BIRTH PREPAREDNESS AND COMPLICATION READINESS IN AMASSOMA COMMUNITY OF SOUTHERN IJAW LOCAL GOVERNMENT AREA, BAYELSA STATE, NIGERIA

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ABSTRACT

Maternal mortality in Nigeria is second only to that of India. Nigeria accounts for only 2 per cent of the world's population but accounts for up to 10 per cent of the maternal mortality rates. This study examined birth preparedness and complication readiness in Amassoma community of Southern Ijaw Local Government Area, Bayelsa State. A descriptive survey design was employed and the target population of this study were booked antenatal mothers in Amassoma general hospital, Bayelsa State. A convenient sampling technique was used to select the respondents for the study. The instrument for this study was a self-structured questionnaire developed by the researcher with a coefficient of 0.83 showing that the instrument is reliable. The statistics used for date analysis include frequencies and percentages. The result of the study showed that the respondents were not prepared for birth and not ready for complications and factors influencing birth preparedness and complication readiness among respondents are lack of money (98.8%) bad roads to health facilities(88.7%) lack of husband support (88.8%) location of hospital far away from home (97.5%) inexperience health workers (88.7%) and lack of family and community support (66.3%).The study revealed that majority of the respondents 50(62.5%) started preparing for birth and delivery from 7-9 months of pregnancy these findings has shown late preparation of birth preparedness and complication readiness this has amount to result that showed most of the respondents 64(80%) have not make provision for birth partner, 78(97.5%) have not made arrangement for blood donor and 52(65%) have not made arrangement for finance as the time of responses. It is recommended that professional nurses play a key role in BP and CR to reduce maternal mortality and morbidity as a result of obstetric emergencies and complications and its socioeconomic effect.

INTRODUCTION

The moment a child is born, the woman is also born, the birth of a baby is a major reason for celebration around the world, inspite of this, preparing for birth is not a common concept in most developing countries, pregnancies are often not acknowledged until there are visible physical signs. (6-7 months), (Mukhopadhyay, Mukhopadhayay, Bahattacharjee, Nayak, Biswas & Biswas 2013). Maternal mortality is a substantial problem in developing countries. (Johns, 2004). Globally, in 2010 an estimated 287000 maternal deaths occurred as a result of complications of pregnancy and child birth (World Health Organisation, 2012). Reduction of maternal mortality is a global priority and it is one of the millennium development goals. (Sterrs, 2006). The key to reducing maternal mortality ratio (MMR) and improving maternal health is increasing attendance by skilled health personnel throughout pregnancy and delivery (WHO, 2004). Birth preparedness and complication readiness (BPCR) is one of the

keys for safe motherhood strategy whose objective is to promote the timely use of skilled maternal and Neonatal care during childbirth by making a birth plan and promoting active preparation and decision making for delivery of pregnant women and their families (Johns Hopkins Program for International Education In Gynecology and Obstetrics 2004, & WHO 2006).

Every pregnancy faces risks and every minute of every day, somewhere in the world, a woman dies as a result of complications arising during pregnancy and childbirth, the majority of these deaths are avoidable by accessing quality maternal health service (Starrs, 2004). Women and Neonates need timely access to skilled care during pregnancy, childbirth and post partum period, but too often their access is impeded by delays in seeking, reaching and receiving care (Dipta,Sharmistha, & Akhil, 2016). Although maternal healthcare services are provided free of cost in Nigeria, a recent survey of the 2004 National Sample Survey Organization revealed over 80% of households had to pay for maternal health care services, with those using private care facilities paying almost four times more than those using public facilities (Leone, James, & Padmadas, 2013). Also studies have shown that in many societies in the world, cultural belief socio-economic characteristics, and lack of awareness among other personal factors, inhibit preparation in advance for delivery and expected baby, most families tries to act only when labour begins, since no action is taken prior to the delivery, the majority of pregnant women and their families do not know how to recognize the danger signs of complications when they occur, the unprepared family waste a great deal of time in recognizing the problem, getting organized, getting money, finding transport and reaching the appropriate referral facility (Hiluf, & Fantahun, 2007).

Maternal mortality in Nigeria is second only to that of India (Emma, Nwokeukwu, & Uzochukwu 2014). Nigeria accounts for only 2% of the world's population but accounts for up to 10% of the maternal mortality rates (Federal Ministry of Health, Nigeria, 2005). Nigeria is also a leading contributor to the maternal deaths figure in sub-saharan Africa not only because of the hugeness of her population but also because of her high MMR (Hill, Thomas, Abonzahr, Walker, Say, & Suzuki, 2007). As at 2008, its Maternal Mortality Ratio (MMR) was 840 per 100,000 live births (Trends in Maternal Mortality, 2012). And the proportion of births attended by skilled health professional was about 36% (MDG Report, Nigeria, 2010). World Health Organization (WHO) recommends focused antenatal care which requires individual's health education on BPCR as one of its pillars. (WHO, 2013). Therefore, BPCR strategy encourages women to be informed of danger signs of obstetric complications and emergencies, choose a preferred birth place and attendant at birth, and make advance arrangement with the attendant at birth, arrange for transport to skilled care site in case of emergencies, saving or arranging alternative fund for costs of skilled and emergency care and finding a companion to be with the woman at birth or to accompany her to emergency care source, other measures include identifying a compatible donor in case of hemorrhage, obtaining permission from the head of household to seek care in the event that birth emergency occurs in his absence and arrange a source of household support to provide temporary family care during her absence (Ministry of Health and family welfare, 2007).

Responsibilities for BPCR must be shared among all safe motherhood stakeholder, since coordinated effort is needed to reduce the delays that contribute to maternal and Newborn deaths (Johns, 2004). Globally, in 2010 an estimated 287000 maternal deaths occurred as a result of complications of pregnancy and child

birth (WHO, 2012). Maternal mortality is a substantial problem in developing countries (Johns, 2004). Decreasing maternal mortality has got recognition of reducing maternal mortality in the millennium development goals (JHPLEGO; 2004). Meanwhile, in many societies in the world, cultural beliefs, socioeconomic characteristics, and lack of awareness among other personal factors, inhibit preparation in advance for delivery and expected baby, most families tries to act only when labour begins, since no action is taken prior to the delivery, the majority of pregnant women and their families do not know how to recognize the danger signs of complication when they occur, the unprepared family waste a great deal of time in recognizing the problem, getting organized, getting money, finding transport and reaching the appropriate referral facility (Hiluf, & Faantahun, 2007). In as much as BPCR is a safe motherhood strategy which addresses delays that could increase the immediate postpartum period, the strategy has not been effectively implemented in Nigeria, hence maternal mortality remains unacceptably high. This situation prompted the researcher's choice of the topic "Birth preparedness and complication readiness" to ascertain what women do in Amassoma community of Southern Ijaw Local Government Area, Bayelsa State, in Preparation for delivery.

Research questions

1. What is the level of birth preparedness and complication readiness among booked antenatal women in Amassoma general hospital?
2. What are the factors influencing Birth preparedness and complication readiness?
3. At what gestational age does the mothers start preparing for delivery?

METHODOLOGY

A descriptive survey design was employed to determine birth preparedness and complication readiness among antenatal women in General Hospital Amassoma, Bayelsa State. The research was carried out in General Hospital Amassoma, Southern Ijaw Local Government, Area, Bayelsa State. The Hospital is a State Government Secondary Health care institution situated in the south-south region of Nigeria, in the oil rich city of Bayelsa state located in Amassoma community. Amassoma community is an Ijaw speaking community in Southern Ijaw Local Government area in Bayelsa state of Nigeria. It shares common boundaries with the Ijaw speaking communities, on the north with Ogobiri, south with Oporoma, East with Otuan and west with Torugbene. The Hospital is made up of a reception which is the Nurse's station, male/female wards with 14bed spaces and 5 cots, a theatre, a Pharmacy and a laboratory. The staff strength is made up of; 3 Doctors, 18 Nurses, 2 Pharmacist, 3 laboratory technicians, 5 ward cleaners and a security man, making a total of 32 workers. The Hospital rendered general medical services.

The target population of this study were booked antenatal mothers in Amassoma general hospital, Bayelsa state. The total population of booked antenatal mothers of age range 15-49 is 101. The total number of antenatal mothers in the hospital is 101. The sample size 81 was calculated using Taro Yemane formula, A convenience sampling technique was used to select the respondents of the study. The instrument for this study was a self-structured questionnaire developed by the researcher. It consists of four sections: Face and content validation was done. Reliability of the instrument was ensued by a test-retest method and yielded 0.83 coefficient. The method of data collection was through the administration of questionnaire. Data collection was on each antenatal day and a period of 2 weeks was used

to collect data from respondents. The data so collected were analyzed and presented in Tables.

RESULTS

Research question 1: What is the level of birth

Table 1: Level of birth preparedness and its complications readiness

VARIABLES	Yes (%)	No (%)
Do you attend antenatal clinic up to date?	49 (61.3)	31 (38.8)
Have you made an arrangement for transportation before labour?	28 (35)	52 (65)
Have you made preparation for finance?	28 (35)	52 (65)
Have you made provision for birth partner?	16 (20)	64 (80.2)
Have you made arrangement for a blood donor in case of emergency?	2 (2.5)	78 (97.5)

In table 1, majority of the respondents 49 (61.3%) attend antenatal clinic (ANC) regularly while 31 (38.8%) does not attend (ANC) regularly. Majority of the respondents 52 (65%) have not made arrangement for transportation before labour while 28 (35%) have made arrangement for transportation. Majority of the respondents 52 (65%) have not prepared financially for labour while 28 (35%) have made preparation for finance. Majority of the respondents 764 (80.2%) have not made provision for birth partner while 16 (20%) have made provision for birth partner. Majority of the respondents 78 (97.5%) have not made arrangement for blood donor, while 2 (2.5%) have make arrangement for blood donor. Majority of the respondent 46 (57.5%) have carried out all necessary investigation while 34 (42.5%) have not done all the necessary investigation.

Research question 2: what are the factors influencing Birth preparedness and complication readiness?

Table 2: Factors influencing birth preparedness and complication readiness

Variable	Frequency	Percentage
Lack of money		
Yes	79	98.8%
No	1	1.3%
Bad roads to the health facility		
Yes	71	8.7%
No	9	11.3%
Lack of husbands support		
Yes	71	88.7%
No	9	11.3%
Location of hospital far away from home		
Yes	78	97.5%
No	2	2.5%
Inexperience health workers		
Yes	71	88.7%
No	9	11.3%
Lack of family and community support		
Yes	53	66.3%
No	27	33.8%
Maternal or neonatal complication in previous pregnancy		
Yes	53	66.3%
No	27	33.8%

As presented in Table 2, majority of the respondents 79 (98.8%) believes that lack of money can influence birth preparedness and complication readiness, 1 (13%) do not believe lack of money can influence birth preparedness and complication readiness. Majority 71 (88.7%) believes that bad roads to the health facility can influence birth preparedness and complication readiness, 9 (11.3%) do not believe that bad road can influence BP and CR. Majority of the respondents 78 (97.5%) believe that location of hospital far away from home can influence BP and CR, 2 (2.5%) do not believe that location of hospital far away from home can influence BP and CR. Majority of the respondents 71 (88.7%) believes that inexperience health workers can influence BP and CR, 9 (11.3%) do not believe that inexperience health workers can influence BP and CR. Majority of the respondents 53 (66.3%) believe that lack of family and community support an influence BP and CR, 27 (33.8%) do not believe that lack of family and community support can influence BP and CR. majority of the respondents 53 (66.3%) believe that maternal or neonatal complication in previous pregnancy can influence BP and CR.

Research question 3: At what gestational age does the mothers start preparing for delivery?

Table 3: Gestational age at which mothers started preparing for delivery

Gestational age		
1 – 3 months	11	13%
6 – 4 months	19	23.8%
7 – 9 months	50	62.5%

In table 3, majority of the respondents 50 (62.5%) start preparing for delivery at 7 – 9 months. 19 (18.8%) start preparing at 6 – 4 months, 11 (13.7%) started preparing for delivery at 1 – 3 month(s).

DISCUSSION OF FINDINGS

The study revealed that the respondents were not prepared for birth and not ready for complications for example. Majority of respondents 49 (61.3%) do not attend antenatal regularly, majority of the respondents 52 (65%) have not make arrangement for transportation. Majority of the respondents 52 (65%) have not made preparation for finance. Majority of the respondents 64 (80%) have not make provision for birth partner. Majority of the respondents 78 (97.5%) have not made arrangement for blood donor, these findings corresponded with that of Kaso and Addisse (2014) who concluded that the study identify very low magnitude of birth preparedness and complication readiness. It also corresponded with that of Markos, Daniel & Bogale (2014), they concluded that only a small number of respondent were prepared for birth and its complication. This finding did not correspond with that of Mutiso (2008) which shows that over 84.3% of the correspondents had set aside funds for transport to hospital during labour. While 62.9% had fund for emergency and 65.2% had identified a birth companion.

Study revealed that factors influencing birth preparedness and complication readiness among respondents are lack of money (98.8%) bad roads to health facilities(88.7%) lack of husband support (88.8%) location of hospital far away from home (97.5%) inexperience health workers (88.7%) and lack of family and community support (66.3%) These finding correspond to that of Nwokeukwu, Ukaegbu and Hukwu, (2014), whose findings revealed that role of husbands, educational level and parity, non-existence of community base support services for maternal health services are factors influencing birth preparedness and complication readiness among their respondents.

The study revealed that majority of the respondents 50(62.5%) started preparing for birth and delivery from 7-9 months of pregnancy these findings has shown late preparation of birth preparedness and complication readiness this has amount to result that showed most of the respondents 64(80%) have not make provision for birth partner, 78(97.5%) have not made arrangement for blood donor and 52(65%) have not made arrangement for finance as the time of responses.

Implication to Nursing Practice

Professional nurses have a key role to play in BP and CR to reduce maternal mortality and morbidity as a result of obstetric emergencies and complications and its socioeconomic effect. Professional nurses also have the responsibility to health educate the pregnant women and women of child bearing age on the importance of birth preparedness and complication readiness in other to prevent and treat obstetric complication.

Conclusion and Recommendations

The study revealed that pregnant women especially the women attending Amassoma General Hospital are not prepared for birth and its complications. Birth preparedness and complication readiness campaign messages should be a target for the government and health team towards general potential mothers because the effect of not preparing for birth and its complication will bore down on socio-economic factors and productivity. Emphasis should be placed on health education on BP and CR and the need for prompt prevention of complications also the need for referral to appropriate system to manage complications and reduce maternal mortality and morbidity rate by health workers.

Community based health education should be prompted by the government to increase knowledge on BP and CR and effect applicable prevention and assessment of BP and CR and other dangerous signs of pregnancy.

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