The managers of health facilities should make sure that services are friendly for the users. Hospital staff needs to be reoriented on the importance of good interpersonal relationship with patient, and having good and friendly attitude towards them. Improved staff training in good clinical practice and interpersonal skills is recommended, and medical services must be more sensitive to community needs and preferences. There should be a system in place for rewarding service providers with good incentives, and better working conditions. Putting in place more structural facilities (labour wards) will immensely help to improve the issue of privacy for patients.

Other recommendations

Quality assurance system should be introduced within the health system to protect the rights of the women, improve services and make it user friendly.

Women should be asked to produce a valid document when they are registering((passport, birth certificate, voter's card or identification card).This will ensure adequate information on home addresses and phone numbers for proper follow up during the ante-natal care period and delivery.

Suggestions for future research

Traditional views on pregnancy and motherhood are important cultural factors influencing health care- seeking behaviour and this should be kept in mind and made a subject for further research. Allowing a husband to accompany a woman during labour might be a possible intervention, to overcome the cultural need.

This study interviewed women who attended clinic for antenatal care, the results may not provide an accurate profile of all women who delivered outside the health facility. Future investigations should explore the beliefs and attitudes of a community based sample to better identify the background factors that contribute to choices made for delivery.

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APPENDIX I

IN-DEPTH INTERVIEW GUIDE FOR HEALTH WORKER FACTORS INFLUENCING LOW USE OF MOTHER AND CHILD HOSPITAL FOR DELIVERY SERVICE

Introduction

I want to thank you for taking the time to meet with me today.

My name is Oloruntoba Jacinta Astosime from Health Promotion and Education department, Faculty of Public Health University of Ibadan, Ibadan. I would like to talk to you about your experiences as a health worker in Mother and Child Hospital Akure. Specifically, as one of the components of my overall project evaluation, I am investigating reasons why women who register at the Ante-Natal Clinic do not deliver in the hospital, in order to capture lessons that can be used in future interventions.

The interview should take less than an hour. I will be taping the session because I do not want to miss any of your comments, though I will be taking some notes during the session, I cannot possibly write fast enough to get it all down. Because we are on tape, please be sure to speak up so that we do not miss your comments.

Your identity, opinions and all responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. You are encouraged to feel free to give honest response Remember, your participation in this discussion is entirely voluntary, you do not have to talk about anything you do not want to and you may end the interview at any time.

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

Interviewee

Date

Questions

1. What is your cadre as a health worker?
2. When did you last receive in-service training in life skills in Obstetric or integrated maternal and neonatal care?
4. What information do registered pregnant women receive on the importance of utilizing this hospital for delivery? Please elaborate further
5. Skilled birth attendance in ante-natal care and delivery promotes maternal and fetal wellbeing, what are your strategies to ensure this is achieved?
4. Do you lack supplies to work effectively? Please explain and give examples.
5. In what way are you lacking motivation to work effectively? Would you explain that further?
6. What strategies, interventions, tools, and so on, would you recommend be put in place, sustained and/or scaled up? Please provide a justification for your response.
7. What strategies, interventions, tools should be discontinued? Why? Please elaborate further.
8. What are the reasons why women attend Ante-Natal Clinic (ANC) in this hospital but do not deliver here? Is it insufficient bed space? Shortage of staff? Delay in admitting women during labour? Please list and elaborate
9. What effect, if any, do you feel the free health services have on the community in which you work? Increased use of services by the community? Increased knowledge of reproductive health friendly services by clinic staff? Please explain in detail.
10. What recommendations do you have for better interventions on health facility utilisation? Is there anything more you would like to add?

Thank you for your time.

APPENDIX II

IN-DEPTH INTERVIEW GUIDE

FACTORS INFLUENCING LOW USE OF MOTHER AND CHILD HOSPITAL FOR DELIVERY SERVICE

Introduction

I want to thank you for taking the time to meet with me today.

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The interview should take less than an hour. I will be taping the session because I do not want to miss any of your comments, though I will be taking some notes during the session, I cannot possibly write fast enough to get it all down. Because we are on tape, please be sure to speak up so that we do not miss your comments.

Your identity, opinions and all responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. You are encouraged to feel free to give honest response Remember, your participation in this discussion is entirely voluntary, you do not have to talk about anything you do not want to and you may end the interview at any time.

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

Interviewee

Date

Questions

1. What information do registered pregnant women receive at the ante-natal clinic on the importance of utilising Mother and Child Hospital (MCH) for delivery services? Please elaborate further.
2. The services of nurses and doctors in MCH promote maternal and fetal wellbeing. What can you say about their services? Please explain further
3. What are the reasons why women delivered their babies at mission home (or Traditional Birth Attendant's (TBA) home?) Please list. What were your own specific reasons (Was there no space in MCH? was admission into the ward delayed in labour? or the staff in mission home is always available). Would you please elaborate further
4. What are your perceptions and experiences that influenced your use of mission home (or TBA) for delivery? (Is that mission home (or TBA) delivery is safer? Or is it that you don't want to show off your pregnancy? Please explain in details
5. What traditional or socio-cultural belief can be a barrier to the use of health facility for delivery?
6. What health service- related factors contribute to the low use of health facility for delivery? Would you please explain in details? (Is it fear of being verbally abused and beaten by maternity nurses? or bad reception and unfriendly attitude of health workers?)
7. Where will you choose to have your next delivery? Is it mission home or traditional birth attendant's home or health facility? Give your reasons
8. What advice will you give to a woman in labour about delivery in mission home, traditional birth attendant's home or health facility? Give your reasons
9. What other factors do you want to add to all you have said that accounts for reasons why mothers who registered at the ante-natal clinic in MCH Akure do not deliver in the facility?
10. What are your expectations from Ondo State Government on delivery services in MCH? Please explain in details.

Thanks so much for your cooperation

APPENDIX III

ITONA FUN IFOROWANILENUWO NI O YE KORO

OKUNFA DIDEKUN LILO ILE IWOSAN IYA ATI OMO NI AKURE FUN OMO

BIBI NI ARIN AWON IYA TI WON FI ORUKO SILE FUN ETO AMOJUTO OYUN

Ifihan

Mo fe dupe lowo yin fun akoko ti e fun mi lati ri yin loni. Oruko mi ni Oloruntoba Jacinta Astome, mo je akeko giga ti eka Gbigboro ati Eko ilera, Iye ti ilera gbogbogbo, eka ti isegun igbalode ti fasiti Ibadan. Ma fe bayin soro lori lotri iriri yin gege bi osise eleto ilera ni ile Iwosan Iya ati Omo ti Akure. Ninu ise yi, mo n wo awon okufa didekun lilo awon eto omo bibi ti ile iwosan Iya ati Omo ti Akure fun omo bibi fun afaani lilo awon eko ti a ba ri fun ojo waju.

Iforowanilenuwo yi ni ko ni to wakati kan. Awon idahun yin ni mo ma ka si nu ero lati le ma fo idahun yin Kankan ru, bo ti le je pe mo ma se awon akosile idahun yin sugbon mi ko le yara to ero yi. Nitori wipe ama lo ero yi, e ri mo wipe e soro si oke ki a ma se jeki idahun Kankan ki o fo was ru.

Bi eti je, ero yin ati awon idahun yin ni o wa ni apamo. E leyi tunmo si wipe a ko ni so fun enikeni ju awon agbe akosemose iwadi nikan ati wipe oruko atoka yin ko ni pelu awon aroko wa. A ron yin lati le fun wa ni awon esi ti o ye koro bi ose to ati mi o se ye. Ni iranti, kikopa yin o se danadan , e si le ma dan awon ibeere kan ti ko ba wun yi e de le peru ifiorowanilenuwo yi ni akoko ti o wun yin.

N je ibere Kankan wa ti e fe ki n salaye?

Se o wun yin lati ko pa bi?

Olukopa

Ojoo

Ibeere

1. Ki ni awon iroyin ti won ma n fun awon alaboyun ti won fi oruko sile fun ipade orekore lori awon idi ti se gbodo je aanfani ti ile iwosan Iya ati Omo ti gbe kale fun gbigbebi omo? Jowo salaye si wa ju si.
2. Awon agbekale eto ti awon eleto ilere(dokita ati awon noosi) ma n se ma je ki ilera iya ati omo ki o gboro si. Kini o le so ni pa awon eto na? Jowo salaye si waju si.
3. Kin awon idi ti obinrin ma se n bimo si ile agbebi ti ijodin tabi odo awon agbebi ti abele? Jowo to ka si won. Kini idi ti o se koko julo(se aye ti ko si ni? Abi eto ibaniwole ni gba ti o n robi ma n fa seyi? Abi awon osise ti ile ijodin ti agbebi wa ni arowo to? Jowo salaye ni ekurere si
4. Kini awon ero yin tabi iriri ti ose okunfa lilo ile agbebi ti ile ijodin(tabi abgbebi ti abele) fun omo bibi? (Se abgebi ti ile jodin tabi ti abele dara ju lo ni?abi o ko fe je ki opo ki o ri o ninu oyun? Jowo salaye ni ekun rere
5. Awon igbagbo ajogunba tabi igbeaye won ni o ma n pagidina lilo ile iwosan fun omo bibi?
6. Awon nkan won ni otunbo ma n fa didedun lilo ile iwosan fun omobi? N je e ma le salaye ni ekunrere si? (se eru ebu abi nina eni lati owo awon noosi agbebi? Tabi iwuwasi awon eleto ilera?)
7. Ibo ni e ma bi omo ti okan si? ile agbebi ti ile ijodin, odo agbebi ti ibile tabi ile iwosan? Kini awon idina
8. Kini imoran ti e le fifun awon obinrin ti o n robi nipe gbigbebi won si ile agbebi ti ile ijodin, odo agbebi ti ibile tabi ile iwosan? Kini awon idina
9. Afikun wo ni e fe so ni pa awon okunfa ti awon aboyun ti won ti fi oruko si le ni ile iwosan Iya ati Omo fun amojuto oyun ti Akure fun ipade orekore ti won si ni pada lati bi omo si ibe?
10. Kini awon erogbayin yi lati odo ijoba ipinle ti Ondo fun awon eto omo bibi ni ile iwosan ti Iya ati Omo? E jowo salaye ni ekunrere

Ese pupo fun ifowosowopo yin

APPENDIX IV

QUESTIONNAIRE FOR INVESTIGATING THE FACTORS INFLUENCING LOW USE OF DELIVERY SERVICES AT THE MOTHER AND CHILD HOSPITAL, AKURE

Dear Respondent,

My name is Oloruntoba Jacinta Astosime a postgraduate student of Health Promotion and Education, Faculty of Public Health, University of Ibadan, Nigeria.

The questionnaire is designed to investigate the factors influencing the low use of Mother and Child Hospital, Akure for delivery services. The information needed is strictly for academic purposes in partial fulfillment for the award of the degree of Masters in Public health. Be free to express your views based on what you really know and do; as there is no right or wrong answer.

The information provided will be treated with utmost confidentiality and the completion of the questionnaire is entirely voluntary. I will greatly appreciate your participation in this study and you are encouraged to give HONEST and ACCURATE information. NO NAME IS REQUIRED IN FILLING THE QUESTIONNAIRE.

Consent Form

Now that the study has been explained to me and I fully understand the essence of the study and the study process, I am willing to participate in the study. I understand that the information to be collected will be kept confidential and will be used strictly for the purpose of research.

- a) I am willing to sign and participate
Signature Tick ()
- b) I am willing to participate but do not want to sign.....
Tick ()

Thank you for your cooperation

SECTION A: SOCIO-DEMOGRAPHIC DATA

Instruction: In this section, please tick in the appropriate boxes that correspond to your answers or complete the spaces provided below.

- Religion: 1.Christianity (), 2.Islam (), 3.Traditional (), 4.Others (please, specify)_____
- Marital Status: 1. Single (never married) () 2.Currently Married () 3. Widowed

- () 4. Divorced () 5. Separated ()
3. Type of Marriage: 1. Monogamy (), 2. Polygamy ()
4. Parity (No. of births) -----
5. Age (as at last birthday): _____
6. What is your highest educational qualification? 1. No formal education (), 2. Primary (), 3. Secondary (), 4. Tertiary (), 5. Others (please specify) _____
7. Ethnic Background: 1. Yoruba (), 2. Igbo (), 3. Hausa (), Others (please specify) _____
8. Employment: 1. Unemployed () 2. Employed but not for cash () 3. Employed for cash payment ()
9. Average monthly income(#) -----
10. Head of Household Employment: 1. Unemployed (), 2. Employed but not for cash (), 3. Employed for cash payment ()
11. Cash Spending Decision maker 1. Woman () 2. Husband/Partner (), 3. Both ()

SECTION B: THE INFORMATION RECEIVED BY REGISTERED PREGNANT WOMEN IN MOTHER AND CHILD HOSPITAL, AKURE ON THE IMPORTANCE OF UTILIZING THE HEALTH FACILITY FOR DELIVERY.

Instruction: Kindly pick the most appropriate option as far as this health facility is concerned.

S/N	ITEMS	YES	NO	I DON'T KNOW
12	Do the health providers at Mother and Child Hospital have the required professional skill to handle antenatal care, delivery, and postnatal care?			
13	Have you undergone any examination by any of the SBAs?			
14	Are you aware of the numerous benefits of Skilled Birth Attendance, such as; normal pregnancy and delivery, safe delivery and healthy baby, good health of mother, and short hospital stay?			
15	Where will you choose to have your next delivery? 1.Mission home 2.TBAs' home 3.Your home 4.Health facility If outside health facility(1-3) go to question 16, if health facility go to question 17			
16	If you think outside health facility is better, how and why? 1.Staff is always available 2.No need of transport 3.There is privacy 4.There is respect for mothers 5.other (specify)_____			

17	If you think health facility is better how and why? 1. Clean 2. Save mother's life 3.No retain placenta 4.Save child's life 5. Other (specify)_____			
18	ANC and Delivery in health facility promotes maternal and fetal wellbeing			
19	Confirm pregnancy and expected date of delivery			
20	Prevention of disease, early detection of complication and treatment			
21	Advise and counsel on reproductive health, breastfeeding, tobacco, and alcohol use.			

SECTION C: PERCEPTIONS AND EXPERIENCES OF RESPONDENTS THAT INFLUENCES THE LOW USE OF THE HEALTH FACILITY

Instruction: Please give your opinion on the following factors that influences low utilisation of delivery services in mother and child hospital, Akure.

S/N	ITEMS	STRONGLY AGREE	AGREE	UNDECI-DED	STRONGLY DISAGREE	DISAGREE
22	As no of children increased utilisation reduced					
23	Women's socio-economic status influences delivery in health facility					
24	Perceive it is not necessary to					

	deliver in the health facility					
25	Stayed for a long time before attention					
26	Maternal perception of not wanting to show off pregnancy					
27	Sudden onset and onset at night					
28	Mission home delivery is safer					
29	Limited resources(money for transport, money to buy baby materials) affects delivery in MCH					
30	Missing attention support and care					
31	Experienced physical and verbal abuse					
32	Delay in carrying out laboratory investigation					
33	Left alone to push during delivery					

34	Assistance during birth outside health facility					
35	TBA/ 'Agbebi' provide confidentiality					
36	TBA/'Agbebi' are helpful and show respect/sympathy					
37	Previous uneventful delivery at health facility					
38	Traditional beliefs/socio-cultural barriers, such as: adherence to traditional birthing practices and belief that pregnancy is a test of endurance.					

SECTION D: HEALTH SERVICE-RELATED FACTORS CONTRIBUTING TO THE LOW UTILISATION OF THE HEALTH FACILITY FOR DELIVERY SERVICE.

Instruction: Kindly pick the most appropriate option as far as this health facility is concerned.

S/N	ITEMS	YES	NO	I DON'T KNOW
39	Delay in admission to health facility once mothers report in labour			
40	Refusal of the presence and support from somebody known to you during delivery			
41	Inadequate bed space for the admission of patients when in labour, equipment, and materials			
42	Shortage of staff (nurses, and doctors)			
43	Believe that hospital equipment is dangerous			
44	Believe that hospital is a place for complicated delivery			
45	Ignorance of the complications of unskilled attendance.			
46	Seeking permission to deliver at the facility			
47	Fear of being tested for HIV			
48	Hospital insist on delivery on the delivery bed			
49	Hospital staff slow to respond to patient's needs			
50	Fear of being verbally abused and beaten by maternity nurses			
51	Fear of being attended to by male staff			
52	Lack of trust for health facility and providers			
53	Fear of caesarean delivery(operation)			
54	Bad reception and unfriendly attitude of health workers			
55	Lack of privacy in the wards			
56	Errors in estimating the EDD which could lead to the baby being delivered supposedly unexpected			
57	Poor access to hospital(bad roads and few transport vehicles)			

58.Others;(please,specify)

i) _____

ii) _____

THANK YOU VERY MUCH FOR PATICIPATING.

APPENDIX V

AWON OPO IBEERE TI N'TOPINPIN OKUNFA DIDEKUN LILO ILE IWOSAN
IYA ATI OMO NI AKURE FUN OMO BIBI NI ARIN AWON IYA TI WON FI
ORUKO SILE FUN ETO AMOJUTO OYUN

Awon akopa,

Oruko mi ni Oloruntoba Jacinta Astosime, mo je akeko giga ti eka Gbigboro ati Eko ilera, Iye ti ilera gbogbogbo, eka ti isegun igbalode ti fasiti Ibadan

Awon opo ibeere wonyi ni ati pese lati to pinpin awon okunfa didekun lilo awon eto omo bibi ti ile iwosan iya ati omo ti Akure fun omo bibi. Awon idahun wonyi ni a nilo lati keko gboye ti ilera ti gbogbogbo. Aanfani wa lati dahun si awon ibeere wonyi to se to ati to se ye, ko si idahun ti ko tanna.

Awon idahun wonyi ni owa ni apomo ti idahun si ibeere Kankan ko je dandan

Awa pe yin lati le je akopa ninu iwadi yin ti a si ran yin ki idahun si ibeere ki oje OTITO ati TIOSE YE

O wunmi la ti kopa ninu iwadi yi, mo ni oye wipe awon idahun si awon ibeere wonyi ni oma wa ni apamo fun aanfani iwadi nikan. A KO NILO ATOKA ORUKO TI A BA TI N DAHUN AWON IBEERE WONYI

Nje mo ti ri esi mo gba lati kopa lo wo yin? Beni[] Beko[]

Ese fun ifowosowopo yin

ISORI IKINI: AWON IBEERE TI OFARA PE IGBEAYE OLUKOPA

Itona: Ni eka yi, fi ami sinu apo wonyi fun ibeere to o ba papo mo idahun e abi ki o ko idahun si awon aye ti a ti pese sile

1. Esin: 1. Kiristani () 2. Musulumi () 3. Esin ibile
2. Ipo igbeyawo re: 1. Apon (Mi o gbeyawo ri) () 2. Mo wanile oko () 3. Opo () 4. Oko ati aya ti pinya () 5. Oko ati aya n da gbe
3. Iru ebi wo 1. Oniyawo kan () 2. Oniyawo pupo ()
4. Omo melo.....
5. Ojo oti t’ose gbeyin (ni odun).....
6. Ipo eko ti o gaju? 1. Mi o kawe rara () 2. Iwe mefa () 3. Iwe mewa () 4. Ile eko giga () 5. Omiran (jowo s’alaye) _____
7. Eya: 1. Yoruba () 2. Igbo () 3. Hausa () 4. Omiran (jowo s’alaye) _____
8. Ise: 1. Mi o sise kankan () 2. Mo n’sise sugbon ki n se fun owo () 3. Mo n’sise fun owo
9. Elo l’owo osu(#) -----
10. Ise olori idile 1. Ko ni ise l’owo () 2. O n’sise sugbon ki n se fun owo () 3. O n’sise fun owo
11. Olusepinu nina owo 1. Emi () 2. Oko mi/ekeji (), 3. Awa mejeeji ()

ISORI KEJI: AWON IROYIN ATEWOGBA FUN AWON ALABOYUN TI WON FI ORUKO SILE NI ILE IWOSAN IYA ATI OMO, AKURE NI PA IWULO LILO ILE IWOSAN NA FUN OMO BIBI .

Atona: Jowo toka si awon idahun ti o pe ye fun awon ibeere wonyi

ONKA LESEESE	IBEERE	BENI	BEK O	MI O MO
12	Nje awon eleto ilera ni ile iwosan iya ati omo keko gboye lati le se awon itoju ti o ran mo alaboyun, ni gba ti o ba n bimo lowo ati leyin to ba ti bimo na tan?			
13	Nje awon akosemose ti agbebi abele ti se ayewo fun e ri?			

14	Nje o ti mo ni pa awon afaani ti o le jere lati owo awon akosemose agbebi ti abele fun apeere: nini oyun ati bibi ti o ye, ilera ti o pe ye fun omo ati iya ati gbigbe ojo kuru ni ile iwosan?			
15	Ni bo ni owun e lati bi omo ti okan si? 1.Ile igbebi ti ijosi 2.Ile agbebi ti ibile 3.Ile e 4.Ile iwosan Ti idahun ba yato si ile iwosan, tesiwaju si ibeere 16. Ti idahun ba je ile iwosan tesiwaju si ibeere 17			
16	TI o ba lero pe ita ile iwosan ni o dara ju, ki ni di at wipe lo na wo? 1.Awon osise ma n wa l'arowo to 2.ko nilo owo oko 3.Apa mo wa 4. Owo wa fun awon iya olomo 5.Omiran(salaye)_____			
17	TI o ba lero pe ile iwosan ni o dara ju, ki ni di at wipe lo na wo? 1. Imototo 2. Ifokan ba le wa fun gbigba iya la 3. Ikeji omo ko ni se ku 4. Ifokan ba le wa fun gbigba omo la 5.Omiran(salaye)_____			
18	Lilo si ipade awon alaboyun ati bibi omo si ilewosan ma n jeki ilera iya ati omo gboro si.			
19	Aridaju oyun ati ireti ojo ibi			
20	Didena aisan, riri awon ami ijanmba ati itoju fun awon ijanmba wonyin ni aipe ojo			
21	Amoran ati riro eniyan nipa lera ti oran mo eya ara, fifun omo loyun, ciga ati mimu oti lile.			

ISORI KETA: ERO ATI IRIRI AWON AKOPA TI N'SE OKUNFA DIDEKUN LILO ILE IWOSAN FUN OMO BIBI

Atona: Jowo toka si imo lori awon okunfa didekun lilo eto ilana omo bibi ti ile iwosan iya ati omo ti Akure

Onka leseese	Ibeere	Mo gba gan ni	Mo gba	Mi o le so	Mi o gba rara	Mi o gba
22	Bi omo bibi se n gboro si ni lilo awon eto na se n dekun si					
23	Bi eto isuna obirin se ri ni o ni se pelu lilo ile iwosan na fun omo bibi					
24	Ko po dandan lati bi mo si le iwosan					
25	O ma n pe ki won to dasi eniyan					
26	Alaboyun ki n fe fi oyun re han					
27	Ai ni ifokan bale ni alale					
28	Itoju ti o peye ju wa ni ile agbebi ti ile ijosi					
29	Si sa fere owo(owo oko.owo eru omo) ni se pelu ati bimo ni ilewosan					
30	Ko si itoju ati ikani si tio o peye					
31	Iriru fifi oro buni ati awon ijanmba ti ale fi ojuri					
32	Ifaseyin sise itopinpin ayewo ti igbalode					
33	Fifi ani sele lati da ro bi					
34	Iranlowo wa ni odo awon					

	agbebi ti ki nse ti ile iwosan					
35	Awon agbebi ma n se apomo ohun ko ohun					
36	Awon agbebi ma n se iranlowo fun eni, won ma n bowo ati wipe won ni oju anu si eniyan					
37	Awon iriri ibanileru omo bibi ti ateye wa ni ile iwosan					
38	Awon igbagbo ti ibile ati ipagidina ise ti eya fun apeere didena agbebi ti ibile					

ISORI F: AWON AGBEKALE ETO TI O RAN MO OKUNFA DIDEKUN LILO ETO NA FUN OMO BIBI

Atona: Jowo toka si awon idahun ti o pe ye

Onka leseese	Ibeere	Beni	Beko	Mi o mo
39	Ifeseyin igbani ni wo le si ile iwosan logan ti aboyun ba bere si ni robi			
40	Ijanikule fun nini eni sodo ti eniyan ba n'robi lowo			
41	Ai n'aye busun, ohun elo ise ti eniyan ba n'robi lowo			
42	Ai ni osise ti o po (noosi ati dokita)			
43	Igbagbo wipe ewu nla wa ni lilo ohun elo ti ile iwosan			
44	Igbagbo pe le iwosan wa fun awon ti ijanmba ba ti wi nigba ti won wa ninu oyun			
45	Ai n'imo awon agbebi awon alaikose mo se lori awon ijanmba ti o le jeyo ninu oyun.			

46	Gbigbaye lati bimo si ile iwosan			
47	Iberu sise ayewo fun kokoro HIV			
48	Ile iwosan ma n'kan ni pa fun eniyan lati bimo si ori busun wo			
49	Awon osise eleto ilera ma n'se ifaseyin ni pa di dahun si awon ohun ini awon eniyan			
50	Iberu ebu bibu ati nina lati owo awon noosi agbebi			
51	Iberu ki awon noosi okunrin ma da eniyan l'ohun			
52	Ai ni igbagbo lori ile iwosan ati awon osise eleto ilera			
53	Iberu ise abe sise			
54	Iwakiwa awon osise eleto ilera			
55	Ai ni aye fun ara enikan ni yara itoju eni			
56	Awon asise ni pa ireti ojo ibi ti lo ma se okunfa bibi omo ni ipe ojo ti oyato si ojo ireti			
57	Si sa fere oko ati ona ti ko dara ni ona ile iwosan na			

58.Omiran(jowosalaye)

i) _____

ii) _____

ESE PUPO WIPE E KOPA

APPENDIX VI
APPROVAL OF ETHICAL REVIEW COMMITTEE

