TO BE OR NOT TO BE: ANTECEDENT FACTORS RELATED TO HOME BIRTH AMONG WOMEN IN SABO COMMUNITY OF IBADAN, NIGERIA

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ABSTRACT

Home birth (HB) accounts for 63% of place of delivery in Nigeria and factors driving the practice have not been fully explored. This study investigated the perception, attitude and practice of HB among 399 mothers of under-five children in Sabo community. Methodology consisted of a cross-sectional survey. Data were analysed using descriptive statistics and chi square test at $p<0.05$. Age was 32.1 ± 8.8 years, 79.4% perceived HB as safe, 61.9% registered for ante-natal but gave birth at home and17.2% had a skilled birth attendant present during HB. Factors responsible for HB practices included low economic status (36.8%), health worker attitude (24.3%), distance to health facility (4.5%), husband's wish (2.5%), cultural style of kneeling down instead of lying when delivering (1.7%) and industrial action by health workers (0.8%). Significant association was found between educational level, socio-cultural belief and HB. Reducing HB practice demands a shift towards advocacy and community driven interventions.

Introduction

Home births are common occurrences. Out of the world's estimated annual 130million births, nearly half occur at home (Darmstadt, Lee, Cousens, Sibley, Bhutta, et al 2009). Home birth could be planned and unplanned. Women with access to high quality medical care may choose homebirth because they prefer the intimacy of a home (Vernon 2007). In developing countries where women may not be able to afford medical care or it may be inaccessible to them, a home birth may be the only option available, and the woman may or may not be assisted by a professional such as obstetricians, doctors and certified midwives. Although, planned home delivery is not associated with increased maternal or perinatal morbidity and mortality in developed countries (Johnson and Daviss 2005), unplanned home births are associated with adverse outcomes for both mother and baby such as maternal, fetal and neonatal mortality that are reported to be considerably worse than those occurring in a hospital (Lawn, Haws, Darmstadt, Yakoob, Menezes, et al 2009).

Home birth account for 63% of place of delivery in Nigeria, this may be with or without skilled birth attendant. Health facility delivery on the other hand account for abysmally low 36% (NPC and ICF 2014). This lack of skilled attendance could be considered as one of the major factors in maternal and infant mortality. As Nigeria is striving towards achieving MDG 4 and 5, there is little information about home birth attendants' roles, both in terms of managing childbirth and in implementing effective referral systems (Darmstadt, Bhutta, Cousens, Adam, Walker, de Bernis 2005). Skilled birth attendant at delivery, timely emergency obstetric care, provision of immediate newborn care and postnatal care is essential in promoting the health of both the neonate and the mother and thereby reducing maternal and child mortality.

This study therefore investigated the attitude, perception and practice of homebirth among and the factors influencing home birth practices among mothers.

Materials and Methods

The study was a descriptive cross-sectional study that utilized survey questionnaire. It explored the attitude, perception and practice of homebirth among 399 mothers selected using cluster sampling in Sabo community of Ibadan, Nigeria. The study population are mothers of children under five years. Data was

collected using pretested questionnaire in Hausa language. The questionnaire had five sections: section A comprised questions regarding socio-demographic characteristics; section B perception of home birth; section C attitudes towards home birth; section D focused on practices of home birth and section E factors influencing home birth practices. The interviews took place at the interviewees' homes at times convenient for them after advance booking. A brief explanation of the aim of the study and confidentiality related issues kicked off the questionnaire administration. Each interview lasted about 20 minutes.

Data analysis

The SPSS statistical package version 16.0 was used for data entry and descriptive analysis after the data collected had been checked for completeness and accuracy. Serial number was given to each copy of the questionnaire for easy identification and for correct data entry and analysis. The data was also subjected to inferential (Chi-square) statistical analyses

Results

Demographic characteristics

The demographic characteristics are presented on Table 1.

Perception of Respondents towards Home Birth

Three hundred and seventeen (79.4%) respondents perceived that homebirth as safe, 254 (63.7%) opined that home birth has no risk to both mother and child while 68 (17.0%) indicated that hospital birth is a waste of time/resources. When asked if they perceived that child delivery is easy and therefore there is no need to have a hospital birth, 181 (45.4%) responded in the affirmative. Eighty-four percent of respondents perceived that there are benefits of home birth over hospital birth, 77.7% perceived that having a skilled birth attendant during delivery is necessary and 75.9% perceived that having a skilled birth attendant during delivery can help prevent maternal or neonatal mortality. Many of the respondents 282 (70.7%) are of the opinion that women have the ability to birth a baby naturally even without man's technology/medical intervention.

Respondents' Attitude towards Home Birth

Majority 247 (61.9%) of the respondents registered for ante-natal in a hospital but gave birth at home. Few of the respondents 95 (23.8%) don't want to have a hospital birth because of medical interventions, 53 (13.3%) have a cultural objection to hospital birth and 69.9% of the respondents planned having a homebirth.

Three hundred and nineteen (79.9%) feel that having their sterile pack and supplies needed for the delivery process ready is necessary while 324 (81.2%) said setting up regular visit with skilled birth attendant is their responsibility. A large number of respondents 376 (94.2%) were concerned with the safe delivery of their baby as well as personal good health status during and after birth.

Respondents Practice of Homebirth

Of the total 399 respondents, 319 (79.9%) have had home birth. Skilled birth attendants were reportedly always present during previous home birth of 83 (26.1%) respondents. To guide the delivery process, birth plan was asked for from 43 (13.5%) respondents, parity and age from 3 (0.9%) respondents, outcomes of previous labour from 18 (5.6%) respondents and only 2 (0.6%) respondents were asked their blood result. Only 24 (7.5%) respondents had their pulse rate examined during labour and 14(4.4%) had their blood pressure examined. Urinalysis was carried out for 14 (4.4%) respondents and another 14 (4.4%) had abdominal examination. Fetoscope was reportedly present to monitor the delivery process in 34 (10.7%) respondents. When respondents were asked the instrument used to cut the cord, 305 (95.6%) mentioned new or boiled blade and 1 (0.3%) indicated household knife.

About half (49.8%) of the respondents attended to by skilled attendant reported that the midwife/birth attendants stayed for 30minutes – 1 hour to observe both the mother and baby after the delivery process, 74 (23.2%) stayed between 1 hour – 2 hours, 15 (4.7%) between 2 hours – 3 hours. Only 17 (5.3%) respondents made provisions for referral to the hospital in case of emergency. A total of 54 (16.9%) respondents were reportedly referred to a skilled birth attendant during delivery due to complication. As a means of caring for

the newborn, personal hygiene was put in place by 306 (95.9%) respondents, 312 (97.8%) dried the baby's skin, and the baby was kept warm by 305 (95.6%) respondents. Many of the respondents 306 (95.9%) initiated breastfeeding early, 271 (85.0%) immunized the newborn and 118 (37.0%) went to a hospital for medical check-up after the delivery.

Factors Influencing Home Birth Practice

Factors influencing home birth practice included fast labour (44.2%), low economic status (36.8%), labour starting at night (35.6%), believe that home birth is safer (35.3%), believe that safe delivery comes from God (28.3%), health worker attitude (24.3%), socio-cultural belief (22.3%), encouragement from family members (21.6%), fear of medical intervention (12.8%), and distance to the health (4.5), husband's wish (2.5%), cultural style of kneeling down instead of lying when delivering (1.7%) and industrial action by health workers at the government (0.8%).

Discussion and Conclusion

Findings from this study affirmed data from other studies in Nigeria (Okesola and Ismail 2013; Lamina 2011;) where home birth has been documented to be safe from the perspective of the study population. This was at variance with the one carried out in Bolivia (Otis and Brett 2008) where the study participants do not perceive home birth as easy.

The proportion of respondents (69.9%) that planned having a home birth is higher than the 66.7% reported by Lamina (2011) in another part of Nigeria and lower than the 87% reported by MacDorman (2012) in the United States. This shows that more women are opting for home birth, which must be planned and attended to by skilled birth attendant. The proportion of birth attended to by skilled birth in this study is low compared with what operates in the developed world. The fact that women register for ante-natal in health facilities but still choose to deliver at home calls for reappraisal of factors driving the decision making process of where a woman would deliver her baby.

The finding that home delivery is common with very few being attended to by skilled birth attendants cannot be over-emphasised. There is the need for comprehensive community sensitization and advocacy that would focus on demystifying the myths about hospital delivery, dangers of unattended delivery and the role that the community and significant others can play in making delivery safer for women and their unborn children.

The findings of this study provide a justification for intensifying programmes for women of child-bearing age, significant others in the lives of these women and the paradigm shift in the health system to improve birthing process. Based on these findings there is need for strong advocacy, enlightenment and community mobilization aimed at reducing the unsafe birthing practices. This should be done using the community directed approach where the community drives the implantation of the interventions.

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Table 1: Respondents' Socio-demographic Characteristics

N = 399 (100%)

Socio-demographic Variables	Frequency (n)	Percentage (%)
Age (Years)*		
14-22	73	18.3
23-31	121	30.3
32-40	134	33.6
41-49	55	13.8
50-55	16	4.0
Religion		
Christianity	11	2.8
Islam	388	97.2
Marital Status		
Married	379	95.0
Separated	8	2.0
Divorced	9	2.3
Widowed	3	0.8
Educational level		
Never went to school	82	20.6
Primary School	124	31.1
Secondary School	189	47.4
Tertiary School	4	1.0
Ethnic Group		
Hausa	363	91.0
Yoruba	29	7.3
Igbo	3	0.8
Others**	4	1.0
Occupation		
House Wife	325	81.5
Trading	53	13.3
Artisan	14	3.5
Civil Servant	3	0.8
Apprentice	3	0.8
Student	1	0.3

*Mean age =32.1±8.8 **other ethnic group include Fulani