CHOICE OF BIRTHPLACE AND USE OF BIRTH ATTENDANTS AMONG CHILD BEARING WOMEN IN AKANU, OHAFIA LOCAL GOVERNMENT AREA, ABIA STATE NIGERIA

BY

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PG/M.Sc./ 2008/53036

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FACULTY OF HEALTH SCIENCES AND TECHNOLOGY
UNIVERSITY OF NIGERIA ENUGU CAMPUS

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A DISSERTATION SUBMITTED TO THE DEPARTMENT OF NURSING SCIENCES, FACULTY OF HEALTH SCIENCES, UNIVERSITY OF NIGERIA ENUGU CAMPUS.

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SUPERVISOR: DR. (MRS.) N. P. OGBONNAYA

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APPROVAL

This Dissertation Titled ñChoice of Birthplace and use of birth attendants among child bearing women in Akanu, Ohafia local Government Area, Abia State, Nigeriaôô was originally the work of Nwokoro, Uchechukwu Irene with Registration Number PG/M.Sc./2008/53036 of the Department of Nursing Sciences, Faculty of Health Sciences and Technology, College of Medicine, University of Nigeria, Enugu Campus.

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CERTIFICATION

This is to certify that this dissertation is the original work of Nwokoro, Uchechukwu Irene, Registration Number PG/M.Sc./2008/53036. The original work is mine except as specified in acknowledgment and reference and that neither, the dissertation nor the original work contained therein has been submitted to the University or any other institution for the award of Masterôs Degree.

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DEDICATION

This work is dedicated to my children Ordinand Dominion Ugochukwu Nwokoro, Chigozie 0. Nwokoro, Ndubuisi C. Nwokoro and Precious C. Nwokoro.

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ABSTRACT

Birth place and birth attendants during delivery are crucial factors in reducing maternal and newborn morbidity and mortality. This study investigated the choice of birthplace and use of birth attendants during delivery and also the factors influencing these choices among child bearing women in Akanu, Ohafia community of Abia State. The need for this study arose because women attend antenatal clinic during pregnancy but do not come to the health facility to deliver their babies; they are only seen when complications arose. Four objectives were set: To determine womenôs choice of birth places in Akanu Ohafia, elicit reasons for their choice of birth places, identify womenôs use of birth attendants during delivery and the factors influencing the use of birth attendants. Cross sectional descriptive survey design was adopted for the study. Total population of 313 women who gave birth between January and December 2012 were used for the study. Data were collected using researcher developed structured questionnaire. Data analysis was done using frequency counts and simple percentages and data presented in tables and pie chart. Mean and standard deviation were used for analysis of the demographic characteristics while Fishers exact test was employed in testing the two null hypotheses at 0.05 level of significance. The findings on choice of birthplace revealed that, hospital/health centre ranked highest with 67.6%, TBAS place 13.7%, church and spiritual homes 10.2 % and home 8.6%%. On the reasons for choice of birth place, respondents chose their places of delivery based on different reasons. For hospital/health centre the major reasons indicated are availability of qualified staff 93.4%, convenience 88.9% and availability of services 85.8%. On choice of TBAs place their reasons were cost 93.0%, availability 93.0% and convenience 81.4%. Reasons for using the church include availability 71.9%, labour starting at night 68.8% and charge low 62.5% while the major reason for delivering at home was that labour started at night 81.4%, Use of birth attendants during delivery showed that Nurse Midwives 70.6% is the highest and that there is reduction in the number of deliveries taken by the TBAS 15.0% and other people compared with results from other researchers. The women gave reasons which include: Provider knows her work, provider treats people with respect, the provider charges low and provider is always available as driving use of birth attendants during delivery. Two hypotheses were formulated; (i) there is no significant difference in the use of birth attendants during delivery between primiparous and multiparous women. (ii) there is no significant difference between some womenôs socio demographic characteristics (age, marital status, educational level of respondent and parity) on choice of birth place. Based on the findings there should be more campaigns for mothers to use the health facilities with skilled health personnel to avert maternal death. Health services should be made available 24hours for easy access; TBAS should undergo some training to equip them for management of simple cases. Health services should be subsidized to reduce direct cost of health services on childbearing women.

CHAPTER ONE
INTRODUCTION

Background to the Study

The choice of birthplace and use birth attendant during delivery is very important for women and their families because it determines to a large extent the outcome of pregnancies and child births. Access to quality healthcare during pregnancy and in particular, during delivery is a crucial factor in explaining the huge disparity in maternal and perinatal morbidity and mortality between developing and the industrialized world. (Gayawan,2012)

Every year, 3.3 million babies are stillborn and maternal deaths have also continued unabated. More than half a million women die of pregnancy related complications with ninety-nine percent (99%) of these deaths occurring in developing regions particularly Africa and Asia. (WHO 2005). The implication is that every minute, at least a woman dies from pregnancy and childbirth in these regions. . Comparing with other regions of the world, the lifetime risk of maternal deaths in sub Saharan Africa is 1 in 22 mothers. North Africa has 1 in 210, 1 in 62 for Oceania, 1 in 120 for Asia, and 1in 290 for Latin America and the Caribbean (WHO, 2005).

According to the World Health Organization (WHO) (2005), the history of success in reducing maternal death and newborn mortalities show that skilled professional care during and after childbirth can make the difference between life and death for both women and their newborn babies. The converse is true as well; a breakdown of access to skilled care may rapidly lead to increased unfavourable outcomes. Yanagisawa, Oum and Wakai (2006), assert that obstetric complications are the leading cause of death among women of reproductive age in many developing countries. Globally, more than 200 million women become pregnant each year and 40% are estimated to experience pregnancy related health problems with 15% experiencing serious or long term complications and 1.7% developing fatal complications. The lifetime risk of deaths due to pregnancy related complications is 250 folds higher among women in developing countries. It is estimated that 88 ï 98% of these deaths are avoidable and 70% are related to five direct obstetric complications:- postpartum haemorrhage, puerperal pre ï eclampsia and eclampsia, obstructed labour and abortion. AbouZahr, (2003) ; in Yanagisawa et al (2006) stated that the prevention and management of these complications is the key to improving maternal health. It is estimated that 97% of pregnant women in developed countries receive antenatal care ANC services and 99% use

skilled obstetric services during delivery. In developing countries, 65% and 53% of women use ANC and skilled obstetric care respectively (Uzochukwu, Onyeukwu and Okpala 2004.) Acquiring the service of skilled attendants during delivery to improve the management of pregnancy and related complications is an effective means to reduce maternal mortality.

Iyaniwure and Yusuf (2009) observed that it is not enough to receive ANC only. This is because majority of the complications that cause maternal death occur during or shortly after delivery. It is therefore important that pregnant women have skilled obstetric attendance during delivery because pregnancy related complications are a leading cause of death among women of reproductive age in developing countries. According to joint WHO/UNFPA/UNICEF/World Bank statement(1999),skilled obstetric care or attendance refers to the process by which a pregnant woman and her infant are provided with adequate care during pregnancy, labour, birth, postpartum and immediate newborn period, whether the place of delivery is the home or hospital. In order for this process to take place, the attendant must have the necessary skills and must be supported by an enabling environment at various levels of the healthcare system. For the worldôs 60million non facility based births, addressing who is currently attending these births and what effects they have on birth outcomes is a key starting point towards improving care during delivery.(Darmstadt et al 2009).

A skilled birth attendant refers exclusively to people with midwifery skills (e.g. doctors, midwives, 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 a particular setting.

In Nigeria, the National HIV/AIDS and Reproductive Health Survey (2003) showed that 62% of women who gave birth a year before the study received ANC while 34% had skilled attendance during delivery. In Abia state, it was recorded that TBAôS attend to 80% of births and skilled midwives attend to 20% of births(Health statistics, 2012) In developing countries, conditions are not favourable enough to encourage women living in rural and remote areas to deliver at home. When home deliveries occur, some go well and others lead to complications and death . the later often occurs when the family is not prepared to refer the woman to a health facility or cannot recognize the signs of complications.

Barely 6 months to 2015 ï the year targeted for achieving the global reduction in maternal mortality, the continuing high rate of maternal mortality remained worrisome. According to the United Nationôs and World Bank statistics an estimated 144 women die each day in Nigeria from pregnancy related complications making her one of the worst countries for women to deliver babies in the world (Okeibunor, Onyeneho and Okonofua, 2010). The situation of maternal and child health in Nigeria is among the worst in Africa and has not improved substantially while in some areas of the country, it has worsened over the past decade. The maternal mortality ratio ranges between 800-1,500 per 100,000 live births. Nigeria is second to India in terms of absolute number of maternal deaths and regrettably despite abundant resources, contributes to more than 10% of all global maternal and under five deaths (NHS 2003 in Ladipo 2009). Choice of birth place and birth attendants among childbearing women during delivery is very important for women and their families since this is a very critical period, a period when almost all the complications that bring about maternal morbidity and mortality occur. Women need not die in childbirth; for optimum safety, every pregnant woman without exception needs professional skilled care when giving birth. This can avert, contain or mitigate many of the life threatening problems during childbirth and reduce maternal morbidity and mortality to a significant low level. This study therefore intends to find out the choice of birth place and use of birth attendants during delivery among women of child bearing age in Akanu community of Ohafia L.G.A., Abia State.

Statement of Problem

In spite of all the programs and interventions formulated by the Federal Government in the attempt to strengthen and improve Safe Motherhood, and health programs to reduce morbidity and mortality (e.g. midwives service scheme), women do not think it wise to utilize the skilled healthcare providers during delivery .Approximately 536,000 maternal deaths occur annually of which (95%) occur in sub Saharan Africa and Asia (Fatusi 2009). Nigeria is a leading contributor to the maternal death figure in Sub Saharan Africa with maternal mortality ratio of 1:100. With an estimated 59,000 maternal deaths, Nigeria which has approximately 2% of the worldôpopulation contributes almost 10% of the worldôs maternal deaths . More than 20 million women each year suffer ill health and death due to pregnancy and childbirth. Majority of these maternal deaths can be prevented if deliveries are overseen by skilled birth attendant.

It has been observed by the researcher over the years that in Ohafia community and many parts of Abia North Senatorial zone, women attend ANC during pregnancy but do not come

to the health facility to deliver their babies or use skilled healthcare provider during delivery. Example is a case of a woman from Ndi Aja compound Elu Ohafia who booked at Isiama health centre but for reasons best known to her, she decided to deliver unassisted in her room . At the end of the delivery , she severed the cord with a kitchen knife. When I was called the next morning to attend to her, she had already lost so much blood and the placenta was completely drained of blood and adherent. All attempts made to convince her relations to take her to the hospital for treatment failed and she died about five hours. .This made the researcher wonder why this woman chose to deliver at home unassisted despite the fact that she booked at the health centre. and also why the relations refused to take her to the hospital when complications arose. The researcher also observed that from data available from the health facilities she visited in Ohafia community the ANC coverage is very high > 95% This high attendance has not translated to high institutional delivery which is as low as 35%. The meaning is that women do not return to the health facility during labour /delivery.

Where do these women deliver their babies? and who takes these deliveries. It was found out that Ania compressive health centre and Akanu Ukwu health centre Ohafia all situated at Akanu, have the average of 109 ANC attendance and 37 deliveries per year for five years. This makes them the most implicated from the data collected from the health facilities. The researcher decided to investigate the choice of birthplace and use of birth attendants among child bearing women in Akanu, Ohafia LGA, Abia State.

Purpose of the Study

The purpose of study is to: investigate the choice of birth place and use of birth attendants during delivery among childbearing women in Akanu community, Ohafia LGA, Abia State and also find out reasons for their choices.

Specific objectives were to:

1 Determine women's choice of birth place in Akanu Ohafia Community.

2. Elicit the reasons for womenôs choice of the birth places.

3. Identify womenôs use of birth attendants during delivery in Akanu community.

4. Elicit the factors that influence womenôs use of these birth attendants during delivery.

Research questions

1. What is the choice of birth place for women of Akanu in Ohafia community

2 What are the reasons for women's choice of these birth places.?

3. What type of birth attendants do these women use during delivery?

4. What factors influence the use of these birth attendants during delivery.

Hypothesis 1: There is no significant difference in the choice of birth attendants between primiparous and multiparous women

Hypothesis 2: There is no significant difference in the use of birthplace and some socio-demographic characteristics of women- (age, marital status, educational level of respondents and parity).

Significance of the Study.

Findings of this study will reveal the birth places and type of birth attendants Akanu women prefer during delivery. It will also expose the factors which influence these choices. The findings will enable the researcher make recommendations which will enable Government, policy makers, health planners and managers design appropriate maternity services and put strategies in place that will motivate these mothers to deliver under skilled birth attendants in functional health facilities.

To mothers: when mothers deliver under skilled birth attendants based in functional health facilities, there will be improvement in maternal and child wellbeing and reduction in maternal and child morbidity and mortality.

Family: The families will have access to health services that is available, less costly and convenient to use.

To the community: There will be better quality of life and higher life expectancy for women in Akanu community. This will improve the gross domestic product of Akanu community, thereby contributing to National wellbeing, reduction in maternal morbidity and mortality and achievement of the 5^{th} millennium development Goal.

Scope of the study

This study is delimited to choice of birth place and use of birth attendants during delivery and factors influencing these choices among child bearing women in Akanu Ohafia. The researcher will investigate where Akanu women deliver their babies within the period under study, who took these deliveries?, what were their reasons for choosing that birth place and using that birth attendants. The study will also establish the relationships between some

socio demographic characteristics of the women and choice of birth place and birth attendants.

Operational definition

Birth places: The place where women deliver their babies (eg Hospital/health centre, TBAs place, Church/Spiritual healing homes, Home)

Birth attendants: People who conduct/assist during delivery for these child bearing women. (eg Nurse/ midwife, doctors, TBAS, pastors /spiritual women, mothers, sisters etc).

Women of child bearing age: Women who are still in their reproductive years

Choice of birth place: Preferences of birth places. Where women prefer to deliver their babies eg hospitals,

CHAPTER TWO
LITERATURE REVIEW

This chapter deals with the review of relevant literature as it relates to choice of birth place and use of birth attendants during delivery. It is presented and discussed under the following headings:

1. Conceptual review
2. Review of related theories
3. Empirical review
4. Summary of reviewed literature

Conceptual review

Concept of birth place

A birth place is where someone was born or where something originated (Harper, 2003) Health facility delivery can occur at private or public facility. Public facilities are usually owned and financed by the government and/or supported by some faith based organizations. In these settings costs are usually minimal but available amenities are often sub-optimal. Although private facilities are more expensive, they are often perceived as having the best amenities and offering the best standard of care (Umurungi 2010).

Health institutions: These are public or non profit organizations that provides healthcare and related services including but not limited to the provision of in patient and out patient care, diagnostic and therapeutic services ,medicinal drugs, nursing care, assisted living, elderly care and housing, including retirement communities and equipment used or useful for the provision of healthcare and related services. www.Oregan Laws.Org. According to Izugbara and Duru (2009), in Nigeria and many parts of Africa we have other types of healthcare providers and these include:

The traditional medical practitioner or traditional healer: This is defined as someone who is recognized by the community in which he lives as competent to provide healthcare by using vegetable, animals and mineral substance and certain other methods based on the social, cultural, and religious background as well as certain knowledge attitude and beliefs regarding physical social and mental wellbeing and the causation of disease in the community. The traditional healers are established healthcare workers within their communities. It has been estimated that 60 ï 80% of the South African population currently use traditional medical sector as their first contact for advice and/or treatment of health

concern. (Izugbara & Duru 2009) In Nigeria, it is estimated that ethno medicine is actually the only healthcare resource accessible to a third of the population. Traditional medical practitioners treat all age groups and all problems. Under this group of practitioners are the herbalists, prophets, faith healers, and diviners ((Izugbara & Duru 2009).

1. **The Herbalists: T**hey use herbs in curing and treating their patients
2. **Prophets and Faith healers**: They use prayers, candle lights and water For diagnosis and treatment.
3 **Diviners**: They act as intermediaries between humans and super naturals. They use divination in diagnosis and casting of spell in their treatment. (Izugbara & Duru (2009)

Birth attendants during delivery

There are many types of healthcare providers during delivery. These include both professional health care providers and traditional healthcare providers. Professional healthcare providers are those approved and certified by their professional bodies to take care of women during pregnancy, labour , delivery and immediate post natal period and also to care for the newborn. These include:

Midwives: Midwives are trained to identify possible problems in pregnancy, and they work together with physicians when necessary for complicated pregnancies. Women give birth with midwives in birth centres, at home and in hospitals. Under the types of midwives, there are registered midwife and registered nurse midwife (RM&RN/RM) A registered midwife is one who has undergone midwifery training and is registered by the countryôs nursing and midwifery council to practice midwifery.

Registered nurse/midwife: This is a registered nurse who has additional education and certification in midwifery. A registered nurse midwife is trained to provide pre natal care, education and support; attend birth in a birth centre hospital or home and provide follow up care to mother and newborn after birth.

Family physicians: These focus on the healthcare need of the family, not all family physicians include maternity care in their practice.

Obstetricians: Obstetricians care for woman before, during and after their pregnancies. They are trained to identify and treat medical problems in pregnancy. They are trained in surgery and are able to perform ceasarean section.

Skilled birth attendant

According to WHO (2004) a skilled attendant is a health professional ï such as a midwife, doctor, nurse ï who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and immediate post natal period and to identify, manage or refer women and their Newborns with complications . Recognizing that the qualifications attributed to health providers not only vary between countries but can change over time within a single country, the WHO, the International Confederation of Midwives (ICM) and the International Federation of Gynaecology and Obstetrics (FIGO) have developed a competency based definition of a skilled attendant.

A skilled attendant should be able to do the following:

- Manage normal labor and delivery
- Recognize the early signs of major obstetric complications.
- Perform essential life saving intervention and refer as appropriate.
- Provide high quality culturally appropriate and considerate care, including follow up and linkages with other services (WHO 2004)

The term ñskilled attendants at birthò 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 intervention, start treatment, and supervise the referral of mothers and baby for interventions that are beyond their competence or not possible in the particular setting. In order to save lives, skilled attendants need to be linked up with a larger health care system with facilities, supplies, transportation and professionals to provide emergency obstetric care when it is needed.(UNFPA , 2004).

Skilled Care: This refers to the process by which a pregnant woman and her infant are provided with adequate care during pregnancy, labour, birth , post partum, and immediate newborn period, whether the place of delivery is the home, health centre, or hospital. In order for this process to take place, the attendant must have necessary skills and must be supported by an enabling environment at various levels of the health system, including a supportive policy and a regulatory framework; equipment and infrastructure and efficient and effective system of communication and referral/ transport. Skilled care therefore includes care for women with life threatening complications, but is not limited to that care. The skilled

care approach is based on the premise that all women are entitled to good quality care during childbirth. It assumes that such care can prevent some complications (e.g through hygiene practices and active management of the third stage of labour), increase the likelihood of immediate, appropriate treatment when complications do develop; and encourage prompt, timely referral as necessary. (Skilled care during childbirth information booklet of family health international 2001).

According to WHO (2005) one of the methods of reducing maternal mortality is to ensure skilled attendance at delivery and strengthen health system to ensure 24hours emergency obstetric care. Since much of maternal healthcare depends on skilled attendance long term strategic resource planning cannot be over emphasized. Gabrysh and Campbell (2009) stated that skilled attendance at birth is crucial for decreasing maternal and neonatal mortality; yet many women in the middle and low income countries deliver outside the health facilities without skilled help. Most obstetric complications occur around the time of delivery and cannot be predicted. Therefore it is important that all pregnant women have access to a skilled attendant. Skilled attendance at delivery is advocated as the single most important factor in preventing maternal deaths and proportion of births attended by skilled health personnel is one of the indicators for Millennium Development Goals. Access to skilled delivery care is also crucial to prevent still birth and improve newborn survival.

Skilled attendants can perform deliveries either at home, health centre or in hospitals but it is argued that the most efficient strategy for lower income countries is to place them in health centres with referral capacity. In practice, skilled attendance in most countries is synonymous with facility delivery (Gabrish & Campbell 2009). Idris Gwarzo and Shehu (2003) pointed out that every year, more than 20 million women become pregnant and some 15% are likely to develop complications that will require skilled obstetric care to prevent the unacceptably high maternal morbidity and mortality. Majority of the maternal deaths that occur are avoidable or preventable. An emerging consensus has it that these deaths can be prevented if deliveries are overseen by skilled attendants. They observed that it has been estimated that only 50% of women in the world have access to such skilled care. According to them, maternal deaths are strongly associated with inadequate medical care at the time of delivery and majority of these maternal deaths are avoidable or preventable if skilled care is given during delivery. Many women loose their lives in the process of procreation. Iyaniwure and Yussuf (2009) observed that adequate antenatal care and skilled obstetric assistance during

delivery are important strategies that significantly reduce maternal mortality. They further asserted that it is true that ANC provides avenue to provide pregnant women with information, treat existing social and medical conditions and screen for risk factors; it is not enough to receive ANC since majority of the complications occur during or shortly after delivery. It is therefore important that pregnant women have skilled obstetric attendance during delivery.

Uzochukwu (2004) observed that while an estimate of 97% of the pregnant women in developed countries receive ANC and delivery, 65% and 53% of women in developing countries use ANC and obstetric care respectively. According to WHO (2005), the history of success in reducing maternal and newborn mortalities show that skilled professional care during and after childbirth can make the difference between life and death for both women and their newborn babies. The converse is true as well; a breakdown of access to skilled care may rapidly lead to an increased unfavorable outcome. The challenge is to find a better way of establishing continuity between care during pregnancy, at birth and when the mother is at home with her baby. It observed that the weakest link in care chain is attendance at birth. Women risk death to give life, but with skilled and responsive care at birth and after birth, nearly all fatal outcomes and disabling sequel can be averted ï the tragedy of obstetric fistulas, for example and much of the suffering can be eased.

Childbirth is central event in the lives of families and in the construction of communities it should remain so but it must be safe as well. They further stated that for optimum safety, every woman, without exception, needs professional skilled care when giving birth where she lives and respect her birthing culture. Such care can be provided by a registered midwife or a health worker with midwifery skills in decentralized first level facilities. This can avert, contain or resolve many of the life threatening problems that may arise during childbirth, and reduce maternal mortality to a surprisingly low level. According to UNFPA (2011) Skilled attendance denotes not only the presence of midwives and other 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. Historical as well as contemporarily evidence from many countries, 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 skilled health provider is one of the two indicators for measuring progress towards the 5th MDG improving maternal health.

According to De Bernis, Sherrat, Abouzahr & Lerberghe (2003), today we know how to prevent and manage pregnancy related complications and there is increasing recognition that pregnant women should be assisted by necessary skills, drugs, supplies equipment and backup particularly during and immediately following childbirth. In the absence of such professional assistance women pay a heavy price ï maternal mortality rates of 1000 ï 2000 per 100,000 births. The clinical rationale for skilled care during pregnancy and childbirth is unassailable. Skilled attendants, people with midwifery skills, such as midwives, doctors and nurses who have been trained to manage normal (uncomplicated) pregnancies, childbirth and immediate postnatal period, and identify, manage or refer complications in the woman and newborn are the best placed to ensure the survival and safety of pregnant women and their infants. Whatever their professional title, health professionals functioning as skilled attendants should be able to identify early signs of complications and offer first line emergency obstetric care including emergency in newborn when needed.

Yanagisawa, Oum and Wakai (2009) observed that obstetric complications are the leading causes of death among women of reproductive age in many developing countries. Globally, more than 200 million women become pregnant each year and 40% are estimated to experience pregnancy related health problems with 15% experiencing serious or long term complications and 1.7% developing fatal complications. The lifetime risk of deaths due to pregnancy related complications is 250 folds higher among women in developing countries. It is estimated that 88 ï 98% of these deaths are avoidable and 70% are related to five direct obstetric conditions ï post partum haemorrhage, puerperal pre-eclampsia and eclampsis, obstructed labour and abortion. Thus management of these complications is the key to improve maternal health. Acquiring the aid of skilled attendants to improve the management of pregnancy and related complications is an effective means to reduce maternal mortality.

According to Hunt et al (2002) in Yanagisawa (2006), a previous ethnographic study indicated that despite the ready availability of skilled attendants women often prefer traditional birth attendants (TBAs) to assist during deliveries. To promote the skilled attendant use, it is necessary to identify the determinants that are to be considered in case of skilled and unskilled birth attendants. Globally, some 80% of maternal deaths are due to a

few direct obstetric complications ï sepsis, heamorrhage, eclampsia, abortion; most could be prevented and managed if the woman had access to skilled attendants with the necessary backup and support. The remaining deaths, those caused by conditions exacerbated by pregnancy e.g. severe anaemia, tuberculosis, malaria and HIV/AIDS, also require the assistance of a skilled healthcare provider during pregnancy, birth and immediate post natal period for appropriate management and treatment. Complications that result in maternal mortality and morbidity also contribute to the majority of newborn mortality and morbidity. Some of these complications can be prevented with appropriate management of labour and birth e.g. clean birth and monitoring of labour to recognize prolonged and obstructed lablour as well as signs of fetal distress. Even when these complications cannot be prevented like in vast majority of maternal complications, they can be effectively managed. However this requires Health care provider with requisite skills as well as a functional referral system. (Bernis et al 2003).

Teijingen, Amalraj & Dahkal (2011) observed that in Nepal (81%) deliveries take place at home. Traditional Birth Attendants (TBAs) and unskilled birth attendants such as family members and relatives are common while some women 7% give birth without support. Evidence suggests that having skilled attendants at delivery is one of the key interventions for reducing maternal mortality. Developing countries where professional attendants are used at delivery have reduced maternal mortality up to 50 per 100,000 live births. Local TBAs are not recognized by WHO because they are generally not trained to deal with birth-related complications

The traditional birth attendants (TBA)). WHO(1978) in Mbiydzenyuy (2012) defined the traditional birth attendant as a person (usually a woman) who assist the mother at childbirth and who initially acquired her skills delivering babies by herself or working with other TBAs. The term traditional birth attendant is one around which there is currently a lot of controversy and debate. It is used to define a wide and heterogeneous group of traditional carers most of whom operate in the informal sector, and their individual competencies and skills can vary considerably, as can the names and titles by which they are commonly referred to, depending on the specific country context (Bernis 2003). Although in some countries it is clear that women utilize the skills of such careers. Research findings indicate that training TBAs is not an effective strategy for reducing maternal mortality For example a study comparing maternal mortality and morbidity in two urban populations in Senegal shows that even

trained TBAs were unable to accurately recognize signs of complications early or were unable to make a correct diagnosis and take appropriate actions for managing complications. Bernis et al (2003). According to Iyaniwure and Yusuf (2009), the increased proportion of the deliveries at TBA homes may also be associated with the prevalent supernatural concept of disease in many African communities. Twenty nine percent (29%) of ANC attendees in Equatorial Guinea expressed that TBAs were better than orthodox practitioners in some respects because TBAs possess spiritual powers and can intervene in certain situations where medical interventions cannot help. TBAs may for economic reasons also rank strongly in the preference of some Nigerian women as their services have been reported to be more affordable. Additionally, TBAs may offer more convenient user charges that allow payment to be spread over a period of time or be made in kind.

Among professionals, opinions differ about the role of TBAs in maternity care while some insists that in the interest of maternal health, empowering TBAs through training and retraining is the best option because community members will continue to patronize them, others express that TBAs have little role in obstetric care. The debate of who is qualified to take delivery of a pregnant woman in labour has been renewed as the Lagos state government released its 2010 maternal mortality health survey conducted by IPas, sexual reproductive health organization. According to Adebayo,(2012), stake holders in the medical profession, obstetricians who were present at the presentation called on the state government to reverse its policy that allows (TBAs) trained by the state to take delivery of pregnant women. According to them, the move is practically endorsing unskilled personnel to attend to pregnant women. This they warned could increase maternal and infant mortality rate in the country. The experts criticized the state governmentôs initiative which has seen over 1,264 TBAs trained in the past two years in primary health care centres to offer midwifery services in local government areas in the state. In view of this, the country Director of IPas Dr. Ejike Orji, said ñ though TBAs are a relevant chain in the maternal and child care system of the country, they lack the knowledge and skill to save a mother and her baby from dying during deliveryô. According to him, TBAs cannot recognize and also intervene medically in the five leading causes of maternal deaths during childbirth which include obstructed labour, unsafe abortions, eclampsia, heamorrhage and infection. He pointed out that previous programmes that championed the training of TBAs to take deliveries in Africa had been scrapped after research has shown that maternal mortality has increased as a result of such training.

Choice of birth place Umurungi (2010) observed that the majority of births in sub-Saharan Africa still occur at home or in other non-hospital settings. In resource poor settings, home delivery is usually the cheapest option but is associated with attendant risk of infection and lack of available equipment should complications occur. In rural areas of Nigeria, the proportion of institutional deliveries is as low as 4% even in urban areas like Lagos, a significant proportion of women (19%) still deliver at home. This is in spite of a relatively easy access to institutional maternity services in urban areas. Health facility delivery can occur at private or public facilities. Public facilities are usually owned and financed by the government and/or supported by some faith based organizations. In these settings costs are usually minimal but available amenities are often sub-optimal. Although private facilities are more expensive, they are often perceived as having the best amenities and offering the best standard of care (Umurungi 2010). In Nigeria, use of reproductive health services remain low and home delivery among women of childbearing age is widespread (Aremu 2011). According to Babalola & Fatusi (2009),the roles of traditional and religious beliefs as well as the perception of women with regards to comparative efficacy of the medical versus traditional birth attendants may also be contributing to failure to have skilled attendants at birth .Modern (medical) and indigenous maternal health care services coexist in most African countries particularly in rural areas and women may have to choose between the two options He stated that many Nigerian women particularly those in rural areas rate the services of TBAs as being of higher quality than that of medical healthcare practitioners particularly with regards to interpersonal communications and relationship. TBAs have been reported to be more considerate and to provide more compassionate care other places that delivery occur

Consequences of delivering in non-health facility

Childbirth in a health facility while attended by trained health professional has been shown to be associated with lower rates of maternal and neonatal mortality compared to home birth. In poor settings, non-health facility deliveries are associated with increased maternal morbidity and mortality and increased newborn morbidity and mortality. In developed countries, some studies conducted in the United States of America between 1989-1996 have shown an increased maternal and neonatal risk associated with planned home birth (Umurung 2010). According to Titaley, Hunter, Dibley and Heywood (2010), in low and middle income countries, many deliveries still occur at home without the assistance of a trained attendant. This has generated serious concerns since women who develop life threatening complications

during pregnancy and delivery require appropriate and accessible care. 20 ï 30% of infant mortality could be reduced by implementing skilled birth care services.

Determinants of choice of birth attendants among women

Utilization of health services is a complex behavioral phenomenon .The use of health services is related to availability, quality, cost of service as well as social structure, health belief and personal characteristics of the user. Birth place and health care provider during delivery is determined by a barrage of factors which act singly or in combination to enhance or deter women from choosing skilled healthcare provider during delivery. The proportion of births conducted by a skilled attendant has become an indicator for monitoring progress towards reduction of maternal mortality. In Nigeria, the antenatal care coverage according to data from UNICEF (2006) to (2010) once is 58% while coverage for four times is 45%. Delivery coverage for skilled attendant at birth is 39%and institutional delivery coverage is 35% for the same period. This percentage attendance during ANC does not translate to the same percentage of institutional delivery rates. The proportion of deliveries conducted by skilled health care provider is 39% nationally. The gap between antenatal care attendance and attendance during delivery suggests that there are factors making women not to return to the health facilities during delivery and these factors need to be explored and taken care of. Using the themes developed by Gabrysh and Campbell (2009) linked to the conceptual framework developed by Anderson (1995), the determinants are categorized into the following themes:

- Socio-cultural factors
- . Perceived benefit or need of skilled attendance
- . Economic accessibility
- Physical accessibility

Socio-Cultural Factor

Socio-cultural factors considered here are:

Maternal age: According to Gabrysh and Campbell (2009), age is often presented as a proxy for use of health services. Older women are also influential in household decision making than younger women and the adolescent in particular. Furthermore, older women may be told to deliver in a health facility since older age is a biological risk factor. On the other hand, older women may belong to more traditional cohorts and thus be less likely to use modern

facilities than young women. Age is highly correlated with parity, and in some settings, with educational level. It is also associated with marital status unwantedness of a pregnancy, socioeconomic status and decision making power. Umurungi (2010) stated that it is recognized that womenôs current age plays an important role in the utilization of medical services.

Motherôs age may sometimes serve as a proxy for womenôs accumulated knowledge of health care services, which may have a positive influence on the use of health services. On the other hand, because of development in modern medicine and improvement in educational opportunities for women in recent years, younger women might have enhanced knowledge of modern healthcare services and place more value upon modern medicine. Iyaniwure and Yusuf (2009) stated that young women maybe unmarried and may lack social support. They may be unable or unwilling to use maternal health services depending on the circumstances surrounding their pregnancy. It is unfortunate that women who appear to be at higher risk such as young uneducated and poor women are less likely to access the appropriate services.

Marital status: Marital status may influence the choice of delivery place, probably via its influence on female autonomy and status through financial resources. Single or divorced women may be poorer but enjoy greater autonomy than those currently married. Young single mothers may be cared for by their natal families which may encourage skilled attendance especially for a first birth. On the other hand, single mothers may be stigmatized and prefer to deliver at home because they anticipate a negative provider interaction Umurungi (2010)

Family size/family compostion: Family size is an important determinant of health care utilization. Women from large families under-utilize various health care services because of excessive demands on their time. Larger families also cause resource constraints which have a negative effect on health care utilization (Umurungi 2010). On family composition, Gabrysh &Campbell (2009) said that women with young children may have difficulties finding child care while they deliver at a health facility in particular if they live in a nuclear family. Sometimes women are accompanied by family members during their trip to hospital, so that even these cannot take care of other children during the time. In addition to influencing the ease of leaving home, living with an extended family may also influence the decision making power of the woman; Charaborty (2003) observed that one of the important

predisposing factors for utilization of healthcare is family size. Women from large families under-utilize various health care services because too many demands on their time force them to forgo healthcare. Larger families also cause resource constraints which have a negative effect on health care utilization.

Mother's education: There are multiple potential pathways that could explain why maternal education is constantly and strongly associated with all types of health behavior. These include increased knowledge of the benefits of preventive healthcare and awareness of health services, higher receptivity of new health information, socialization to interact with formal services outside the home environment, familiarity with modern medical culture, access to financial resources and health insurance, more control over resources within the household and wiser spending, more egalitarian relationship and better communication with the husband, more decision making power, increased self worth and self confidence, better coping abilities and negotiating skills as well as reduced power deferential towards health care providers and thus better communication and ability to demand adequate services. Education also affects a womanôs childhood background, including familiarity with health services and certain beliefs and norms. It has also been suggested that there may be community effect of education, with more highly educated communities organizing themselves and demanding better public services and a higher position for health on the political agenda.

By contrast, better awareness of poor quality in many facilities and higher confidence in self care may delay care seeking among educated women. Furthermore, where public health programs reach out to disadvantaged sectors of the population, the education gradient in health services use may be small (Gabrysh and Campbell 2009). Womenôs literacy is an important predictor for the use of maternal healthcare services. It is well recognized that a womanôs educational level has a positive impact on healthcare utilization. Increased education influences service use by increasing female decision making power, increasing awareness of health services changing marriage patterns and creating shifts in household dynamics (Umurungi 2010). According to Raghupathy (2009), maternal schooling does not have a uniform impact across all services, nor are these effects necessarily positive. While there is positive effects of schooling in the use of prenatal care, the educational differentials in the use of delivery assistance starts emerging only after secondary school (Sabona,

(Ragupathy 2009) Motherôs education is the most constituent and important determinant of use of child and maternal health services said (Ahmed et al, 2010).

Husband's education: Educated husbands may be more open towards modern medicine, aware of the benefits of skilled attendants and more able to communicate with health workers and demand appropriate care, as described for womenôs education. They may also put fewer constraints on their wives mobility and decision making thus facilitating care seeking.

Women's autonomy: The various dimensions of autonomy such as the position in the household, financial independence, mobility and decision making power regarding oneôs own healthcare may all impact on health facility use. In many countries, women cannot decide on their own to seek care, but have to seek permission a husband or mother-in-law. Furthermore, women may lack control over material resources to pay for expenses, their mobility may be restricted or they may lack access to vehicles or even bicycles or donkeys. (Gabrysh & Campbell 2011). According to Fotso, Ezeh and Essendi (2009), a womanôs autonomy is generally defined as the ability to make and execute decisions regarding personal matters of importance on the basis of the womanôs power over others, access to information, control over material resources and freedom from violence by her husband or other men. Others have conceptualized autonomy as womenôs ability to determine events in their lives even though men and other women may oppose to their wishes. According to Self and Grabowski (2012) decisions within the household determine the allocation of resources. Theory suggests that the more autonomous women are within the household, the greater influence they will have in that allocation. It is hypothesized that the greater the womanôs autonomy, the more likely she will be to visit a doctor, rather than other traditional sources of healthcare when ill. So enhancing the autonomy of women is a laudable goal in and of itself. Determinants of poor maternal and infant outcome include poverty and cultural factor which restrict womenôs autonomy, promote early marriage and or support harmful traditional practices (Reynolds et al 2006).

Decision making on utilization of health services related to womenôs autonomy is defined as ability to make decisions in the household. Studies have indicated that in some sub-Saharan countries, men generally are decision makers regarding the location at which their spouses should give birth. Where as in East-Asia it is mostly mother in-laws who determine the location of birth. At the international conference on population and development held in

Cairo, Egypt in 1994, it was affirmed that when women are empowered to make own decisions, they would access health services more quickly. In some sub-Sahara African countries, men generally are decision makers regarding the location at which their spouses should give birth. (Ahmed et al, 2010), Kabakyenga et al (2012).

Wagle, Sabre and Nielson (2004) in their study on socio-economic and physical distance to the maternity hospital as a predictor for place of delivery, stated that most of the women narrated if they could choose, they would prefer to deliver in a health institution assisted by a professionally skilled person. Nevertheless, the decision was not simply their own, and the influence from other members of the household seemed strong especially older women in the family like mothers, grandmothers, mother in-laws and husbands. According to Furuta and Salaway(2006) earlier work in south-Asia has suggested. Inequitable gender roles and womenôs position within the households, as influencing use of services. Gender roles and relations may operate to restrict womenôs access to health care during pregnancy and at the time of delivery. These include heightened restrictions on womenôs movement because the pregnant state is considered ñshamefulò. Young womenôs lack of say within the family and the fact that pregnancy related knowledge and decision-making authority are commonly vested in older women, young womenôs lack of influence over material resources, and the exclusion of men, who are often the primary decision makers in the use of material resources from the polluting event of childbirth determine use of services

(2) Perceived Benefits/Needs

Under perceived benefits are such factors as:

Information availability, health knowledge, perceived quality of care pregnancy wanted/unwanted, antenatal care use, previous delivery service use, birth order, complications. According to Gabrysh and Campbell (2009). This category comprises factors influencing the perception of how a facility delivery with skilled attendance will benefit mother and newborn and/or how big the personal need for such care is. This perception is shaped by the general awareness of the dangers of childbirth and interventions available at health facilities by individual past experiences with pregnancy childbirth and health services, as well as by risk assessment of the index pregnancy. Factors in this category are thought to primarily affect the decision to seek care.

Information Availability: Having access to information through modern media could influence womenôs knowledge about delivery risks and availability of services. It may be

hard to disentangle access to information from possession of radio or TV and a higher socio-economic status that makes this more likely. Literacy is essential for access to written information

Health Knowledge: Specific knowledge about the risk of childbirth and the benefits of skilled attendance should increase preventive care seeking, while recognition of danger signs and knowledge about available beneficial intervention should increase care seeking for complications. Contact with a skilled attendant could increase specific knowledge on childbirth via health education. Specific knowledge may also be associated with educational level in general (Umuringi 2010).

Perceived Quality of Care: Perceived quality of care is thought to be an important influence on healthcare seeking. Assessment of quality of services largely depends on peoples own experiences with the health system and those of people they know .Elements of satisfaction cover satisfaction with the outcome, the interventions and with the service received ï including staff friendliness, availability of supplies and waiting times. In many cases, the medical culture may clash with the womanôs for example, when family members are not allowed to be present, supine birthing position is imposed or privacy not respected, this may lead to perception of poor quality (Thaddeus and Maine 1994 in Gabrysh & Campbell 2009).

Healthcare providerôs attitude is another essential component of quality of health services. According to Amankwa (2010), staff attitude remains a hindrance to accessing professional services among pregnant women in rural Tanzania (Mrisho et al., 2007) Poor healthcare providerôs attitude and fear of punishment by healthcare provider in form of abusive language, denying women service, lack of compassion and refusing to assist properly resulted in seldom decision making among the pregnant women to deliver in a health facility. Many women report dissatisfaction with rude, arrogant and neglectful behavior at health facilities and prefer the care of TBAs or relatives. (Gabrysh & Campbell 2009)

Wanted or Unwanted pregnancy

Women with unwanted pregnancies may be less likely to invest in skilled attendance at delivery than those who attach high value to the expected child. Delivery care may be sought due to the risk for the mother rather than the child.

Previous delivery service use: Women who delivered with a skilled attendant previously become more familiar with this setting, which may make them likely, use it again.

Birth Order/parity : The first birth is known to be more difficult and the women have no previous experience of delivery. Often a high value is placed on the first pregnancy and in some settings; the womanôs natal family helps her get the best care possible. Furthermore, health workers may recommend a facility delivery for primipara. By contrast women of higher parity can draw on their maternity experiences and may not feel the need to receive professional care if previous deliveries were uncomplicated. Also women with several small children may have greater difficulty in attending facilities due to the need to arrange child care. According to Amankwa (2010) Parity is another significant factor that can influence a womanôs decision to deliver with a skilled attendant He cited Bangladesh where women with lower parity are less likely to deliver at home

Ekene &Tunau (2007)in Amankwa (2010) stated that in Sokoto in Nigeria, women of high parity were found to be more likely to decide to prefer home delivery with unskilled attendants

Antenatal Care. ANC services can provide opportunities for health workers to promote a specific place of delivery or give women information on the status of their pregnancy, which in turn informs their decisions on where to deliver.

Risk assessment during ANC may explicitly recommend a place for delivery, for instance to deliver in a hospital for twin pregnancy. On the other hand women who are told their pregnancy is fine may feel encouraged to deliver without a skilled attendant.

Complications: Complications experienced during previous deliveries or loss of the newborn can make women aware of the dangers of childbirth and the benefits of skilled intervention and thus make them use skilled attendance for subsequent deliveries. Furthermore women with specific medical intervention in a previous delivery example cesareans section will be encouraged by health workers to seek skilled care for subsequent deliveries since there is an increased risk for rupture with a scarred uterus. Complications during an attempted home delivery often influence women and their families to seek professional care, even though the original intention was to deliver at home.

(3) Economic accessibility

Economic accessibility refers to the relation between financial capability of the family and cost of a facility delivery including transportation costs while directly affecting whether a woman can actually have a facility for delivery (second delay) the anticipation of a high cost will affect whether a decision for a facility delivery is made in the first place (first delay) Gabrysh & Campbell (2009). Under this group are factors such as motherôs occupation,

husbandôs occupation and other measures of ability to pay including community level poverty.

Mothers Occupation: Women who are working and earning money will be able to save and decide to spend it on facility delivery. However, in many settings women either do not earn money for their work or do not control what they earn. An increased range of movement and better access to information are suggested as reasons why formal work may promote womenôs use of health facilities for childbirth. On the other hand, working may be poverty induced and indicate resource constraints, which would make working women less likely to use health services for delivery. According to Chakraborty et al (2003) womenôs involvement in gainful employment is one of the important factors positively affecting the use of quality medical care to treat complications. This also empowered women to take part in decision making processes about health care in the family

Husband's occupation: Wives of husbands with higher status occupation could be more able to use facilities for delivery. High status occupations are associated with greater wealth, making it easier for the family to pay costs associated with skilled delivery care. Certain professions include health insurance benefits making care seeking less costly. Women whose husbands worked in business or services were most likely to be users of modern health care services to treat complications during pregnancy (Chakraborty et al., 2003)

Ability to pay: The cost of care seeking may include costs of transportation, medication and supplies, official and unofficial provider fees as well as the opportunity cost of travel time and waiting time lost from productive activities (although women in the late stages of labor are unlikely to do any production other than reproduction) where women do not travel alone, accompanying adults or children for whom no caretaker can be found increase opportunity costs, transportation costs and costs for staying over might in the town where the health facility is located. Wading et al (2009) asserts that empirical evidence has revealed that negative impact of commercialization of public health services delivery on attainment of Millenium Development Goals in Nigeria. Households on a tight budget will have great difficulties to pay their costs and therefore be less likely to use a health facility for delivery. Another reason for greater use of services is that households with higher living standard are more modern and therefore more receptive towards modern health care services on a larger scale Communities with less economic development are likely to be more traditional, give women less autonomy and have less positive attitudes towards services use. An alternative mechanism how economic status affects care seeking is that the characteristics of the health facilities serving the poor may discourage use. This may stem from inferior quality of care or

worse availability of services in poor areas thus requiring users to travel long distances. Cost and distance (from health facility) often go hand in hand as longer distances entail higher transportation costs (Thaddues and Maine 1994 in Gabrysh and Campbell 2009).

(4) Physical accessibility.

Region and place of residence: Since service and social environment are typically very different in urban and rural areas; strong urban-rural differences in use of delivery care are expected. Similar reason applies to differences between regions within a country and it can be difficult to know which factor to ascribe any differences in service use to. Place of residence may be associated with education and ability to pay.

Distance and transport: Distance to health services exerts a dual influence on use as a disincentive to seeking care in the first place and as an actual obstacle to reaching care after a decision has been made to seek it. Many pregnant women do not even attempt to reach a facility for delivery since walking many kilometers is difficult in labor and impossible if labour starts at night and transport means are unavailable. Those trying to reach a far off facility often fail and women with serious complications may die en route. (Thaddeus & Maine 2006 in Gabrysh & Campbell 2009).

Babalola &Fatusi(2009) observed that poor staffing in the health facilities particularly the primary health facilities which makes it difficult to guarantee 24hour availability of services had also been reported as a factor that discourage women in Nigeria even when they have received ANC to seek medical services when labour commence The roles of traditional and religious beliefs as well as the perception of women with regards to comparative efficacy of the medical versus traditional birth attendants may also be contributing to failure to have skilled attendants at birth .Modern (medical) and indigenous maternal health care services coexist in most African countries particularly in rural areas and women may have to choose between the two options He stated that many Nigerian women particularly those in rural areas rate the services of TBAs as being of higher quality than that of medical healthcare practitioners particularly with regards to interpersonal communications and relationship. TBAs have been reported to be more considerate and to provide more compassionate care. Mrisho, M., Schellenberg, A.J, Mushi, K.A. Obrist B., Mshi NDA, H., Tanner, M,. and Schellenberg, D,. (2007) observed that another important factor that influences quality of healthcare services is accessibility to health centre. The standard is that

every pregnant woman should have access to a health facility within less than 5km. Lack of transportation has been identified as one major contributor to many home deliveries in rural areas

Review of Related Theories

Around the world, there is significant unmet need for health care. With a better understanding of why people use or do not use these services, health care organizations can seek to improve the quality of human life by bridging the detected gaps to enhance utilization.:

Anderson's Model Of Health Services Utilization.

Andersonôs model of health services utilization was reviewed and used for this study. Anderson (1968) developed a model of healthcare utilization which looks at three categories of determinants:

1. **Predisposing characteristics**: These categories represent the proclivity to utilize health care services. According to Anderson, an individual is more or less likely to use health services based on demographics, position within the social structure and belief of health services benefit. An individual, who believes health services are useful for treatment, will likely utilize those services.
2. **Enabling characteristics**: These include resources found within the family and the community. Family resources comprise economic status and the location of residence. Community resources incorporate access to health care facilities and the availability of person for assistance.
3. **Need based characteristics**: These include the perception of need for health services, whether individual, social or clinically evaluated perception of need (Wolinsky 1988)

In the 1970ôs Andersonôs model was later expanded and refined to include the health care system. The health care system includes health policy, resources and organization as well as the changes in these over time. Resources comprise the volume and distribution of both labour and capital including education of health care personnel and available equipment. Organization refers to how a health care system manages its resources which ultimately influences access to and structure of health services. According to this level of revised model,

how an organization distributes its resources and whether or not the organization has adequate labour volume will determine if an individual uses their health services. In addition, the updated model includes recognition that consumer satisfaction reflects health care use. The model also includes the notion that there are several health services available, and both the types of service available (i.e. a hospital, dentist, laboratory or pharmacy) and the purpose of the health care service (i.e. primary or secondary) will determine the type of service utilized. Thus according to the revised model, whether or not a specific healthcare service is utilized and the frequency a service is utilized will have different determinants based on characteristics of the population and the health services (Anderson 1995, Anderson and Newman 2005 in Rehban 2008).

During the 1980ôs and 1990ôs Andersonôs model was again revised to form three components with a linear relationship;

1. Primary determinants
2. Health behaviors
3. Health outcomes

Primary determinants: are noted as the direct cause of health behavior. These determinants include characteristics of the population (Demographics) Health care system (resources and organization), external environment (political physical and economic influence on utilization).

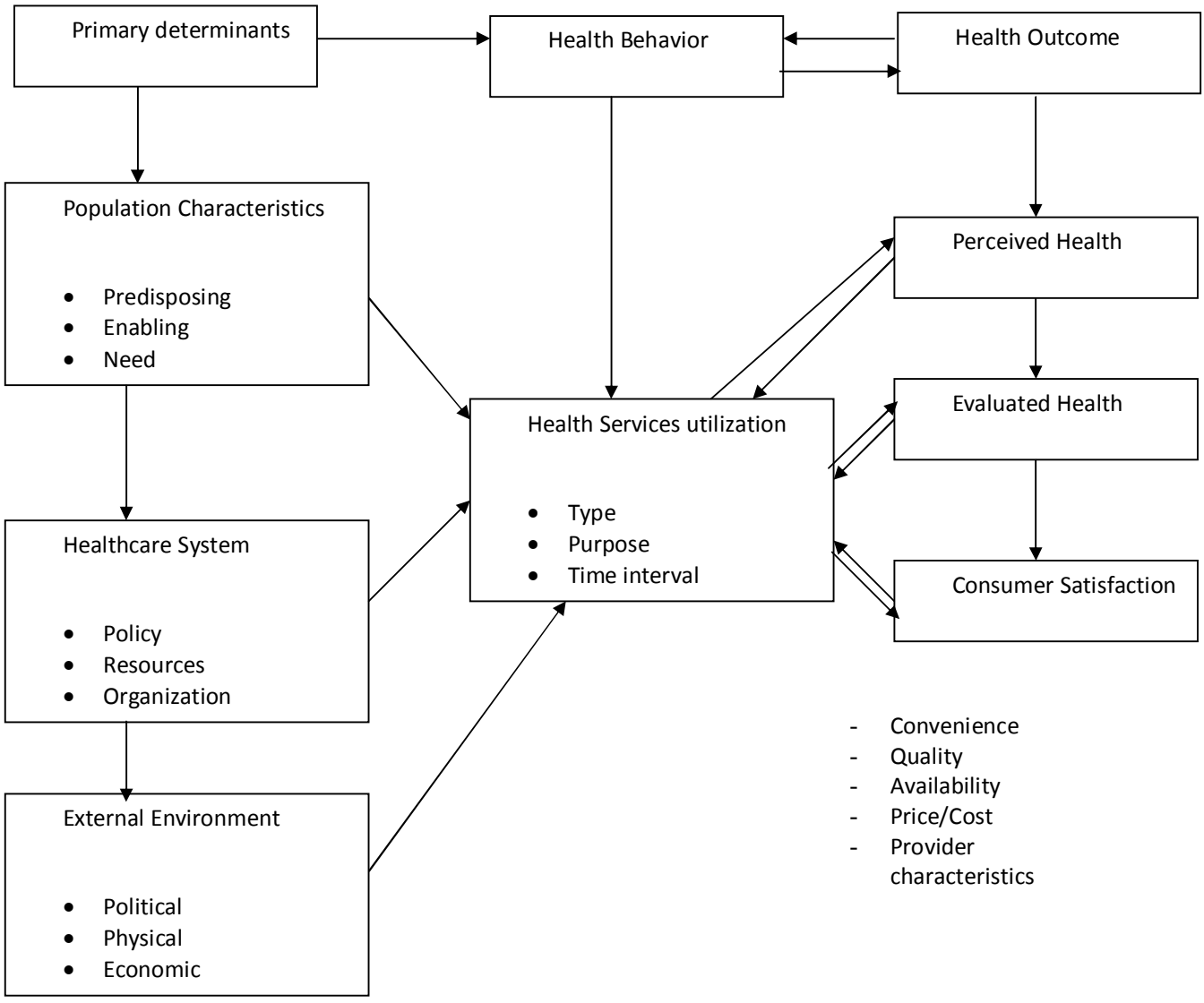
Health behaviour

The model explains that health behaviors are the direct cause of health outcomes

Health behaviours include; personal health characteristics, use of health services

Health outcomes includes: perceived health status, evaluated health status, and consumer satisfaction (Anderson **1995).**

Consumer satisfaction: include convenience of using the services, quality of the services provided, availability of the needed service, price or cost of the service, provider characteristics attitude, skills, proficiency etc. this will lead to the use of both preventive and emergency services.



Phase 3: Anderson's model of health services utilization. (Anderson 2005)

Relating the theoretical framework to this work:

Primary determinants:

Population characteristics: which include?

Predisposing characteristics example- age,

Age is often presented as a proxy. Older women may be told to deliver in the health facility since older age is a biological risk factor. Older women are also more influential in household decision making than younger women and adolescents in particular making them to have power of deciding where to deliver On the other hand, older women may belong to more traditional cohorts and thus be less likely to use modern health facilities than younger women. Young women on the other hand might have enhanced knowledge of modern

healthcare services because of their schooling. This will make them place more value on modern health services and use it. Young women may be unmarried and lack social support and this may make them unable and unwilling to use maternal health services.

Enabling characteristics eg : Income

Income can affect the type of health care provider to be utilized by an individual or family. Income determines the ability of an individual to pay. If the income is low one may decide to use traditional birth attendants, be assisted by family members or even deliver unassisted instead of going to a health facility just because of lack of funds. On the other hand one may prefer to use health care services with highly skilled personnel no matter how costly it may be if the fund is available.

Need Characteristics: If one perceives labour and delivery as a serious problem, need for advanced care arises, she will look for a skilled health care provider. Also if a mother develops an illness or is diagnosed of any abnormality during pregnancy a need arises and it might make her choose to use a skilled healthcare provider based in a functional health facility during delivery. If the mother does not have any problem nor perceive labour as a serious problem she will not see need to use a skilled health care provider.

Health system

Under health system we have policy, resources and organization.

Policy: The type of policy run by a health system will determine whether it should be used or not. If the policy is favourable the populace will like to use it, if not nobody will choose it.

Resources: The resources available in a particular health system eg human resources. Qualified doctors, nurses, midwives etc. available equipments, facilities for blood transfusion , incubators tests etc. will determine whether one will choose it or not. Volume and distribution of labour in an organization also is a determinant

Organisation: The organization of health services eg 24hours service. How resources are managed and the structure of health services also will determine whether one will choose this health system for delivery or not.

Health services This includes type, purpose and time interval. The type of health services rendered by a healthcare provider or health system e.g ANC, post natal services, family planning, paediatric services, immunization, pharmacy, etc will make one choose or not to choose it.

Purpose: purpose include whether it is preventive or curative, primary or secondary health facility. This will make one to choose it or not depending on the need

Time interval: These include how often these services are rendered whether it is regularly available or not. If it is not always available at those intervals it will discourage clients from coming even when it is available.

External environment

Under external environment, we have political, physical and economic health. Political can be situation of health facilities eg some health services suffer non utilization due to political situation. It will not be available for the community if it is situated on problem land or because of lack of political will, it will not be equipped or the road to it will not be graded or tarred, this will bring about non utilization of the facility and the skilled care provider in it

Physical: This has to do with distance; if healthcare facility is far, it will involve paying transport. Some women with serious complications may die on the way thus discouraging clients. Very sick clients with emergency situations will not use it because there may be delay and death; also poor clients are discouraged because of lack of transport.

All the above primary determinants lead to health behavior. (Use of health services)

Health Behaviour

Health behavior here includes choice and use of health services.

The primary determinants will determine whether one will use healthcare services or not, the type of healthcare provider to choose during delivery, and purpose of choosing such healthcare provider. Choice and use of healthcare services leads to health outcome

Health Outcome

Use of health services determine health outcome. Under health outcome are

- Perceived health status
- Evaluated health status
- Consumer satisfaction.

Perceived health status- If a client use health services, she will be able to evaluate self from past experiences or from knowledge gained through health education given at the health facilities. This will make client to use health services promptly to avoid complications e.g a mother who attends ANC will be educated on danger signs of pregnancy and this will make her seek help early enough to avoid further complications and death whenever she sees the sign of complication; because she will perceive the complication as a danger to her health and that of her baby.

Evaluated health status: When one uses health services she will be able to benefit from evaluation of her health status by health care providers and be advised properly on what to do and the best place for her delivery. If any complication is detected, she will be informed earlier to enable her choose the appropriate healthcare provider during delivery.

Consumer satisfaction: Consumer satisfaction is very important for choice of health care provider. It is measured by such factors as

- Providerôs characteristics which include: whether providers are polite, well trained, proficient etc.
- convenience of using the health care services,-
- quality of care given by the provider,
- Time spent in the process of getting care from the provider etc.

When all of the above are met for any client, the client will choose the health care provider again and also recommend it to others; while if the consumer is not satisfied with the services of a particular healthcare provider, she will not choose the healthcare provider again and will not recommend it to anybody. The client will even discourage others from utilizing the services. In fact consumer satisfaction is a very important factor in health service utilization. Health outcome determine whether a client will choose a particular healthcare provider again or not. Health outcome determines health behavior, (choice of healthcare provider and use of health services) and health behavior determines health outcome.(wellness, early intervention in cases of complications, maternal wellbeing and reduction in maternal and infant mortality)

Empirical Review

Gabrysh & Campbell (2009) in their review of determinants of delivery service use, searched electronic databases to identify reviewed articles on determinants of delivery services use. They used already written articles from researchers to ascertain relevant studies on determinants of delivery service use. They identified twenty determinants and grouped these determinants into four themes

1. Socio-cultural
2. Perceived benefits/needs of skilled attendance
3. Economic accessibility
4. Physical accessibility

Using the review articles and over 80 original articles, they described the findings in more detail and from the result of their review, there is ample evidence that higher maternal age, education, household wealth, lower parity and urban residence increase use. Facility use in the previous delivery and antenatal care use are highly predictive of high facility use for the index delivery, though this may be due to confounding by service availability and other factors.

Obstetric complications also increase use. Quality care is judged to be essential in qualitative studies but is not easily measured in surveys. In their review, distance to health facility decrease use. From their study, they observed that studies of determinants of skilled attendance concentrate on socio cultural and economic accessibility variables and neglect variables of perceived benefit/need and physical accessibility. They finally concluded that it is important to consider as many influential factors as possible in any analysis of delivery service use.

In a study on determinants of use of maternal health services in Bangladesh, Chakraborty et al (2003) used random sampling to select 993 pregnant women out of 1020 who had one antenatal follow up , they attempted to examine the factors associated with the use of maternal health care services on the basis of data from the survey of maternal morbidity in Bangladesh conducted by Bangladesh Institute of Research for promotion of essential and reproductive health and technology. The results from both the bivariate and multivariate analysis confirmed the importance of mothersô education in explaining the utilization of healthcare service. They found out that independent of other womenôs background characteristics, household socioeconomic status and access to health care services, female education retain a net effect on maternal health service use.

In another study by Singh Rai, Alagarajan and Singh (2011) on services utilization among married adolescents in rural India, they used data from National family health survey (2005 ï 2006) available in public domain for use by researchers to examine the factors associated with the utilization of maternal healthcare among married adolescents women (aged 15 ï 19yrs) in rural India to measure their components of maternal health services utilization: full antenatal care, safe delivery and postnatal care within 42 days of delivery in the last five years preceding the survey. Findings of their analysis indicate significant difference in selected maternal healthcare utilization by educational attainment, economic status and

region of residence. It was also found out that Muslim women and women who belonged to scheduled castes, and other backward classes are less likely to avail safe delivery services. Also adolescent women from southern region utilize the highest maternal healthcare services than other regions showing regional differences. Thus they concluded that socio economic and cultural factors affect the utilization of maternal health services among rural adolescent women in India. Based on this they recommended that healthcare programs should start targeting households with married adolescent women belonging to poor and specific sub-groups of the population in rural areas to address the needs for maternal care services use.

Aremu, Lawoko and Dahlal (2011) in the study of neighborhood socio-economic disadvantage, individual wealth status and pattern of delivery care utilization in Nigeria, used a population-based multi level discrete choice analysis. This was performed using the most recent population based Nigerian demographic and Health survey data of women aged 15 and 29years .The analysis was restricted to 15,162 ever married women from 888 communities across the 36 states of the federation including the Federal Capital Territory Abuja. Result showed that the choice of place of delivery vary across the socio-economic strata. The multi level discrete choice models used indicates that with every other factor controlled for the household wealth status, womenôs occupation, womenôs and partnerôs high level of education attainment and possession of health insurance were associated with the use of private and government health facilities for childbirth relative to home birth. The results also show that higher birth order and young maternal age were associated with use of home delivery compared to the patronage of government health facilities

Adelaja (2011) studied home delivery and newborn care practices among women in a suburban area of western Nigeria. He carried out a cross sectional survey in the immunization clinic of Shagamu local government. A total of 300 mothers were interviewed using a semi structured questionnaire. Findings showed that, 66.7% of births occur at home were planned while. 33.3% were unplanned. Only 13.4% of deliveries had a skilled birth attendant present and (15.7%) gave birth alone.

A compiled data from national surveys from all continents done by Shanton et al(2006) showed that in all continents low parity women were more likely to seek skilled birth attendance. High birth order was found to be a predisposing factor of home delivery by Thind in India. Gabrysh and Campbell (2009) in their review of the determinants of delivery

service, searched PubMed and Ovid data base for review and ascertained relevant articles from these and other sources. . They found out 20 determinants of the use of health facility delivery or skilled attendant. Factors most consistently associated with receiving skilled care in their multivariate analysis are higher maternal age, low parity, maternal education, and higher household economic resources. According to their review, facility use for previous delivery and ANC use are also nearly always highly predictive of health facility use for the index delivery.

Wegle, Sabroe and Nielson (2004) in their study of socio-economic and physical distance to the maternity hospital as predictors for place of delivery in Nepal used a cross-sectional design to carry out a study between January 2001 and June 2002 in rural parts of Kathmandu and Dhading Districts of Nepal. They interviewed 308 women who delivered within 45days of date of the interview. With a pretested structured questionnaire. Findings showed that a distance of more than one hour to the maternity hospital, low amenity score status, low education, multi-parity and not seeking antenatal care in the present pregnancy were statistically significantly associated with an increased risk of home delivery. Ethnicity, obstetric history, age of mother, ritual observances of menarche, type and size of family and who is head of household were not statistically significantly associated with the place of delivery.

Babalola & Fatusi (2009) in the study of determinants of maternal health services utilization in Nigeria with a focus on household, community and state level factors. An interviewer administered nationally representative survey were analyzed to identify individual, household and community factors that were significantly associated with utilization of maternal care services among 2 148 women who had a baby during the five years preceding the survey. (2005) national HIV/AIDS survey. They analyzed an interviewer administered. Findings showed that approximately three fifths (60.3%) of the mothers in their study used antenatal services at least once during their most recent pregnancy while 43.5% had skilled attendants at delivery and 41.2% received postnatal care. It was also found out that education is the only individual level variable that is consistently a significant predictor of service utilization, while socio-economic level is a consistent significant predictor at the household level. At the community level urban residence and community media saturation are consistently strong predictors.

Selejeskog, Sundby and Chimango (2006)carried an explorative study in the Magochi area of Malawi on factors influencing womenôs choice of place of delivery with the aim of investigating individual, community and health facility factors influencing womenôs choice of place of delivery. In dept interviews and non-participating observation were the method s used. Findings showed that factors fall into three major categories : firstly, sub-optimal quality of care including communication, attitude and cooperation within the healthcare system was identified as a main factor. Secondly, cultural factors such as influence from decision makers, perceptions of danger signs and traditional views on pregnancy and delivery. Finally an unsatisfactory availability of skilled delivery care in terms of distance, transport and cost were also implicated.

Amankwa (2010) studied the determinants of skilled birth attendants in Bolgatanga Ghana. In assessing the determinants of skilled birth attendance, a descriptive cross-sectional survey was used over the period from July to October, 2008. The study involved interviews to a random sample of women (aged 15 to 49 years) who had given birth not more than a year prior to the survey. The survey instruments were pre-tested in two communities. The data collection tools included structured questionnaire (with open and closed ended questions), focus group discussion guide, and in-depth interview schedule. The study populations were women (aged 15 to 49 years) who had given birth within one year prior to the survey, their in-laws and husbands, and the traditional birth attendants (TBAs) in the study area. The following determinants were found to be significantly associated with delivery at health facility; the number of ANC visits, level of education. Religion. Distance to reproductive health facility, Duration of first ANC visit and level of awareness of pregnancy and labour danger signs. The findings also showed that parity is significantly associated with delivery at health facility

(Mahfuzar Shahidur &Syeda 2008) Onah et al (2006) also found in Enugu South eastern Nigeria, that there was statistically significant association between choice of institutional or non institutional deliveries among pregnant women and parity. They found out that primiparous women are more likely to use health services for delivery than multiparous women. Shanton et al in a study using data from several developing countries found out that women with higher parity were more likely to receive assistance from unskilled birth attendants. .

Yanagisawa (2005) on study of determinants of birth attendantôs choice of women in rural areas of Cambodia performed a population based survey on skilled attendant choice. By women in rural Cambodia to identify determinants of birth attendant choice, with contact with birth attendant as an exposure factor. Subjects were women aged 15-49years who had delivered babies during three months prior to the survey. Of the 980 included in the analysis, 19.8% had skilled attendants present at the birth. The determinants of facility delivery choice were different from skilled attendantôs choice in home birth and contact with birth attendants worked differently on the choices. For facility delivery choice, contact with skilled attendant through antenatal care was a significant determinant. For home births, the choice of skilled and unskilled attendants at the preceding delivery was a significant determinant. For community based programs, women who once chose unskilled attendants were five to seven times less likely to choose skilled attendants in the following delivery than primiparas.

In another study on womenôs preference for place of delivery in rural Tanzania by Kruk et al (2009), they fielded a population-based discrete choice experiment (DCE) in rural Western Tanzania, where only one third of women deliver children in a health facility, to evaluate health-system factors that influence women's delivery decisions. Women were shown choice cards that described 2 hypothetical health centres by means of 6 attributes (distance, cost, type of provider, attitude of provider, drugs and equipment, free transport). The women were then asked to indicate which of the 2 facilities they would prefer to use for a future delivery. They used a hierarchical Bayes procedure to estimate individual and mean utility parameters. A total of 1203 women completed the DCE. The model showed good predictive validity for actual facility choice. They found out cost and distance having a negative effect on over all utility. The most important positive facility attributes were a respectful provider attitude and availability of drugs and medical equipment.

Iyaniwura and Yussuf (2009) on their study on utilization of antenatal care and delivery services in Shagamu south western Nigeria found out that majority of the women received antenatal care (84.6%) during their last pregnancy, four fifth of those who received ANC first attended the clinic during the second trimester (79.6%). The places of delivery were government facilities (54.8%) private hospital (24.5%) traditional birth attendants (13%) spiritual healing homes 5.6%. Higher educational status and higher level of income positively affected the pattern of use of these services. Perceived quality of service influenced the choice of facility or obstetric care. According to Iyaniwure and Yusuf (2009), the increased

proportion of the deliveries at TBA homes may also be associated with the prevalent supernatural concept of disease in many African communities. Twenty nine percent (29%) of ANC attendees in Equatorial Guinea expressed that TBAs were better than orthodox practitioners in some respects because TBAs possess spiritual powers and can intervene in certain situations where medical interventions cannot help.

Ogunleshi (2004) in his study of the pattern of utilization of prenatal and delivery services in Ilesha Nigeria, found that out of the 260 women studied churches were most commonly patronized for prenatal care (98.3%) and delivery (92.35.4%) mostly for religious and financial reasons A considerable proportion of those who used traditional brth attendants (36.1%) used it to please their husbands A study carried out by é

Itina in(1997) conducted a study on a group of 52 TBAs in Offot clan in the South eastern Nigeria to help develop effective programmes for TBAs in the safe delivery and early referral of women with complications to hospitals; findings showed that the majority of TBAs were illiterates and had no previous experience or training, even informal training, when they took on the TBA role. Ignorance about maternal complications during childbirth and the appropriate treatment was evidence for most of the groups. A small number of the group relied solely on divine revelation for guidance in the management of childbearing women. In this study, TBAs reported that they managed problems in pregnancy primarily with fasting, prayers, herbal medicine, or enema. They were generally uninformed about the causes of/and management of antepartum and postpartum heamorrhages ï a major cause of maternal mortality.

Zelek and Orantia (2007) in their study on factors affecting where women chose to give birth in Marathon-Canada revealed that the most important factor is being close to home, being where it was easy for a partner to be present, and being where it was easy for a coach to be present. The least important were availability of epidural analgesia, care in a place that did a high number of deliveries and cost.

Idris and Gwarzo (2003) carried out a study on determination of place of delivery among women in semi-urban settlement in Zaria, Northern Nigeria used pretested interviewer questionnaire to interview and collect data from 496 women who had delivered at least once. Findings showed that there is high rate of home deliveries and deliveries not supervised by skilled attendants of 70% and 75% respectively, mothers educational level, husbands

occupation and age at the first pregnancy were the main determinants of place of delivery service use. Amoti ï Kaguna & Nuwaha (2000) in their study on factors that influence choice of delivery sites in Rakai implicated access to maternity services, social influence from spouse and other relatives, TBAs and health workers efficacy habit (from previous experience) and the concept of normal versus abnormal delivery (pre-existing condition), attitude, belief towards various delivery sites; and also that attendance to ANC may discourage delivery in health units if the mothers are told that the pregnancy is normal.

Anyait et al (2012) found in their study of predictors for health facility delivery in Busia district Uganda that out of 500 women interviewed 227 (45.4%) delivered in health facility while 288(58%) of the 227 who delivered at health facility 159(70%) delivered in public health facility and 68(20%) in private health facility. Of the 273 that delivered outside the health facility, 249(91.2%) were at the respondents home 20(7.3%) at the home of TBA and 4(1.5%) on the way to the facility.

In a study on reasons for preference of delivery in spiritual church based clinics by women of South South Nigeria, Udoma , Ekanam, Abastattai and Bassey studied 263 pregnant women who were regular attendants of 47 spiritual church based clinics in South South Nigeria. The study was carried out between 1st February 2003 and 31st July2003. Reasons given by the women include: protection against satanic attacks and safe delivery (36.8%) lack of funds (30.5%) harsh attitude of healthcare workers (12.1%) convenience (10.3) faith in God and previous delivery in church(4.0%), help and good care (2.35%).

Azuh Dominic (2013) conducted a study on Socio demographic factors influencing Health Programs usage by pregnant mothers in Nigeria.

The study covers five (5) rural wards of Ado-Odo/Ota Local Government Area in Ogun State, Nigeria. The study used face-to-face structured interview and focus group discussion (FGD) In-depth interviews were held with specific stakeholders in the community, some officials of the five primary health care u nits in the wards selected and staff of the only general hospital residing in the Local Government of the study area. A stratified sampling technique was adopted in selecting the respondents who were ever married women in child bearing age (15-49) years who had at least one live-birth in the last two years preceding the survey. On the whole, 260 female respondents were randomly selected from five wards out of the sixteen wards in the local government area. They were interviewed through a face-to-

face approach and focus group discussion with a two-level analytical approach capturing both the qualitative data and information from the discussion segment.

The result show that the educational attainment of the respondents is very
poor with slightly above half of the population having only secondary education (55.5%). Respondents with no schooling, those having primary level account for 22.7 and 18.2 per cent respectively. Nevertheless, a negligible number of the respondents had attained above secondary level education (3.6 %).

Distance to the health facility is also a major retarding factor in accessing health services among the five wards in the study area. While 68% of the respondents have health facility within two kilometres distance from their homes, a reasonable proportion (32%) of these respondents has to walk beyond three kilometres distance to access health services. (73%) of the respondents stated that it is their husbands who decide when and where to go for treatment and equally pay for the treatment costs. On awareness of place of antenatal care (ANC), overwhelming proportion of the respondents admitted knowledge of place of ANC treatment (93%). However, the common reasons hindering attendance or registration for antenatal care is high cost of ANC service. Only one-tenth (10.5%) of the respondents agreed that what they spend at health centres is convenient (cheap) for them. However, 51.8 per cent and 37.7 per cent stated moderate and expensive charges respectively. Cost may reduce womenôs use of maternal health services from having hospital ï based deliveries or seeking care even when complications arise. Information gathered through in-depth interview revealed that even when formal fees are low, other informal costs such as buying complete delivery items, drugs, food, etc pose barrier to utilisation of available health services. The assistants during pregnancy and child birth were identified to be nurses/midwives (56.8%), doctors (20%); and traditional birth attendants (17.7%) and relatives (5.5%).

Olufunke and Akinlujoye (2012) on why mothers prefer TBAs include that TBAs have adequate knowledge and skills, to care for them, their services are cheaper. more culturally acceptable in many environments, closer to their houses than hospital, they provide more compassionate care than orthordox workers and some said it is the only maternity service they know.

Summary of Literature Review

Literature on choice of birth place and birth attendants during delivery. was reviewed under the following: Conceptual review which showed different concepts of birth attendants . Empirical review showed other peopleôs work on this topic. Theories related to the topic were also reviewed. Andersonôs model of health service utilization of 1968, 70ôs and 1995 were all reviewed .The theoretical review for this study was taken from Andersonôs model of health care utilization of 1995 (phase 3) which used primary determinants, Health behavior and health outcome to further show inter relatedness between demographic factors, enabling factors, need factors, healthcare system, health behavior (use of health services), and health outcome . From the literature reviewed, mothers level of education, previous use of health facility, attitude of healthcare provider, motherôs age and distance to health facility are all factors that influenced the choice of birth place and use of birth attendants during delivery. The review of literature further showed that no known study has been carried out on choice of birth place and use of birth attendants during delivery and factors that influence the choices in the area of study and Abia state as a whole. Hence this study intends to bridge the gap.

CHAPTER THREE
METHODOLOGY

Introduction

This chapter is discussed under the following: study design, setting/area of study, target population, sample, sampling procedure, instrument for data collection, validity of instrument, reliability of instrument, ethical consideration, procedure for data collection and method of data analysis.

Research Design

The study adopted a cross-sectional descriptive design. This design is concerned with the present and tells how people feel or react to phenomenon under investigation. The purpose of the design is to provide a picture of a situation as it naturally occurs. Cross-sectional descriptive design is considered appropriate for this study because it takes place at a single point in time and allows the researcher to look at numerous things at once (age , income, education, parity, autonomy etc) as they naturally affect the study population .

Area of study

The area of study was Akanu community in Ohafia L.G.A of Abia State.

Akanu is one of the villages in Ohafia. It is an Igbo speaking community. Akanu is the largest village in Ohafia; the population of which was estimated by Philip Nsugbe (1974.) in the mid sixties to be around 12,000. Akanu Ohafia is the largest single community in terms of population and land mass in the eastern part of Nigeria (Tochi Okereke Akanu Ohafia .com E-Zine 2014).

Akanu is bounded in the North by Abia community, East by Ndi Uduma Awoke, South by Ebem community and West by Asaga. Akanu community has people of all professions ï teachers, nurses, doctors, lawyers etc. They also have artisans and farmers. They are mainly Christians. They have primary and secondary schools both governments owned and private. In their health centers, they have both Nurses/midwives and chews as healthcare providers to women during delivery. Akanu is made up of four sub-communities **Ekelogo, Amafor, Ndiodo, and** Utughaokoko. These four communities are made up of 26 compounds. Each compound is made up of about 20 households bringing the total households to about 520.

Target population

The population for this study were women of childbearing age (15 ï 49yrs) in Akanu community; 313 number of women who gave birth between Jan-Dec 2012 were used for the study. (Source: BCG immunization registers of Ania & Akanu Ukwu health centers) for Jan. to Dec. 2012.

Sample

No sampling was carried out. Entire populations recorded were all used for the study.

Inclusion criteria:

1. Women of childbearing age who delivered between January and December 2012 in the four sub communities of Akanu.
2. Willingness to participate.
3. Availability

Instrument for data collection

The instrument for data collection was a researcher developed questionnaire generated from reviewed literature. The questions were formulated according to the research objectives stated. It has two sections and contained 24 items.

Section A Is concerned with the respondentsô demographic data.

Section B contained items designed to elicit responses on choice of birth place and use of birth attendants during delivery among child bearing women in Akanu, Ohafia. The questionnaire was made up of closed and open ended items. The closed ended questions contained options to choose. While the open ended questions gave room for the respondents to write in their opinion on topic.

Validity of Instrument

The questionnaire was submitted to the researcherôs supervisor and two other senior lecturers in the department of nursing sciences for face validity. The items were scrutinized and modifications were made where possible. All the inputs were used to effect corrections in the final copy of the questionnaire which was presented to the supervisor for signing before use.

Reliability of Instrument:

The questionnaire was used for pilot study in a smaller but similar population to test for clarity and reliability. 20 copies of the questionnaire were administered to 20 women in another community which was similar to the sample studied. Split half method was used and Pearsonôs Product moment correlation statistics was applied and a correlation coefficient of 0.89 was obtained which was considered appropriate for use in the study.

Ethical Consideration

Written administrative permission was obtained from the community leader of Akanu Ukwu Autonomous community after explaining the purpose of the study to him. Summary of the research proposal was also submitted to the ethical review Board of Federal Medical centre Umuahia and approval was given for the data collection, permission was also obtained from the women leader. The purpose of the study was explained to her. Respondentsô consent was also obtained and the need for the study explained to them to gain their co-operation, confidentiality and anonymity of information was guaranteed. Respondents were not forced to participate in the study and were not prevented from backing out if they wanted.

Procedure for data collection

Written administrative permission to carry out the study had already been obtained from the traditional ruler of Akanu Ukwu Autonomous community. Permission was also obtained from the women leader. The town crier was paid to disseminate the information to all the members of the community which he did. The researcher and research assistants went from house to house in each sub community collecting data from all available mothers who met the inclusion criteria. Data were collected in the morning and evening hours between 9am-12noon and 3pm-6pm respectively till the number for that sub-community was reached. Data collection lasted for five weeks.

Method of data analysis:

Data analysis was done with the statistical Package for Social Sciences (SPSS) version 17.0. Data were analyzed using descriptive statistics namely frequencies and percentages for objectives 1 ï 4. Inferential statistics involving chi-square, fisher's exact-test and correlational coefficient was used to test the two hypotheses stated for the study

CHAPTER FOUR
PRESENTATION OF RESULTS

This chapter presents the results of the data analysis on choice of birth place and use of birth attendants among childbearing women in Akanu community and reasons for their choice. Three hundred and thirteen (313) questionnaires were distributed to the respondents; all of the questionnaires were filled correctly and returned giving the return rate of (100%). This is because questionnaires were administered in an interview format

Socio- demographic characteristics of the respondents

Table 1 showing the socio-demographic profile of the respondents

N = **313**

Variables	Frequency	Percentage
Age range		
< 20 years	49	15.7%
20 -29 years	128	40.9%
30 -39 years	90	28.8%
40 ï 49 years	46	14.7%
Mean age X –	**28.7**	
SD	**4.49years**	
Marital status		
Single	81	25.9%
Married	232	74.1%
Religion		
Christianity	311	99.4%
African Traditional Religion	2	0.6%
Respondent's Level of education		
No formal education	4	1.3%
Primary	51	16.3%
Secondary	249	79.6%
Tertiary. Education	9	2.9%
Husband's level of education		
No formal education	81	25 9%
Primary education	26	8.3%
Secondary education	195	62.3%
Tertiary education	11	3.5%
Respondent's occupation		
Trading	89	28.4%
Farming	69	22.0%
Seamstress	26	8.3%
Government worker	14	4.5%
Jobless	83	26.5%
Others	32	10.2%
Parity		
Primiparous	101	32.3%
Multiparous	212	67.7%
Place of ANC		
Hospital /Health centre	276	88.2%
TBA'S place	19	6 1%
Church/ spiritual home	6	1.9%
Home	1	0.3%
No ANC received	11	3.5%
Who decided on place of ANC		
Self	143	45.7%
Husband	101	32.3%
Mother	52	16.6%
Others	10	3.2%
No response	7	2.2%
Decision maker on place of delivery		
Self	138	44.%
Husband	87	27.8%
Mother	39	23.0%
Mother in-law	3	1.9%
Sister	2	1.0%
Pastor	1	0.6%
Brother	5	1.6%

Table 1 shows the demographic characteristics of the respondents. Out of the 313 respondents involved in this study, 49 (15.7%) of them were less than 20years, 128 (40.9%) were 20-29years, 90 (28.8%) were 30-39years, while 46 (14.7%) of them were 40-49years. Their marital status showed that 81 (25.9%) of the respondents were single, while 232 (74.1%) of them were married. Their ethnicity showed that 304 (97.1%) of the respondents were Ibos, while 9 (2.9%) were from other ethnic groups. Religion showed that 311 (99.4%) were Christians while 2(0.6) were of African traditional religion. The respondentsô level of education showed that 4 (1.3%) had no formal education, 51 (16.3%) had primary education, 249 (79.6%) had secondary education, while 9 (2.9%) of them had tertiary education. The respondents husbandsô highest level of education showed that 81 (25.9%) had no formal education, 26 (8.3%) had primary education, 195 (62.3%) had secondary education, while 11 (3.5%) had tertiary education. As regards respondentsô occupation, Table 1 showed that 89 (28.4%) of them were traders, 69 (22.0%) were farmers, 26 (8.3%) were seamstress, 14 (4.5%) were government workers, 83 (26.5%) were jobless, while 32 (10.2%) of them belong to other occupational groups such as-apprentice, caterers, hair dressers, interior decoration, teaching, school leavers, students, housewife. The parity of the respondents showed that 101(32.3%) were primiparous, while 212 (67.7%) were multiparous.

As regards where respondents received ANC, the result showed that more than three quarters 276 (88.2%) of the respondents received their ANC in their last pregnancy at the hospital/ health centre A few 19(6.1%) received ANC at TBAôs place while 6(1.9%) a small proportion received at the church/spiritual homes. Only 1 person 1(0.3%) received from home. Six 11 (3.5%) received no ANC at all. On who decided where the respondents went for ANC, Majority 143 (45.7%) said they decided where to receive ANC by themselves, 101(32.3%) said that their spouses took the decision on where they received ANC in their last pregnancy while 52(16.6%) indicated that their mother decided for them where they received ANC. Others indicated in this decision making were aunty 2(0.6%)ô brother 2(0.6%). .Father of my child 4(1.3) and a relative 2(0.6) The result on the final decision on where the respondents delivered the last baby showed that, 138(44.1%) said they made the decision by themselves while 87(27.8%) said it was their husbandôs decision, 72(23.0%) said it was their mother, while 6 (1.9%) said the decision was made by their mother in-law . Other people implicated were sister 3(1.0%), pastor 2(0.6%), Aunty 3(1.0%) and brother 2(0.6%)

Objective One: To determine respondent's choice of birthplace.

Table 2: Where the respondents had their last baby.

N= 313

Place of delivery	Frequency	Percentage
Hospital/health centre	211	67.6%
TBAôS place	43	13.7%
Church/spiritual home	32	10.2%
Home	27	8.6%
Total	313	100%

From the result on Table 2 above, more than half of the respondents 211 (65.6%) had their last baby delivered at the hospital/health centre, 43 (13.7%) had their last baby delivered at TBAôs place, 32 (10.2%) delivered at the church/spiritual home and 27 (8.6%) delivered at home.

Objective Two

To elicit reasons for womenôs choice of birth place.

Table 3: Responses on reasons for womenôs choice of birth places.

Reasons	**Hospital/ Healthcentre n=221**	**TBA's Place n=43**	**Church/Spiritual home n= 32**	**Home n=27**
They are always available	189(85.5%)	41(95.8%)	26(%)	0(0.0%)
They took good care of me	144(65.2%)	32(75%)	0(0.0%)	0(0.0%)
I was told at ANC to deliver here	96(43.4%)	0(0.0%)	0(0.0%)	0(0.0%)
They have equipment and drugs	96(43.4%)	0(0.0%)	0(0.0%)	00.0%)
Their services are convenient to use	96(43.4%)	35(83.3%)	19(58.8%)	(0.0%)
It is near my house	84(37.8%)	35(83.3%)	17(52.9%)	0(0.0%)
I had problem in my last delivery and was told to deliver here	10(4.5%)	0(0.0%)	9(29.4%)	0(0.0%)
They give traditional medicine	0(0.0)	18(41.6%)	0(0.0%)	0(0.0%)
They charge low (no cost)	0(0.0)	38(87.5%)	26(82.3%)	22(80.0%)
Labour started at night	0(0.0)	7(12.5%)	4(11.7%)	9(33.3%)
Labour was too short	0(0.0)	4(8.3%)	0(0.0)	7(26%)
Protection from demonic attacks	0(0.0)	0(0.0)	32(100%)	0(0.0%)
They pray for people	0(0.0)	0(0.0)	32(100%)	0(0.0)

***Responses not exclusive**

The result on Table 3 showed responses on why they preferred to deliver their last baby in the place they specified. The result showed that out of 211 that delivered their last baby at the hospital/healthcare, the major reasons were that ó They are always availableò (85.5%), ñThey took good care of meò (65.2%), ñThey run 24hours serviceò (62.6 %) and òThey have qualified staff (52.1%) . Other reasons indicated here were ó I was told at ANC to deliver hereô(43.4%). óThey have equipment and drugs(43.4%)ô óTheir services are convenient to use(43,4%)ò and óHad problem in my last delivery and was told to deliver here (43.4%)ô. Out of the 43 respondents that delivered their last baby in TBAsô place, the major reasons were that ñ They are always available 41 (95.8.0%) , ñThey charge lowò 38(87.5%,

ñTheir services are convenient to use 35 (83.3%) The place is near my houseò35 (83.3%),andñThey took good care of meò32(75%) . Others were they give traditional medicine 18(41.6%), Labour started at night 7(16.6%),It was raining 5(12.5%) and ólabour was too shortôô4(8.3%). Out of the 32 respondents that delivered in the church/spiritual home, the major reasons were ñòProtection from demonic attacksôô32(100%), They pray for people (32(100%), cost (I will not pay money 26(82.3%) and óHad problem in my last delivery and was told to deliver hereô 17(52.9%). Other reasons indicated here include ï nearness 9(29.4%) and labour started at night 4(11.7%) Out of the 27 respondents that delivered at home, the major reasons given were cost 22(80.0%) and ñ labour started at night 11 (40.7%), and labour was too short 7(26%)

Objective Three: To identify the personel that attended their delivery.

Table 4: Responses on who took the delivery of the last baby

N= 313

Response	Frequency	Percentage
Nurse/Midwife	221	70.6%
TBA	47	15.0%
Pastor/Spiritual Woman of God	38	12.1%
Doctor	2	0.6%
Others mothers, mother in-law and sister in-law	5	1.6%
Total	313	100%

The result on Table 7 shows the responses on who took the delivery of the last baby. Majority 221(70.6%) of the deliveries were conducted by nurse/midwives.; 47(15.0%) were taken by TBAs; 38(12.1%) by pastor/spiritual woman of God; 2(0.6%) by a doctor and 5(1.6%) were taken by others which include: mother 1(0.3%); mother in-law 2(0.6%); and sister in-law 2(0.6%)

Objective four: To elicit the factors that influence women's use of birth attendants during delivery.

Table 5: **Factors that influence women's use of birth attendants during delivery.**

Factors	**Nurse/Midwife 221**	**TBA 47**	**Pastor/Spiritual woman of God 38**	**Doctors 2**
I used this healthcare provider in my last baby.	80(36.2%)	19(40.4%)	3(7.9%)	2(100%
The provider lives near me.	51(23.1%)	34(72.3%)	13(34.2%)	2(100%)
The provider charges low.	113(51.1%)	43(91.5.%)	26(68.4%)	2(100%)
The provider knows the work.	194(87.8%)	34(72.3%)	30(78.9%)	2(100%)
Provideriswell qualified to do the work	(190(86.0.%)	1(2.3%)	1(2.6 %)	2(100%)
Provider treats people with respect.	152(72.0%)	35(74.0%)	32(84.2%)	2(100%)
Provider is always available.	183(82.8%)	37(78.7.0%)	32(84.2%)	2(100%)
The provider knows our tradition.	0(0.0%)	26(55.3%)	16(42.1%)	0(0.0%)
Gives traditional medicine	0(0.0%)	26(55.3%)	(0.0.0%)	0(0.0%)
Sees vision	0(0.0%)	0(0.0%)	38(100%)	0(0.0%)
Prays for people	0(0.0%)	0(0.0%)	38(100%)	0(0.0%)

***Responses not exclusive**

The result on Table 5 showed the factors that influence women to use specific birth attendants during their last delivery. The result showed that that had the delivery of their last babies through nurse/midwife, their reasons in order of preference when allowed to pick more than one option showed that more than three quarters 194(87.8%) said the provider knows her workô a similar number 197(87.8%), said ñ The provider is well qualified to do the jobò 190(86.0%) said óShe is always availableô while 183(82.8%) said they used her because óShe treats people with respectô. From the 47 respondents that had the delivery of their last baby through TBA, when allowed to pick more than one option showed that majority (91.5%) said óshe charges lowô, more than three quarters (78.7%) said ñShe is always availableôô (74.5%) said óProvider treats people with respect and (72.3%) said the provider knows the work. From the 38 respondents that had the delivery of their last baby through

Pastor/Spiritual woman of God, All the respondents 38(100%) said she sees vision, a similar number 38(100%) said óShe prays for them. Other reasons given by the respondents include provider is always available 32 (84.2%), ñShe treats people with respectò 32(84.2%)and óProvider knows he workôõ30 (78 9%).

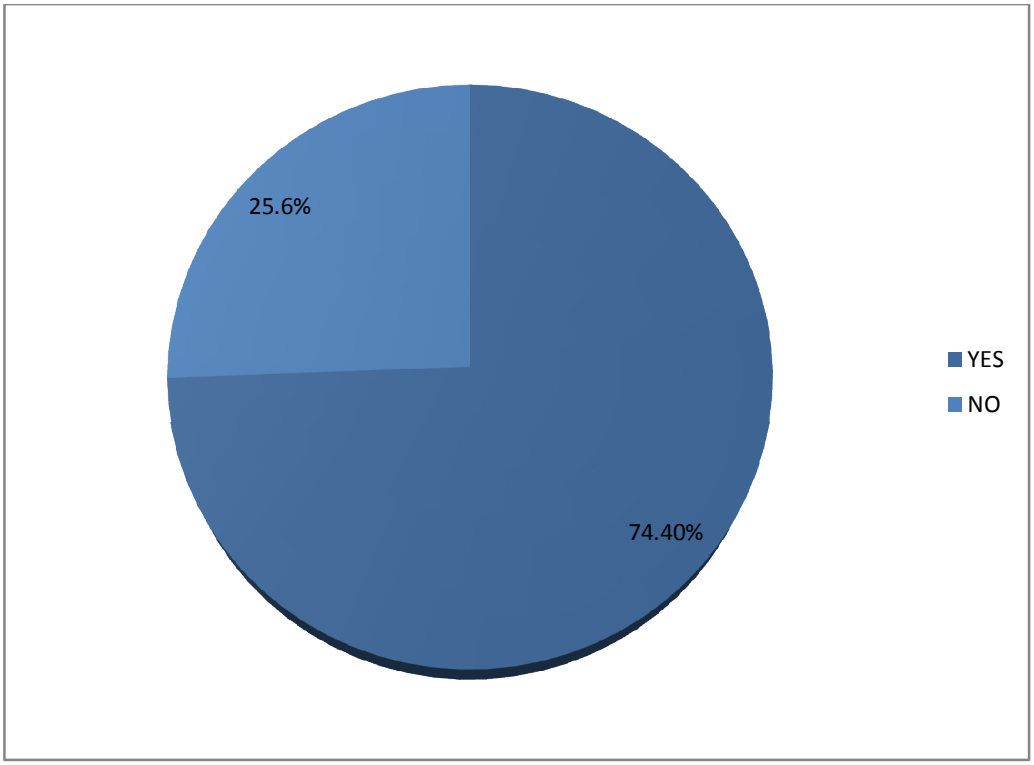


Figure 1 on whether the respondents will want to use the same birth place in future.

The responses on whether the respondents will want to use the same birth place for delivery in future showed that 233(74.4%) said yes while 80(25.6%) said no.

Table 6: Reasons for wanting to use the same birth place for delivery in future.

n= 233

Reasons	Frequency	Percentage
Staff efficiency and good care	107	46 .0%
Availability of equipment/ facility/drugs	93	39.8%
They are always available	51	21.9%
They charge low	40	17.1%
It is convenient to use	36	15.6%
I always use it/previous use	30	13.2%
They pray for people	29	12.5%
They have qualified staff	25	10.9%

***Responses not exclusive**

Findings on respondentsô reasons for wanting to use the same birthplace in future delivery showed that out of the 223(74.4%) of respondents that said yes, 107(46.0%) said it was because of "Staff efficiency /good care ò;more than one quarter 93(39.8%) of the respondents said they will use it in future because of ñAvailability of equipment and drugs while 51(21.9%) of the respondents said ñ They are always availableò40 (17.1%) said they charge lowò while 36(15.4%) of the respondents said that òTheir services are convenient to useò. Another 30(13.2%) of the respondents said it is because ñ I always use itò (previous use). A similar number 29(12.5%)said ñThey pray for peopleò. Fourteen 25(10.9%) it is because ñThey have qualified staffò.

Table 7: Reasons for not wanting to use the same birth place for delivery in future. **n =80**

Reasons	Frequency	Percentage
No qualified health personnel	36	45.4%
Not enough equipment /drugs	34	43.1%
No proper care/treatment	31	38.6%
Not convenient to use	9	11.3%
They are not always available	7	9.0%
Their charges are high	4	4.5%

***Responses not exclusive**

Findings on respondentsô reasons for not wanting to deliver in the same birth place in future showed that out of the (25.6%) of the respondents who said they will not deliver in the same birthplace, a little below half 36(45.4%)of the respondents said it is because ñThey donôt have qualified health personnelôõ;34(43.1%) of the respondents said it is because ñThey donôt have enough equipment/drugsò while 31(38.6%) of the respondents said ñThey donôt give proper care/treatmentò. Five 9(11.3%) of respondents said the place is not convenient to useò, while 7(9.0%) of the respondents said it is because ñThey are not always availableò and 4(4.5%) said ñTheir charges are highò.

Test of Hypotheses

Hypothesis 1: There is no significant difference in the use of birth attendants between primiparous and multiparous women.

Questions number 8 grouped and 17 were cross tabulated to test this hypothesis.

Table 8: Relationship between primiparous and multiparous women in the use of birth attendants during delivery.

	Primiparous	Multiparous	Fisherôs Exact	P-value
Nurse/Midwife	85(84.2%)	135(64.2%)		
Doctor	0 (0.0%)	2 (0.9%)		
TBA	5 (5.4%)	44 (19.8%)	15.85	0.001
Pastor/Spiritual Woman of God	10 (9.9%)	27 (13.2%)		
Others	1 (1.0%)	4 (1.9%)		
Total	101 (100%)	212(100%)		

From the result of the hypothesis, since there are some of the expected values that are less than 5, Fisherôs exact is more reliable than Chi-square. Since the P-value < 0.05, the hypothesis is rejected and thus, there is significant difference in the use of birth attendants between primiparous and multiparous women. This implies that greater percentage of primiparous women delivered their baby by nurse /midwife, while greater percentage of multiparous women delivered their baby by TBA.

Hypothesis 2: There is no significant difference in the choice of birth place and some socio-demographic characteristics of women (age, marital status educational level of respondents and parity).

Table 9: Age cross tabulated with place of delivery

	<20yrs	20-29yrs	30-39yrs	40-49yrs	Fisherôs Exact	P-value
Hospital/Healthcare	40(81.6%)	91(71.1.%)	47(52.2.%)	21(45.7.%)		
Church	0(0.0%)	5(3.9%)	5(10.0%)	10(21.7%)		
TBAôs place	5(10.2%)	9(7.0%)	18(20.0%)	10(21.7%)	73.376	0.000
Home	0(0.0%)	12(9.4.%)	10(11.1%)	5(10.9%)		
Private hospital	0(0.0%)	10(7.8%)	2(2.2%)	0(0.0%)		
Spiritual home	4(8.2%)	0(0.0%)	4(4.4%)	0(0.0%)		
Others	0(0.0%)	1(0.8%)	0(0.0%)	0(0.0%)		
Total	49(100%)	128(100%)	90(100%)	46(100%)		

From the result of the hypothesis, since there are some of the expected values that are less than 5, Fisherôs exact is more reliable than Chi-square. Since the P-value < 0.05, the hypothesis is rejected and thus, there is significant difference in the place of delivery according to age group. This implies that the younger the women, the more they delivered in the hospital/healthcare.

Table 10: Place of delivery cross tabulated with marital status

	Single	Married	Fisherôs Exact	P-value
Hospital/Healthcare	63(77.8%)	135(58.3%)		
Church	2(2.2%)	22(9.4%)	11.644	0.045
TBAôs place	7(8.9%)	36(15.7%)		
Home	5(4.4%)	24(10.2%)		
Private hospital	0(0.0%)	11(4.7%)		
Spiritual home	4(4.4%)	4(1.6%)		
Others	2(2.2%)	0(0.0%)		
Total	81(100%)	232(100%)		

From the result of the hypothesis, since there are some of the expected values that are less than 5, Fisherôs exact is more reliable than Chi-square. Since the P-value is < 0.05, the hypothesis is rejected and thus, there is significant difference in the place of delivery between single and married women. This implies that greater percentage of single women delivered their baby in the hospital/health centre while greater percentage of married women delivered their baby in the church, TBA or home than single women.

Table 11: Level of education cross tabulated with place of delivery

	No formal education	Primary	Secondary	Tertiary	Fisherôs Exact	P-value
Hospital/Healthcare	0(0.0%)	28(54.9%)	166(66.7%)	5(55.6.%)		
Church	0(0.0%)	2(3.9%)	20(8.0%)	2(22.2.%)		
TBAôs place	2(50.0%)	7(13.7%)	33(13.3%)	0(0.0%)	25.496	0.152
Home	2(50.0%)	8(15.7%)	17(6.8%)	0(0.0%)		
Private hospital	0(0.0%)	2(3.9%)	8(3.2.%)	2(22.2%)		
Spiritual home	0(0.0%)	4(7.8%)	4(1.6%)	0(0.0%)		
Others	0(0.0%)	0(0.0%)	1(0.4%)	0(0.0%)		
Total	4(100%)	51(100%)	249(100%)	9(100%)		

From the result of the hypothesis, since there are some of the expected values that are less than 5, Fisherôs exact is more reliable than Chi-square. Since the P-value is > 0.05, the hypothesis is accepted and thus, there is no significant difference in the place of delivery according to respondentôs level of education.

Table 12:Parity of respondents crosstabulated with place of delivery

	Primiparous	Multiparous	Fisherôs Exact	P-value
Hospital/Healthcare	79(76.8%)	120(56.9%)	14.105	0.015
Church	2(2.0%)	22(10.3%)		
TBAôs place	4(7.1%)	35(17.2%)		
Home	5(8.9%)	19(8.6%)		
Private hospital	0(0.0%)	12(5.2%)		
Spiritual home	2(3.6%)	4(1.7%)		
Others	1(1.8%)	0(0.0%)		
Total	101(100%)	212(100%)		

From the result of the hypothesis, since there are some of the expected values that are less than 5, Fisherôs exact is more reliable than Chi-square. Since the P-value is < 0.05, the hypothesis is rejected and thus, there is significant difference in the place of delivery between primiparous and multiparous women. This implies that greater percentage of primiparous women delivered their baby in the hospital/healthcare, while greater percentage of multiparous women delivered their baby in the church or by TBA.

Summary of Findings

1. Findings showed that more than half of the respondents delivered at the Health centre/hospital.
2. A little bit below three quarter 221(70.6%) used nurse/midwives as their birth attendants during their last delivery**.**
3. On decision making, majority of the respondents (more than half) decided by themselves on where they went for ANC and delivery of their last baby.
4. The findings also showed that TBAS took the deliveries for substantial number of the respondents.
5. On reasons for their choice, the respondents gave different reasons for choice of different birth places and birth attendants. The most common reasons that appeared in all choices of birth places and birth attendants is ócostô; others are: availability of

care providers, good care, convenience, availability of equipment, drugs, knowledge/skill of care provider protection from demonic attacks and praying for people.

6. The findings generally showed that choice of birth place and use of birth attendants during delivery is a multi-factorial issue since so many factors interact to guide a mother and her family in choosing where to deliver and who should take the delivery

7. Findings on the hypothesis tested showed a significant relationship between some socio-demographic characteristics (age, marital status, parity and choice of birth places. There is also significant relationship between parity and use of birth attendants.

CHAPTER FIVE

DISCUSSION OF FINDINGS

The discussion of the findings is presented in this chapter. Discussion was done based on the objectives set for the study. Also the limitation of the study, implication of the findings, recommendations and suggestions for further studies were all presented.

Objective one: To determine respondentsô choice of birthplace.

The results shows that majority of the respondents delivered their last baby at the hospital/health centre. This is in contrast to the findings of Umurungi (2010), Aremu (2011) and Adelaja (2011) that most deliveries took place at home or in other non hospital settings. The increased use of health facilities for delivery may be attributed to the constant awareness campaign that is going on in the Nation and States on improving care in the area of maternal and child health to achieve the 5th millennium development goal. The government is also providing support and services to mother and child in rural communities through subsidy reinvestment and empowerment program SURE-P. S U R E ï P MCH, is an intervention programme where they give incentives to mothers for attending ANC during pregnancy and using skilled attendants in health facilities during delivery. Midwives service scheme (MSS) and other free medical treatment programmes that mothers can utilize have also been provided to all the rural communities in the country including Abia State. Added to these are the provisions of health facilities in all communities all over the states and federation for easy access. Ado (2013) stated that the federal government deployed 6,500 midwives to 1,500 health facilities to ensure the presence of skilled attendants during childbirth, particularly in rural areas. This result agrees with Iyaniwure and Yusuf,(2009)which reported that greater percentage of their study population used government facilities followed by private hospitals for delivery.

The findings that a reasonable proportion of the respondents used the TBAôs home is still worrisome to maternal and child health advocates. In spite of the campaigns and sensitizations going on in our rural communities to encourage women to deliver in the hospital/health centres, many women still use the TBAôs place for delivery as found out in this study. Iyaniwure and Yusuf (2009), observed that the increased proportion of deliveries at TBA homes may also be associated with the prevalent supernatural concept of disease in many African communities. Twenty nine percent (29%) of ANC attendees in Equatorial Guinea expressed that TBAs were better than orthodox practitioners in some respects because

TBAs possess spiritual powers and can intervene in certain situations where medical interventions cannot help.

On use of church / spiritual homes for delivery it was found out that 10.2% of the of the respondents used church/spiritual homes during their last delivery . This finding is in line with Ogunleshi (2004) who found out in his study that 33.3% of respondents who took prenatal care in the teaching hospitals deflated into churches for delivery. 8.7% of respondents delivered at home. This is still substantial going by the amount of sensitization and awareness being created by both federal states and local government on the need for women to deliver at the health facilities to avert maternal morbidity and mortality. This finding agrees with the findings of Titaly,Hunter and Debley (2010), Umurugi, (2010), Aremu, (2011) and Adelaja, (2011),Teigingan, Amalray and Dahkal (2011). They reported that women deliver at home in spite of a relatively easy access to institutional maternity service. Home delivery is usually the cheapest option but is associated with lack of available equipment should complication occurs. (Umurungi 2010).

Objective two

Reasons for women's choice of these birth places.

Findings on reasons for womenôs choice of birth place showed that out of the (67.6%) that chose health facility , three quarters gave the reason for their choice as ñavailability of health services.ò Women are always frustrated when they come to a health facility during labour and the place is not open for them. They will be discouraged and may not go there again This is in line with Selejescog Sandby and Chimago (2006) who found unavailability as a factor deterring women from delivering in health facilities. The next reason is ñgood careò which denotes consumer satisfaction from previous use by a particular user or his/her relative. This supports the findings of Amankwa (2010) that individualôs past experience with pregnancy, child birth and health services affect the decision to seek care. More than half of the respondents said they used the place because they run 24 hours service followed by less than half who chose the place because of availability of qualified staff . These findings agree with Pearl &Joseph (2011) who reported that reasons for delivery in a health facility include availability of various cadre of professionals and specialists, availability of drugs and equipment to handle emergencies and availability of doctors and nurses. Poor staffing in a health facility especially in primary health facility makes it difficult to guarantee 24hours availability of services. This is a factor that can discourage women from seeking medical

services when labour commences even when they received ANC at the health facility asserts Babalola and Fatusi (2009), Gabrysh & Campbell (2009) Other reasons mentioned here are being advised at ANC to deliver at the health facility, equipment and drugs , convenience, nearness, and problem in the clientôs last delivery.

On reasons for womenôs choice of TBAôs place for delivery, results showed that out of the 13.7% of the study population that used TBAôs place for delivery , almost all of them 95.8% gave their reasons as óavailability of services.

More than three quarters indicated ñlow chargeôô, more than half indicated convenience and similar number indicated nearness and . Women patronise the TBA because of the above reasons. The TBAS live in the midst of the people and can be accessed at any point in time. They are equally more convenient to use in terms of distance from homes, finance, time spent, and so forth.

Cost of service can hinder a woman from seeking care in orthodox health facility if she has no support or any means of raising money to pay for the services. Nearness of health facility to residence is important because it determines the distance a woman in labour will walk before accessing care. Other reasons given by these mothers for using the TBAôS place include the fact TBAS ñgive traditional medicineò, Labour started at night, ñit was rainingò and ñLabour was too shortô. These findings support the findings of Olfunke & Akintujo (2012) that the reasons for using TBA services are because they are cheaper, more culturally acceptable, closer to the homes than hospital services, and provide more compassionate care than orthodox health workers

On reasons for choice of church /spiritual homes for delivery , the result showed that all the respondents that chose church said they went there for óprotection from demonic attacksôô, more than three quarters said ót is because they prayed for peopleô and more than two thirds said they will not pay money (cost).More than half said they used the place because óIt is convenient for themô. Other reasons implicated here include nearness to residence, problem in last delivery and labour started at night. These findings are in congruence with findings of Udomo, Ekanem Abasiatta,& Bassey (2008) that protection from evil attacks, cost and good care make women to deliver in the church. Ogunleshi (2004) also found that churches were mostly patronised for prenatal care and delivery for religious reasons.

Findings on reasons why women choose to deliver at home showed that more than three quarters of all the respondents that delivered at home said their reason for delivering at

home was cost, less than half said ólabour started at nightô, and less than one quarter said labour was too short. These findings are in line with Gabrysh and Campbell (2009) Sychaneun et al (2012) who also found that labour starting at night, quick progressive labour, (precipitate labour) were also given for reasons for home delivery in their study.

Objective Three

To determine womenôs use of health care provider during delivery.

The findings showed that the highest number of deliveries taken in the community were by nurses/ midwives.(70.3%). This can be attributed to the level of awareness of the respondents on the need to use skilled attendants during delivery to reduce maternal death. Majority of the respondents are also empowered through education since majority had education up to secondary school level and above, this encourages the use of health services.

The above findings can also be attributed to the federal governmentôs institution and implementation of programmes like the midwives service scheme and making provision for mothers through SURES-P to make available skilled health care providers during delivery in all communities in the country.

Recently, Abia State government in collaboration withé Shell BP gave scholarships to practising nurses who have not done their midwifery programme to read midwifery ,this is to ensure the availability of skilled midwives in the health facilities in the state especially the primary health facilities. The findings above are in agreement with Azuh (2013) who found out in his study that assistants during pregnancy and delivery were identified to be nurse/midwives (56.8%), doctors (20%), traditional birth attendants (17.7%) and relatives (5.5%) Also WHO (2013) stated that midwife initiatives have made it possible for a personnel to be at the health care system always, hence women may determine to utilize their services. The second highest birth attendants indicated here is the TBA which was fifteen percent (15.0%.) . Many Nigerian women particularly in the rural areas rate the services of the TBAôs as being of higher quality than that of the medical health practitioners particularly with regards to interpersonal communications and relationships. TBA has been reported to be more considerate and to provide more compassionate care. This supports the findings of Iyaniwure and Yusuf (2009) that many women for several reasons ranging from skill, proximity, cost etc patronise the TBAS in spite of skilled health care providers made available by both the government and the private sectors. The result of Abia state, health statistics of (2010) showed that TBAS attend up to (80%) of births and skilled midwives

(20%.) The continual use of TBAS despite mass campaign and awareness on the need for mothers to use skilled birth attendants can also be connected to the recognition and training by some state government which make women regard the TBAS as approved birth attendants during delivery. From the result above, there is a reduction from the (2010) report that 80% of women use TBAõS, this may be due to increased awareness and sensitisation to use skilled birth attendants in order to reduce maternal morbidity and mortality.

Another birth attendant implicated are the pastors/ spiritual women of God (11.6%). Although the percentage of those using these birth attendants have been reduced, substantial number of women are still using them and this is detrimental to maternal and child health if nothing is done to stop them or train them to improve their services.

Objective four

To elicit the factors that influence womenõs use of birth attendants during delivery. Findings on factors that influence the use of birth attendants during delivery showed that out of 70.6% that chose nurse midwives, more than three quarters said they used the provider because" she knows the job " A similar number said õThe provider is well qualified to do the job" The above findings show that a provider is visited over and over again if she knows her work. If a provider is proficient, and there is positive outcome in her services, there is the tendency that the consumer will use that provider again and also recommend her to others. This is in agreement with the findings of Apmooti-Kaguna (2000) that health workers and TBAs proficiency are factors influencing use of delivery sites in Rakai. More than half of the respondents said they used the provider because "she is always available", like birth place, availability of healthcare provider in all health facilities determines whether a client should use it or not.

If health facilities are provided everywhere without health workers to give the needed services, mothers will not use it. The findings agrees with Anderson and Newman (2005) which states that the resources (qualified doctors, nurses/midwives, available equipment etc) available in a facility will determine whether one will use him/her or not. More than half of the respondents said they used the place because the provider is well qualified to do the job. Due to current sensitization on use of skilled birth attendant during. delivery, many mothers go to qualified care providers since they now know that they are trained. This is in agreement with UNFPA (2004) that skilled health attendants refers to " people with midwifery skills for

example (doctors, nurses and midwives.) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer obstetric complications. Other reasons indicated for using the nurse/midwife include "she is caring and kind", treated me well in the last delivery and treated me with respect.

On use of TBA's as healthcare provider during delivery; out of the 15.0% that used the TBA more than three quarters of the respondents said they used the TBA because of cost "she charges low" followed by "availability", "she treats people with respect " knows the workò and "nearness". Cost of health services is another reason that deter women from using skilled healthcare provider during delivery. Inability to pay for services rendered to clients is a very important factor to be considered when making decisions on where to deliver and who the healthcare provider should be. In many government institutions, women deliver but due to their inability to pay bills, they are kept in the hospital for months until their relations come up and pay. Some stay for months and are not opportuned to lie on the bed with their babies. This brings down the ego of the client and this explains why some of them prefer the TBA's where they can pay gradually or even in kind. In considering cost, it is not only the cost of health services rendered that matters. Cost of seeking care includes cost of transportation; medications, supplies, official and unofficial fees, provider fees and opportunity cost of travelling time and waiting time lost during this period. Cost of having assistance to accompany the woman, who and how to care for the other children at home are all considered. When women cannot put up with all these costs, they choose to deliver with the TBA's. These findings are in agreement with the findings of Gabrysh and Campell (2009) and Kruk et all (2009) .TBAs may offer more convenient user charges, that allow payment to be spread over a period of time or be made in kind (Iyaniwure and Yusuf 2009). The second reason for use of TBA for delivery is availability. The TBA lives in the community in the midst of the people unlike the health facilities which are located away from the compounds where the people live. The TBA can be assessed at any time.

On the third reason, ñshe treats people with respect". 74% said she treats people with respect and 57.4%said "She lives near me". Respect is very important for maintenance of human dignity. Respect for client irrespective of her status, colour or tribe goes a long way in the development of trust and confidence between the care provider and her client. This is in agreement with Selejescog et al (2006,) Gabrysh & Campbell (2009) that quality of care is one of the determinants of use of healthcare provider and respect is part of quality of care .

On nearness, findings show that 57.4% said they chose the provider because "She lives near themò. Women tend to use a care provider which is near for convenience. This is because it will reduce the travelling time and distance the woman will walk if labour starts. World Health Organization standard is that every woman should have access to health facility which should not be more than 30 minutes walking distance or less than 5 kilometers. Distance exerts a dual influence since walking many kilometres is difficult for a woman in labour and impossible if labour starts at night and there is no means of transport. Women may deliver on the road and develop complications which may claim their lives or that of their baby .Traditional birth attendants live in the midst of the villagers and may be the most likely care provider to take the delivery under this situation. This support the work of Kurk (2004), Selejescog , Wagle and Sabroe (2004) that cost and distance have negative effects on utilization and a distance of more than one hour to maternity hospital increase risk of home delivery

Reasons for use of pastor /spiritual woman of God showed that all the respondents indicated "She sees vision", a similar number said ósshe charges lowô or óno charge at all" while more than three quarters said she prays for them. Other factors indicated here are: protection from evil attack and she knows the job. These findings support the findings of Udoma and Ekanem (2008) that spiritual protection against satanic attacks, safe delivery, lack of funds, harsh attitude of healthcare providers ,faith in God, previous use, help and good care are reasons for preference for delivery in spiritual church based clinic by women of South South in Nigeria .

Findings on whether the respondents will want to use the same birth place in future showed that 74.4% said yes while 25.6% said no. Future choice of place of delivery depends on the previous experience of the chooser with health system. Findings showed that majority said they will use the place because of staff efficiency/good care, more than half said they will use it because of availability of equipment and facilities, and availability of healthcare provider in the birth place. Other factors indicated are ó$hey charge lowô, ó$heir services are convenient to useô, ó$hey pray for people. ó$I have always used itô; ó$hey have qualified staffô. The last 0.8% said they will use because they went for ANC there and their people recommended it respectively.

Findings on respondentôs reasons for not wanting to use the same birth place in future, shows that respondents implicated such factors as the place not having enough equipment /drugs, not giving proper /adequate care, and not having qualified staff. Other reasons given were that the place was not convenient to use, not always available and their charges are high. These reasons denote consumer satisfaction with services rendered. Consumer satisfaction is measured by such factors as; providers characteristics which include whether the provider is polite, well trained, proficient, respectful and so forth. These findings agree with Umurungi (2010),Gabrysh and Campbell(2009). If the consumer of health services is satisfied with the previous services used, there is the tendency to use it again and recommend it to others but if not satisfied, the mother will neither use nor recommend it to others.(Anderson and Newman, 2005)..

Relationship between primiparous and multiparous women in the use of healthcare provider.

The study showed that there was a statistical significant difference in the use of healthcare provider during delivery between primiparous and multiparous women. The result shows that greater percentage of primiparous women deliver their babies by nurse/midwives while greater percentage of multiparuos women deliver their babies by TBAs. This is in agreement with Umurungi (2010) who said that often a high value is placed on the first pregnancy and in some settings; the womanôs natal family helps her get the best care possible. Furthermore, health workers may recommend a facility delivery for primipara. By contrast women of higher parity can draw on their maternity experiences and may not feel the need to receive professional care if previous deliveries were uncomplicated. Also women with several small children may have greater difficulty in attending facilities due to the need to arrange child care. Amankwa (2010) also reported that parity is another significant factor that can influence a womanôs decision to deliver with a skilled attendant. He cited Bangladesh where women with lower parity are less likely to deliver at home.

Ekene &Tunau (2007)in Amankwa (2010) observed that in Sokoto in Nigeria,
women of high parity were found to be more likely to decide to prefer home delivery with unskilled attendants

The Relationship between some socio-demographic characteristics age, marital status, educational level of respondents and parity, on choice of birth place.

The result shows that there is significant difference in the place of delivery according to age group. This implies that the younger the women the more they delivered at the hospital/healthcentre. Age is often presented as a proxy for use of health services. Older women many belong to more traditional cohorts and thus be less likely to use modern facilities than young women. On the other hand older women may be told to deliver in the health facility since older age is a biological risk factor (Gabrysh and Cambell 2009). Young women may be single and may be supported by their parents and this may make them deliver at the health facility. Age is also related to parity and it may be the first pregnancy making young women to seek facility delivery more.

Findings on relationship between marital status and choice of birth place showed that there is significant difference in the choice of place of delivery between single and married women . Result shows that greater percentage of single women delivered their babies at the hospital/health centre while greater percentage of married women delivered at the church, TBAs. or home. Marital status may influence the choice of delivery place, probably via its influence on female autonomy and status through financial resources. Single or divorced women may be poorer but enjoy greater autonomy than those currently married. Young single mothers may be cared for by their natal families which may encourage skilled attendance especially for a first birth Umurungi (2010)

Result on relationship between respondentôs level of education and choice of place of delivery shows that there is no significant difference in the place of delivery according to educational level of respondents. Women deliver at the health facility irrespective of their level of education. The finding is so because of the constant sensitizations carried out in the communities on utilization of maternal health services as a strategy for reducing maternal mortality. Rural women are now more aware of health services than before, they are empowered in so many other ways even when they are not educated up to secondary school level. This women empowerment has brought autonomy and decision making power to rural women thereby influencing choice of birth place. Furthermore women attend ANC and receive health information through health education in their own dialect on risk factors of childbirth and the benefits of skill attendance. Added to these is the provision of health

facilities very close to the members of the community with skilled health care provider to attend to mothers in need.

On parity the result showed that there is significant relationship between motherôs parity and place of delivery. Greater percentage of primiparous women delivered their babies in the hospital/health centre and greater percentage of multiparous delivered theirs at IBAs place, church and home. This is in agreement with Umurungi (2010) that the first birth is known to be more difficult and women have no previous experience of delivery. Often a high value is placed on the first pregnancy and in some settings; the womenôs natal family helps her to get the best care possible. Furthermore, the health workers may recommend a facility delivery for prinipara. By contrast, women of higher party can draw on their maternity experiences and may not feel the need to receive professional care if previous deliverances are uncomplicated.

Conclusion

Choice of birthplace and use of birth attendants during delivery have important influence on maternal and child health and wellbeing in Nigeria. The study has identified where women deliver their babies, who takes the deliveries and factors influencing these choices in the area of study. Among these factors include : cost of health services, availability of health services and birth attendants, qualified staff equipment, and drugs. Good care, respect for client,convenience and problem in last delivery.

It was also found that no single factor can be implicated alone. These factors interact to bring about choice of health services during delivery. Without available and accessible healthcare that is less costly, all other efforts to reduce maternal mortality will be in vain.

Nursing implication

The findings of this study provide an overall picture of the choice of birth place and use of birth attendants during delivery and reasons for their choices. The findings will inform healthcare providers of where women prefer to deliver their babies, who they mostly use for this deliveries and why they took these decisions. This will help the nurse managers to plan services in such a way that it will provide 24 hours availability of service for consumers and at a reduced cost too. Nurses or care providers in the communities should intensify their campaign on need to use health facilities.

Reproductive health education should be intensified by health wokers. It will help midwives in the communities avoid those characteristics that scare consumers from the health facilities eg. Unavailability, lack of respect for consumers, high cost of services and so forth. Nurses

who work in communities should try to establish good rapport with their clients and family to build confidence and enhance use. Health workers should apply more empathy in their relationship with clents and there should be good communication between the provider and consumer.

Recommendations

- Since the government alone cannot provide health services and the TBAS are aways used by rural women, some training should be given to the TBAS on care during delivery and need for early referal to prevent maternal morbidity and mortality.
- Because of the level of poverty in the country that discourage mothers on the use of health facilities, health services should be subsidised and made available to women of child bearing ages if the MDGôS will be achieved since cost is one of the major deterents from choosing health care facility.
- It is true that the government has done much in terms of trainning of healthcare providers and provision of health facilities; the healthcare providers posted to rural health facilities should be encouraged to stay in their health facilities by being provided with the necessary amenities like ï security,light,water,and some monitary incentives eg rural allowance to motivate them to stay in rural areas .
- They should also be monitored to avoid abandonment of facilities and their work to unskilled attendants
- For protection of human dignity, government facilities should off-set the bills of the very poor ones after they have paid the little they can afford to avoid the degrading situation of keeping a woman in the hospital for months in an inhuman condition for not being able to pay
- Women should be given incentives in all the states for using government health facilities and skilled providers during (ANC) and delivery to courage use.
- Education of the girl child up to secondary school level is very important to empower them on the use of the media and in understanding health messages which will make them increase use.

Limitations of the study

There were some limitations in the course of this study which include: The terrain in some places in the community is confussing and this brought about the use of two research assistants as the local guides. Dearth of current data on population of Akanu as a whole and data on women of reproductive age in Akanu.

A weakness to this study was the use of self report regarding palce of deliery and birth attendants. This could not be verified since there are not records available immediately to use to really authenticate the report. Mothers may deliver at home or other palces and say they delivered in a health facility since it can not be verified further to authenticate the infroamtion. however, previous reprots have found verbal interviews a reliable way of assessing womenôs palce of delviery and the time lag is not much for women to have forgotten the right inforamtion. Inspite of the above limitations, this study contributes to the knowlede about choice of birth palces and use of birth attendants during delivery and factors influencing these choices.

Suggestions for further studies.

The scope of this study was limited to only one community, similar studies can be conducted using a wider population for example the entire state and other locations in Nigeria.

Research should also be conducted on the coverage of skilled healthcare provider in our rural communities.

Summary

The study investigated choice of birthplace and use of birth attendants among child beraing in Akanu, Ohafia local Government area of Abia State and also the factors that influence their choices. The reasearch was prompted by observation of the researcher that women attend ANC but do not use health facility for delivery. Four research objectives and two hypotheses were formulated. The theory which was reviewed for this study was Andresonôs model of healthcare utilization which was used for analysing the choice of birth place and use of birth attendants during delivery. 313 respondents were used for the study. Researcher developed questionaire was used for data collection. This was administered to respondents in an interview format for about 10-20 minutes but a good number of women completed their questionnaire by themselves. An important observation of this study is that in contrast to the findings of so many studies that majority of their study population used other birth places and unorthodox birth attendants during delivery, the researcherôs findings showed that majority of the studied population used the health facilities for delivery and used

nurse/midwife as birth attendents during delivery. On reasons for choice, the study implicated reasons like availability of healthcarebirth attendants, availability of equipment, good care, knowledge of the work (skill of birth attendants) respect for health services consumers, convinience and cost. Cost of healthcare and availability of services consistently appeared as factors that influence choice of birthplace and use of birth attendants during delivery.

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APPENDIX 1

Statistics of (ANC) attendance and attendance during delivery in the three comprehensive health centres in Ohafia

ANIA HEALTH CENTRE

Year	Anc Attendance	Delivery
2007	163	45
2008	164	43
2009	73	38
2010	72	39
2011(JAN ï AUG)	72	20

Source: Delivery register Ania health centre

OHAFOR HEALTH CENTRE ASAGA

Year	Anc Attendance	Delivery
2007	79	No data
2008	36	No data
2009	49	No data
2010	75	47
2011	124	66

Source: ANC & Delivery register Ohafor health centre

ISIAMA HEALTH CENTRE EBEM OHAFIA

Year	Anc Attendance	Delivery
2007	400	150
2008	385	I52
2009	405	160
2010	370	145
2011(JAN-AUG)	309	112

Source: Isiama Health centre ANC/Delivery register

APPENDIX 11

The sub- communities that make up Akanu-Ukwu autonomous community in Ohafia LGA

Ekelogo	**Amafor**	**Utugha Okoko**	**Ndi Odo**
Ndi Uma	Ndi Agboke	Ndi Uka	Ndi Agwu Odo
Ezi Ukwu	Ndi Ulu	Ndi Uche	Ndi Awa Nta Odo
Ndi Okoro	Ndi Ikpo	Ndi Ulu Agboke	Ndi Odo Ukpai
Ndi Agwunta	Ndi Alulu	Ndi Agwu	Ndi Edum
Ndi Udo	Ndi Ezera Uka	Ndi Mba	Ndi Anya
Ndi Akamandu	Ndi Ogbu	Ndi Ijere	
Ndi Ibe	Ndi Ekele	Ndi Uda	

APPENDIX 1V

Department of Nursing sciences,
Faculty of Health Science & Technology.
University of Nigeria
Enugu campus
Enugu.

Dear Respondent,

I am an MSc student of the above named institution conducting a research on choice of birth place and healthcare provider during delivery among women of childbearing age (15 - 49)yrs in Akanu Ohafia community of Abia state.

I solicit your sincere impute as all information given will be treated confidentially
Thank you.

Nwokoro, U. I.
(Researcher)

APPENDIX 1V

Department of Nursing sciences,
Faculty of Health Science &Technology.
University of Nigeria
Enugu campus
Enugu.

15 th January 2013.

The Chairman ,
Health Research and Ethic Committee,
Federal medical Centre
Umuahia

Through:
The head of department,
Department of Nursing Sciences,
University of Nigeria ,
Enugu campus.

APPLICATION FOR ETHICAL APPROVAL

I humbly apply for ethical clearance to conduct a study on choice of birth place and healthcare provider during delivery among women of childbearing age in Akanu community of Ohafia LGA.

I am a post graduate student of the Department of Nursing Sciences , University of Nigeria, Enugu Campus. The subjects of the study are childbearing women aged (15 ï 49years) in Akanu Ukwu autonomous community of Ohafia LGA state.

Participation in will be voluntary and no risk is anticipated as no aspect of the study is invasive. All information shall be confidential and used only for academic purposes
Thanks.

Yours faithfully,

Nwokoro, U.

Appendix V

QUESTIONNAIRE ON CHOICE OF BIRTHPLACE AND USE OF BIRTH ATTENDANTS AMONG CHILD BEARING WOMEN IN AKANU, OHAFIA LOCAL GOVERNMENT AREA, ABIA STATE NIGERIA

SECTION A

1. Age in years
   - < 20 years [ ]
   - 20-29 years [ ]
   - 30-39 years [ ]
   - 40-49 years [ ]

2. Marital status:
   - Single [ ]
   - Married [ ]
   - Divorced [ ]
   - Widow [ ]

3 Religion: [ ]
   - Christianity [ ]
   - Islam [ ]
   - African traditional [ ]

4. Highest level of education of respondent:
   - Formal education [ ]
   - Primary [ ]
   - Secondary [ ]
   - Tertiary [ ]

5. Occupation of respondent:
   - Farming [ ]
   - Trading [ ]
   - Seamstress [ ]
   - Government worker [ ]
   - please specify [ ]

6. Parity:
   - 1 [ ]
   - 2 [ ]
   - 3 [ ]
   - 4 [ ]
   - 6 and above. [ ]

7 Place of (ANC) Antenatal care in your last pregnancy?

Hospital/health centre	[ ]
TBAôs place	[ ]
Church/Spiritual Healing home	[ ]
Home	[ ]
Others please specify	[ ]

8 Who decided where you went for ANC during your last pregnancy?

Self	[ ]
Husband	[ ]
Mother	[ ]
Mother-in law	[ ]
Pastor	[ ]
Others please specify	[ ]

9 Who had the final decision on where you delivered your last baby?

Self	[ ]
Husband	[ ]
Mother	[ ]
Mother- in law	[ ]
Pastor	[ ]
Others please specify	[ ]

SECTION B
CHOICE OF BIRTHPLACE AND BIRTH ATTENDANTS DURING DELIVERY

10 Where did you deliver you last baby?

Hospital/health centre	[ ]
TBAôs place	[ ]
Church/spiritual home	[ ]
Home	[ ]
Others please specify	[ ]

11 If you delivered at the hospital, why did you prefer to deliver your baby there?

i) The place is near my house	[ ]
ii) I was told at ANC to deliver here	[ ]
iii) I had problem in my last delivery and was told to deliver here	[ ]
iv) Labour started at night	[ ]
v) They have equipment /drugs	[ ]
vi)They charge low	[ ]
vii)They are always available	[ ]
viii)They have qualified staff	[ ]
ix)They run 24hour service	[ ]
x)Their services are convenient to use	[ ]

12. If you delivered at the TBAôs place, why did you choose to deliver there?(tick)

i) The place is near my house. [ ]
ii) Labour started at night. [ ]
iii) They charge low [ ]
iv) Their services are convenient to use [ ]
v) They are always available [ ]
vi) Labour was too short [ ]
vii) They give traditional medicine [ ]

13. If you delivered at the church, why did you prefer to deliver there? (tick)
i)The place is near my house [ ]
ii)I had problem in my last delivery and I was told to deliver here [ ]
iii) Labour started at night. [ ]
iv)They see vision . [ ]
v)They pray for people. [ ]
vi) Protection from demonic attack [ ]
vii) Convenience [ ]
viii) Cost [ ]

14 .if you delivered at home, why did you prefer to deliver at home? (tick)
No money to pay for hospital bill [ ]
Labour started at night [ ]
Labour was too short(precipitate labour) [ ]
It was raining [ ]

15. Who took the delivery of your last baby?
a) Nurse/midwife [ ]
b) Doctor [ ]
c) TBA [ ]
d) Pastor /Spiritual woman of God [ ]
e) Others please specify----------

16. What were your reasons for choosing nurse/midwife to take your delivery:

She is always available [ ]
She is well qualified to do the job [ ]
She is caring and kind [ ]
She respects people [ ]
She treated me well in the last delivery [ ]

17) What were your reasons for choosing a TBA in your last delivery?
She knows the job [ ]
Treats people with respect [ ]
She lives near me [ ]
She is always available [ ]
She gives traditional medicine. [ ]
She knows our tradition [ ]
She charges low [ ]

18) What were your reasons for choosing pastor/Spiritual woman during your last delivery?

She prays for me [ ]
She sees vision [ ]
She knows the job [ ]
She can prevent evil attacks [ ]
She does not charge me [ ]

19) Why did you choose the doctor during your last delivery?
She knows the job [ ]
Well qualified to do the job. [ ]
Can do operation [ ]
I had problem in my last delivery. [ ]

20) What were your reasons for choosing any other healthcare provider specified here (mother, mother in law, sister, friend)
It is more convenient [ ]
I will not pay any money [ ]
She will take care of me [ ]
She is my mother [ ]
She knows the job

21) In future, do you hope to use the same birthplace?
Yes b. No

22) If yes, give reasons for your answer

---

23) If no give reasons for your answer

---

24) In future, would you want to use the same healthcare provider?
Yes b. No

25) If yes give reasons for your answer

---

26) If no give reasons for your answer

CHAPTER ONE
INTRODUCTION

Background to the Study

The choice of birthplace and use birth attendant during delivery is very important for women and their families because it determines to a large extent the outcome of pregnancies and child births. Access to quality healthcare during pregnancy and in particular, during delivery is a crucial factor in explaining the huge disparity in maternal and perinatal morbidity and mortality between developing and the industrialized world. (Gayawan,2012)

Every year, 3.3 million babies are stillborn and maternal deaths have also continued unabated. More than half a million women die of pregnancy related complications with ninety-nine percent (99%) of these deaths occurring in developing regions particularly Africa and Asia. (WHO 2005). The implication is that every minute, at least a woman dies from pregnancy and childbirth in these regions. . Comparing with other regions of the world, the lifetime risk of maternal deaths in sub Saharan Africa is 1 in 22 mothers. North Africa has 1 in 210, 1 in 62 for Oceania, 1 in 120 for Asia, and 1in 290 for Latin America and the Caribbean (WHO, 2005).

According to the World Health Organization (WHO) (2005), the history of success in reducing maternal death and newborn mortalities show that skilled professional care during and after childbirth can make the difference between life and death for both women and their newborn babies. The converse is true as well; a breakdown of access to skilled care may rapidly lead to increased unfavourable outcomes. Yanagisawa, Oum and Wakai (2006), assert that obstetric complications are the leading cause of death among women of reproductive age in many developing countries. Globally, more than 200 million women become pregnant each year and 40% are estimated to experience pregnancy related health problems with 15% experiencing serious or long term complications and 1.7% developing fatal complications. The lifetime risk of deaths due to pregnancy related complications is 250 folds higher among women in developing countries. It is estimated that 88 ï 98% of these deaths are avoidable and 70% are related to five direct obstetric complications:- postpartum haemorrhage, puerperal pre ï eclampsia and eclampsia, obstructed labour and abortion. AbouZahr, (2003) ; in Yanagisawa et al (2006) stated that the prevention and management of these complications is the key to improving maternal health. It is estimated that 97% of pregnant women in developed countries receive antenatal care ANC services and 99% use

skilled obstetric services during delivery. In developing countries, 65% and 53% of women use ANC and skilled obstetric care respectively (Uzochukwu, Onyeukwu and Okpala 2004.) Acquiring the service of skilled attendants during delivery to improve the management of pregnancy and related complications is an effective means to reduce maternal mortality.

Iyaniwure and Yusuf (2009) observed that it is not enough to receive ANC only. This is because majority of the complications that cause maternal death occur during or shortly after delivery. It is therefore important that pregnant women have skilled obstetric attendance during delivery because pregnancy related complications are a leading cause of death among women of reproductive age in developing countries. According to joint WHO/UNFPA/UNICEF/World Bank statement(1999),skilled obstetric care or attendance refers to the process by which a pregnant woman and her infant are provided with adequate care during pregnancy, labour, birth, postpartum and immediate newborn period, whether the place of delivery is the home or hospital. In order for this process to take place, the attendant must have the necessary skills and must be supported by an enabling environment at various levels of the healthcare system. For the worldôs 60million non facility based births, addressing who is currently attending these births and what effects they have on birth outcomes is a key starting point towards improving care during delivery.(Darmstadt et al 2009).

A skilled birth attendant refers exclusively to people with midwifery skills (e.g. doctors, midwives, 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 a particular setting.

In Nigeria, the National HIV/AIDS and Reproductive Health Survey (2003) showed that 62% of women who gave birth a year before the study received ANC while 34% had skilled attendance during delivery. In Abia state, it was recorded that TBAôS attend to 80% of births and skilled midwives attend to 20% of births(Health statistics, 2012) In developing countries, conditions are not favourable enough to encourage women living in rural and remote areas to deliver at home. When home deliveries occur, some go well and others lead to complications and death . the later often occurs when the family is not prepared to refer the woman to a health facility or cannot recognize the signs of complications.

Barely 6 months to 2015 ï the year targeted for achieving the global reduction in maternal mortality, the continuing high rate of maternal mortality remained worrisome. According to the United Nationôs and World Bank statistics an estimated 144 women die each day in Nigeria from pregnancy related complications making her one of the worst countries for women to deliver babies in the world (Okeibunor, Onyeneho and Okonofua, 2010). The situation of maternal and child health in Nigeria is among the worst in Africa and has not improved substantially while in some areas of the country, it has worsened over the past decade. The maternal mortality ratio ranges between 800-1,500 per 100,000 live births. Nigeria is second to India in terms of absolute number of maternal deaths and regrettably despite abundant resources, contributes to more than 10% of all global maternal and under five deaths (NHS 2003 in Ladipo 2009). Choice of birth place and birth attendants among childbearing women during delivery is very important for women and their families since this is a very critical period, a period when almost all the complications that bring about maternal morbidity and mortality occur. Women need not die in childbirth; for optimum safety, every pregnant woman without exception needs professional skilled care when giving birth. This can avert, contain or mitigate many of the life threatening problems during childbirth and reduce maternal morbidity and mortality to a significant low level. This study therefore intends to find out the choice of birth place and use of birth attendants during delivery among women of child bearing age in Akanu community of Ohafia L.G.A., Abia State.

Statement of Problem

In spite of all the programs and interventions formulated by the Federal Government in the attempt to strengthen and improve Safe Motherhood, and health programs to reduce morbidity and mortality (e.g. midwives service scheme), women do not think it wise to utilize the skilled healthcare providers during delivery .Approximately 536,000 maternal deaths occur annually of which (95%) occur in sub Saharan Africa and Asia (Fatusi 2009). Nigeria is a leading contributor to the maternal death figure in Sub Saharan Africa with maternal mortality ratio of 1:100. With an estimated 59,000 maternal deaths, Nigeria which has approximately 2% of the worldôpopulation contributes almost 10% of the worldôs maternal deaths . More than 20 million women each year suffer ill health and death due to pregnancy and childbirth. Majority of these maternal deaths can be prevented if deliveries are overseen by skilled birth attendant.

It has been observed by the researcher over the years that in Ohafia community and many parts of Abia North Senatorial zone, women attend ANC during pregnancy but do not come

to the health facility to deliver their babies or use skilled healthcare provider during delivery. Example is a case of a woman from Ndi Aja compound Elu Ohafia who booked at Isiama health centre but for reasons best known to her, she decided to deliver unassisted in her room . At the end of the delivery , she severed the cord with a kitchen knife. When I was called the next morning to attend to her, she had already lost so much blood and the placenta was completely drained of blood and adherent. All attempts made to convince her relations to take her to the hospital for treatment failed and she died about five hours. .This made the researcher wonder why this woman chose to deliver at home unassisted despite the fact that she booked at the health centre. and also why the relations refused to take her to the hospital when complications arose. The researcher also observed that from data available from the health facilities she visited in Ohafia community the ANC coverage is very high > 95% This high attendance has not translated to high institutional delivery which is as low as 35%. The meaning is that women do not return to the health facility during labour /delivery.

Where do these women deliver their babies? and who takes these deliveries. It was found out that Ania compressive health centre and Akanu Ukwu health centre Ohafia all situated at Akanu, have the average of 109 ANC attendance and 37 deliveries per year for five years. This makes them the most implicated from the data collected from the health facilities. The researcher decided to investigate the choice of birthplace and use of birth attendants among child bearing women in Akanu, Ohafia LGA, Abia State.

Purpose of the Study

The purpose of study is to: investigate the choice of birth place and use of birth attendants during delivery among childbearing women in Akanu community, Ohafia LGA, Abia State and also find out reasons for their choices.

Specific objectives were to:

1 Determine women's choice of birth place in Akanu Ohafia Community.

2. Elicit the reasons for womenôs choice of the birth places.

3. Identify womenôs use of birth attendants during delivery in Akanu community.

4. Elicit the factors that influence womenôs use of these birth attendants during delivery.

Research questions

1. What is the choice of birth place for women of Akanu in Ohafia community

2 What are the reasons for women's choice of these birth places.?

3. What type of birth attendants do these women use during delivery?

4. What factors influence the use of these birth attendants during delivery.

Hypothesis 1: There is no significant difference in the choice of birth attendants between primiparous and multiparous women

Hypothesis 2: There is no significant difference in the use of birthplace and some socio-demographic characteristics of women- (age, marital status, educational level of respondents and parity).

Significance of the Study.

Findings of this study will reveal the birth places and type of birth attendants Akanu women prefer during delivery. It will also expose the factors which influence these choices. The findings will enable the researcher make recommendations which will enable Government, policy makers, health planners and managers design appropriate maternity services and put strategies in place that will motivate these mothers to deliver under skilled birth attendants in functional health facilities.

To mothers: when mothers deliver under skilled birth attendants based in functional health facilities, there will be improvement in maternal and child wellbeing and reduction in maternal and child morbidity and mortality.

Family: The families will have access to health services that is available, less costly and convenient to use.

To the community: There will be better quality of life and higher life expectancy for women in Akanu community. This will improve the gross domestic product of Akanu community, thereby contributing to National wellbeing, reduction in maternal morbidity and mortality and achievement of the 5^{th} millennium development Goal.

Scope of the study

This study is delimited to choice of birth place and use of birth attendants during delivery and factors influencing these choices among child bearing women in Akanu Ohafia. The researcher will investigate where Akanu women deliver their babies within the period under study, who took these deliveries?, what were their reasons for choosing that birth place and using that birth attendants. The study will also establish the relationships between some

socio demographic characteristics of the women and choice of birth place and birth attendants.

Operational definition

Birth places: The place where women deliver their babies (eg Hospital/health centre, TBAs place, Church/Spiritual healing homes, Home)

Birth attendants: People who conduct/assist during delivery for these child bearing women. (eg Nurse/ midwife, doctors, TBAS, pastors /spiritual women, mothers, sisters etc).

Women of child bearing age: Women who are still in their reproductive years

Choice of birth place: Preferences of birth places. Where women prefer to deliver their babies eg hospitals,

CHAPTER TWO
LITERATURE REVIEW

This chapter deals with the review of relevant literature as it relates to choice of birth place and use of birth attendants during delivery. It is presented and discussed under the following headings:

1. Conceptual review
2. Review of related theories
3. Empirical review
4. Summary of reviewed literature

Conceptual review

Concept of birth place

A birth place is where someone was born or where something originated (Harper, 2003) Health facility delivery can occur at private or public facility. Public facilities are usually owned and financed by the government and/or supported by some faith based organizations. In these settings costs are usually minimal but available amenities are often sub-optimal. Although private facilities are more expensive, they are often perceived as having the best amenities and offering the best standard of care (Umurungi 2010).

Health institutions: These are public or non profit organizations that provides healthcare and related services including but not limited to the provision of in patient and out patient care, diagnostic and therapeutic services ,medicinal drugs, nursing care, assisted living, elderly care and housing, including retirement communities and equipment used or useful for the provision of healthcare and related services. www.Oregan Laws.Org. According to Izugbara and Duru (2009), in Nigeria and many parts of Africa we have other types of healthcare providers and these include:

The traditional medical practitioner or traditional healer: This is defined as someone who is recognized by the community in which he lives as competent to provide healthcare by using vegetable, animals and mineral substance and certain other methods based on the social, cultural, and religious background as well as certain knowledge attitude and beliefs regarding physical social and mental wellbeing and the causation of disease in the community. The traditional healers are established healthcare workers within their communities. It has been estimated that 60 ï 80% of the South African population currently use traditional medical sector as their first contact for advice and/or treatment of health

concern. (Izugbara & Duru 2009) In Nigeria, it is estimated that ethno medicine is actually the only healthcare resource accessible to a third of the population. Traditional medical practitioners treat all age groups and all problems. Under this group of practitioners are the herbalists, prophets, faith healers, and diviners ((Izugbara & Duru 2009).

1. **The Herbalists: T**hey use herbs in curing and treating their patients
2. **Prophets and Faith healers**: They use prayers, candle lights and water For diagnosis and treatment.
3 **Diviners**: They act as intermediaries between humans and super naturals. They use divination in diagnosis and casting of spell in their treatment. (Izugbara & Duru (2009)

Birth attendants during delivery

There are many types of healthcare providers during delivery. These include both professional health care providers and traditional healthcare providers. Professional healthcare providers are those approved and certified by their professional bodies to take care of women during pregnancy, labour , delivery and immediate post natal period and also to care for the newborn. These include:

Midwives: Midwives are trained to identify possible problems in pregnancy, and they work together with physicians when necessary for complicated pregnancies. Women give birth with midwives in birth centres, at home and in hospitals. Under the types of midwives, there are registered midwife and registered nurse midwife (RM&RN/RM) A registered midwife is one who has undergone midwifery training and is registered by the countryôs nursing and midwifery council to practice midwifery.

Registered nurse/midwife: This is a registered nurse who has additional education and certification in midwifery. A registered nurse midwife is trained to provide pre natal care, education and support; attend birth in a birth centre hospital or home and provide follow up care to mother and newborn after birth.

Family physicians: These focus on the healthcare need of the family, not all family physicians include maternity care in their practice.

Obstetricians: Obstetricians care for woman before, during and after their pregnancies. They are trained to identify and treat medical problems in pregnancy. They are trained in surgery and are able to perform ceasarean section.

Skilled birth attendant

According to WHO (2004) a skilled attendant is a health professional ï such as a midwife, doctor, nurse ï who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and immediate post natal period and to identify, manage or refer women and their Newborns with complications . Recognizing that the qualifications attributed to health providers not only vary between countries but can change over time within a single country, the WHO, the International Confederation of Midwives (ICM) and the International Federation of Gynaecology and Obstetrics (FIGO) have developed a competency based definition of a skilled attendant.

A skilled attendant should be able to do the following:

- Manage normal labor and delivery
- Recognize the early signs of major obstetric complications.
- Perform essential life saving intervention and refer as appropriate.
- Provide high quality culturally appropriate and considerate care, including follow up and linkages with other services (WHO 2004)

The term ñskilled attendants at birthò 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 intervention, start treatment, and supervise the referral of mothers and baby for interventions that are beyond their competence or not possible in the particular setting. In order to save lives, skilled attendants need to be linked up with a larger health care system with facilities, supplies, transportation and professionals to provide emergency obstetric care when it is needed.(UNFPA , 2004).

Skilled Care: This refers to the process by which a pregnant woman and her infant are provided with adequate care during pregnancy, labour, birth , post partum, and immediate newborn period, whether the place of delivery is the home, health centre, or hospital. In order for this process to take place, the attendant must have necessary skills and must be supported by an enabling environment at various levels of the health system, including a supportive policy and a regulatory framework; equipment and infrastructure and efficient and effective system of communication and referral/ transport. Skilled care therefore includes care for women with life threatening complications, but is not limited to that care. The skilled

care approach is based on the premise that all women are entitled to good quality care during childbirth. It assumes that such care can prevent some complications (e.g through hygiene practices and active management of the third stage of labour), increase the likelihood of immediate, appropriate treatment when complications do develop; and encourage prompt, timely referral as necessary. (Skilled care during childbirth information booklet of family health international 2001).

According to WHO (2005) one of the methods of reducing maternal mortality is to ensure skilled attendance at delivery and strengthen health system to ensure 24hours emergency obstetric care. Since much of maternal healthcare depends on skilled attendance long term strategic resource planning cannot be over emphasized. Gabrysh and Campbell (2009) stated that skilled attendance at birth is crucial for decreasing maternal and neonatal mortality; yet many women in the middle and low income countries deliver outside the health facilities without skilled help. Most obstetric complications occur around the time of delivery and cannot be predicted. Therefore it is important that all pregnant women have access to a skilled attendant. Skilled attendance at delivery is advocated as the single most important factor in preventing maternal deaths and proportion of births attended by skilled health personnel is one of the indicators for Millennium Development Goals. Access to skilled delivery care is also crucial to prevent still birth and improve newborn survival.

Skilled attendants can perform deliveries either at home, health centre or in hospitals but it is argued that the most efficient strategy for lower income countries is to place them in health centres with referral capacity. In practice, skilled attendance in most countries is synonymous with facility delivery (Gabrish & Campbell 2009). Idris Gwarzo and Shehu (2003) pointed out that every year, more than 20 million women become pregnant and some 15% are likely to develop complications that will require skilled obstetric care to prevent the unacceptably high maternal morbidity and mortality. Majority of the maternal deaths that occur are avoidable or preventable. An emerging consensus has it that these deaths can be prevented if deliveries are overseen by skilled attendants. They observed that it has been estimated that only 50% of women in the world have access to such skilled care. According to them, maternal deaths are strongly associated with inadequate medical care at the time of delivery and majority of these maternal deaths are avoidable or preventable if skilled care is given during delivery. Many women loose their lives in the process of procreation. Iyaniwure and Yussuf (2009) observed that adequate antenatal care and skilled obstetric assistance during

delivery are important strategies that significantly reduce maternal mortality. They further asserted that it is true that ANC provides avenue to provide pregnant women with information, treat existing social and medical conditions and screen for risk factors; it is not enough to receive ANC since majority of the complications occur during or shortly after delivery. It is therefore important that pregnant women have skilled obstetric attendance during delivery.

Uzochukwu (2004) observed that while an estimate of 97% of the pregnant women in developed countries receive ANC and delivery, 65% and 53% of women in developing countries use ANC and obstetric care respectively. According to WHO (2005), the history of success in reducing maternal and newborn mortalities show that skilled professional care during and after childbirth can make the difference between life and death for both women and their newborn babies. The converse is true as well; a breakdown of access to skilled care may rapidly lead to an increased unfavorable outcome. The challenge is to find a better way of establishing continuity between care during pregnancy, at birth and when the mother is at home with her baby. It observed that the weakest link in care chain is attendance at birth. Women risk death to give life, but with skilled and responsive care at birth and after birth, nearly all fatal outcomes and disabling sequel can be averted ï the tragedy of obstetric fistulas, for example and much of the suffering can be eased.

Childbirth is central event in the lives of families and in the construction of communities it should remain so but it must be safe as well. They further stated that for optimum safety, every woman, without exception, needs professional skilled care when giving birth where she lives and respect her birthing culture. Such care can be provided by a registered midwife or a health worker with midwifery skills in decentralized first level facilities. This can avert, contain or resolve many of the life threatening problems that may arise during childbirth, and reduce maternal mortality to a surprisingly low level. According to UNFPA (2011) Skilled attendance denotes not only the presence of midwives and other 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. Historical as well as contemporarily evidence from many countries, 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 skilled health provider is one of the two indicators for measuring progress towards the 5th MDG improving maternal health.

According to De Bernis, Sherrat, Abouzahr & Lerberghe (2003), today we know how to prevent and manage pregnancy related complications and there is increasing recognition that pregnant women should be assisted by necessary skills, drugs, supplies equipment and backup particularly during and immediately following childbirth. In the absence of such professional assistance women pay a heavy price ï maternal mortality rates of 1000 ï 2000 per 100,000 births. The clinical rationale for skilled care during pregnancy and childbirth is unassailable. Skilled attendants, people with midwifery skills, such as midwives, doctors and nurses who have been trained to manage normal (uncomplicated) pregnancies, childbirth and immediate postnatal period, and identify, manage or refer complications in the woman and newborn are the best placed to ensure the survival and safety of pregnant women and their infants. Whatever their professional title, health professionals functioning as skilled attendants should be able to identify early signs of complications and offer first line emergency obstetric care including emergency in newborn when needed.

Yanagisawa, Oum and Wakai (2009) observed that obstetric complications are the leading causes of death among women of reproductive age in many developing countries. Globally, more than 200 million women become pregnant each year and 40% are estimated to experience pregnancy related health problems with 15% experiencing serious or long term complications and 1.7% developing fatal complications. The lifetime risk of deaths due to pregnancy related complications is 250 folds higher among women in developing countries. It is estimated that 88 ï 98% of these deaths are avoidable and 70% are related to five direct obstetric conditions ï post partum haemorrhage, puerperal pre-eclampsia and eclampsis, obstructed labour and abortion. Thus management of these complications is the key to improve maternal health. Acquiring the aid of skilled attendants to improve the management of pregnancy and related complications is an effective means to reduce maternal mortality.

According to Hunt et al (2002) in Yanagisawa (2006), a previous ethnographic study indicated that despite the ready availability of skilled attendants women often prefer traditional birth attendants (TBAs) to assist during deliveries. To promote the skilled attendant use, it is necessary to identify the determinants that are to be considered in case of skilled and unskilled birth attendants. Globally, some 80% of maternal deaths are due to a

few direct obstetric complications ï sepsis, heamorrhage, eclampsia, abortion; most could be prevented and managed if the woman had access to skilled attendants with the necessary backup and support. The remaining deaths, those caused by conditions exacerbated by pregnancy e.g. severe anaemia, tuberculosis, malaria and HIV/AIDS, also require the assistance of a skilled healthcare provider during pregnancy, birth and immediate post natal period for appropriate management and treatment. Complications that result in maternal mortality and morbidity also contribute to the majority of newborn mortality and morbidity. Some of these complications can be prevented with appropriate management of labour and birth e.g. clean birth and monitoring of labour to recognize prolonged and obstructed lablour as well as signs of fetal distress. Even when these complications cannot be prevented like in vast majority of maternal complications, they can be effectively managed. However this requires Health care provider with requisite skills as well as a functional referral system. (Bernis et al 2003).

Teijingen, Amalraj & Dahkal (2011) observed that in Nepal (81%) deliveries take place at home. Traditional Birth Attendants (TBAs) and unskilled birth attendants such as family members and relatives are common while some women 7% give birth without support. Evidence suggests that having skilled attendants at delivery is one of the key interventions for reducing maternal mortality. Developing countries where professional attendants are used at delivery have reduced maternal mortality up to 50 per 100,000 live births. Local TBAs are not recognized by WHO because they are generally not trained to deal with birth-related complications

The traditional birth attendants (TBA)). WHO(1978) in Mbiydzenyuy (2012) defined the traditional birth attendant as a person (usually a woman) who assist the mother at childbirth and who initially acquired her skills delivering babies by herself or working with other TBAs. The term traditional birth attendant is one around which there is currently a lot of controversy and debate. It is used to define a wide and heterogeneous group of traditional carers most of whom operate in the informal sector, and their individual competencies and skills can vary considerably, as can the names and titles by which they are commonly referred to, depending on the specific country context (Bernis 2003). Although in some countries it is clear that women utilize the skills of such careers. Research findings indicate that training TBAs is not an effective strategy for reducing maternal mortality For example a study comparing maternal mortality and morbidity in two urban populations in Senegal shows that even

trained TBAs were unable to accurately recognize signs of complications early or were unable to make a correct diagnosis and take appropriate actions for managing complications. Bernis et al (2003). According to Iyaniwure and Yusuf (2009), the increased proportion of the deliveries at TBA homes may also be associated with the prevalent supernatural concept of disease in many African communities. Twenty nine percent (29%) of ANC attendees in Equatorial Guinea expressed that TBAs were better than orthodox practitioners in some respects because TBAs possess spiritual powers and can intervene in certain situations where medical interventions cannot help. TBAs may for economic reasons also rank strongly in the preference of some Nigerian women as their services have been reported to be more affordable. Additionally, TBAs may offer more convenient user charges that allow payment to be spread over a period of time or be made in kind.

Among professionals, opinions differ about the role of TBAs in maternity care while some insists that in the interest of maternal health, empowering TBAs through training and retraining is the best option because community members will continue to patronize them, others express that TBAs have little role in obstetric care. The debate of who is qualified to take delivery of a pregnant woman in labour has been renewed as the Lagos state government released its 2010 maternal mortality health survey conducted by IPas, sexual reproductive health organization. According to Adebayo,(2012), stake holders in the medical profession, obstetricians who were present at the presentation called on the state government to reverse its policy that allows (TBAs) trained by the state to take delivery of pregnant women. According to them, the move is practically endorsing unskilled personnel to attend to pregnant women. This they warned could increase maternal and infant mortality rate in the country. The experts criticized the state governmentôs initiative which has seen over 1,264 TBAs trained in the past two years in primary health care centres to offer midwifery services in local government areas in the state. In view of this, the country Director of IPas Dr. Ejike Orji, said ñ though TBAs are a relevant chain in the maternal and child care system of the country, they lack the knowledge and skill to save a mother and her baby from dying during deliveryô. According to him, TBAs cannot recognize and also intervene medically in the five leading causes of maternal deaths during childbirth which include obstructed labour, unsafe abortions, eclampsia, heamorrhage and infection. He pointed out that previous programmes that championed the training of TBAs to take deliveries in Africa had been scrapped after research has shown that maternal mortality has increased as a result of such training.

Choice of birth place Umurungi (2010) observed that the majority of births in sub-Saharan Africa still occur at home or in other non-hospital settings. In resource poor settings, home delivery is usually the cheapest option but is associated with attendant risk of infection and lack of available equipment should complications occur. In rural areas of Nigeria, the proportion of institutional deliveries is as low as 4% even in urban areas like Lagos, a significant proportion of women (19%) still deliver at home. This is in spite of a relatively easy access to institutional maternity services in urban areas. Health facility delivery can occur at private or public facilities. Public facilities are usually owned and financed by the government and/or supported by some faith based organizations. In these settings costs are usually minimal but available amenities are often sub-optimal. Although private facilities are more expensive, they are often perceived as having the best amenities and offering the best standard of care (Umurungi 2010). In Nigeria, use of reproductive health services remain low and home delivery among women of childbearing age is widespread (Aremu 2011). According to Babalola & Fatusi (2009),the roles of traditional and religious beliefs as well as the perception of women with regards to comparative efficacy of the medical versus traditional birth attendants may also be contributing to failure to have skilled attendants at birth .Modern (medical) and indigenous maternal health care services coexist in most African countries particularly in rural areas and women may have to choose between the two options He stated that many Nigerian women particularly those in rural areas rate the services of TBAs as being of higher quality than that of medical healthcare practitioners particularly with regards to interpersonal communications and relationship. TBAs have been reported to be more considerate and to provide more compassionate care other places that delivery occur

Consequences of delivering in non-health facility

Childbirth in a health facility while attended by trained health professional has been shown to be associated with lower rates of maternal and neonatal mortality compared to home birth. In poor settings, non-health facility deliveries are associated with increased maternal morbidity and mortality and increased newborn morbidity and mortality. In developed countries, some studies conducted in the United States of America between 1989-1996 have shown an increased maternal and neonatal risk associated with planned home birth (Umurung 2010). According to Titaley, Hunter, Dibley and Heywood (2010), in low and middle income countries, many deliveries still occur at home without the assistance of a trained attendant. This has generated serious concerns since women who develop life threatening complications

during pregnancy and delivery require appropriate and accessible care. 20 ï 30% of infant mortality could be reduced by implementing skilled birth care services.

Determinants of choice of birth attendants among women

Utilization of health services is a complex behavioral phenomenon .The use of health services is related to availability, quality, cost of service as well as social structure, health belief and personal characteristics of the user. Birth place and health care provider during delivery is determined by a barrage of factors which act singly or in combination to enhance or deter women from choosing skilled healthcare provider during delivery. The proportion of births conducted by a skilled attendant has become an indicator for monitoring progress towards reduction of maternal mortality. In Nigeria, the antenatal care coverage according to data from UNICEF (2006) to (2010) once is 58% while coverage for four times is 45%. Delivery coverage for skilled attendant at birth is 39%and institutional delivery coverage is 35% for the same period. This percentage attendance during ANC does not translate to the same percentage of institutional delivery rates. The proportion of deliveries conducted by skilled health care provider is 39% nationally. The gap between antenatal care attendance and attendance during delivery suggests that there are factors making women not to return to the health facilities during delivery and these factors need to be explored and taken care of. Using the themes developed by Gabrysh and Campbell (2009) linked to the conceptual framework developed by Anderson (1995), the determinants are categorized into the following themes:

- Socio-cultural factors
- . Perceived benefit or need of skilled attendance
- . Economic accessibility
- Physical accessibility

Socio-Cultural Factor

Socio-cultural factors considered here are:

Maternal age: According to Gabrysh and Campbell (2009), age is often presented as a proxy for use of health services. Older women are also influential in household decision making than younger women and the adolescent in particular. Furthermore, older women may be told to deliver in a health facility since older age is a biological risk factor. On the other hand, older women may belong to more traditional cohorts and thus be less likely to use modern

facilities than young women. Age is highly correlated with parity, and in some settings, with educational level. It is also associated with marital status unwantedness of a pregnancy, socioeconomic status and decision making power. Umurungi (2010) stated that it is recognized that womenôs current age plays an important role in the utilization of medical services.

Motherôs age may sometimes serve as a proxy for womenôs accumulated knowledge of health care services, which may have a positive influence on the use of health services. On the other hand, because of development in modern medicine and improvement in educational opportunities for women in recent years, younger women might have enhanced knowledge of modern healthcare services and place more value upon modern medicine. Iyaniwure and Yusuf (2009) stated that young women maybe unmarried and may lack social support. They may be unable or unwilling to use maternal health services depending on the circumstances surrounding their pregnancy. It is unfortunate that women who appear to be at higher risk such as young uneducated and poor women are less likely to access the appropriate services.

Marital status: Marital status may influence the choice of delivery place, probably via its influence on female autonomy and status through financial resources. Single or divorced women may be poorer but enjoy greater autonomy than those currently married. Young single mothers may be cared for by their natal families which may encourage skilled attendance especially for a first birth. On the other hand, single mothers may be stigmatized and prefer to deliver at home because they anticipate a negative provider interaction Umurungi (2010)

Family size/family compostion: Family size is an important determinant of health care utilization. Women from large families under-utilize various health care services because of excessive demands on their time. Larger families also cause resource constraints which have a negative effect on health care utilization (Umurungi 2010). On family composition, Gabrysh &Campbell (2009) said that women with young children may have difficulties finding child care while they deliver at a health facility in particular if they live in a nuclear family. Sometimes women are accompanied by family members during their trip to hospital, so that even these cannot take care of other children during the time. In addition to influencing the ease of leaving home, living with an extended family may also influence the decision making power of the woman; Charaborty (2003) observed that one of the important

predisposing factors for utilization of healthcare is family size. Women from large families under-utilize various health care services because too many demands on their time force them to forgo healthcare. Larger families also cause resource constraints which have a negative effect on health care utilization.

Mother's education: There are multiple potential pathways that could explain why maternal education is constantly and strongly associated with all types of health behavior. These include increased knowledge of the benefits of preventive healthcare and awareness of health services, higher receptivity of new health information, socialization to interact with formal services outside the home environment, familiarity with modern medical culture, access to financial resources and health insurance, more control over resources within the household and wiser spending, more egalitarian relationship and better communication with the husband, more decision making power, increased self worth and self confidence, better coping abilities and negotiating skills as well as reduced power deferential towards health care providers and thus better communication and ability to demand adequate services. Education also affects a womanôs childhood background, including familiarity with health services and certain beliefs and norms. It has also been suggested that there may be community effect of education, with more highly educated communities organizing themselves and demanding better public services and a higher position for health on the political agenda.

By contrast, better awareness of poor quality in many facilities and higher confidence in self care may delay care seeking among educated women. Furthermore, where public health programs reach out to disadvantaged sectors of the population, the education gradient in health services use may be small (Gabrysh and Campbell 2009). Womenôs literacy is an important predictor for the use of maternal healthcare services. It is well recognized that a womanôs educational level has a positive impact on healthcare utilization. Increased education influences service use by increasing female decision making power, increasing awareness of health services changing marriage patterns and creating shifts in household dynamics (Umurungi 2010). According to Raghupathy (2009), maternal schooling does not have a uniform impact across all services, nor are these effects necessarily positive. While there is positive effects of schooling in the use of prenatal care, the educational differentials in the use of delivery assistance starts emerging only after secondary school (Sabona,

(Ragupathy 2009) Motherôs education is the most constituent and important determinant of use of child and maternal health services said (Ahmed et al, 2010).

Husband's education: Educated husbands may be more open towards modern medicine, aware of the benefits of skilled attendants and more able to communicate with health workers and demand appropriate care, as described for womenôs education. They may also put fewer constraints on their wives mobility and decision making thus facilitating care seeking.

Women's autonomy: The various dimensions of autonomy such as the position in the household, financial independence, mobility and decision making power regarding oneôs own healthcare may all impact on health facility use. In many countries, women cannot decide on their own to seek care, but have to seek permission a husband or mother-in-law. Furthermore, women may lack control over material resources to pay for expenses, their mobility may be restricted or they may lack access to vehicles or even bicycles or donkeys. (Gabrysh & Campbell 2011). According to Fotso, Ezeh and Essendi (2009), a womanôs autonomy is generally defined as the ability to make and execute decisions regarding personal matters of importance on the basis of the womanôs power over others, access to information, control over material resources and freedom from violence by her husband or other men. Others have conceptualized autonomy as womenôs ability to determine events in their lives even though men and other women may oppose to their wishes. According to Self and Grabowski (2012) decisions within the household determine the allocation of resources. Theory suggests that the more autonomous women are within the household, the greater influence they will have in that allocation. It is hypothesized that the greater the womanôs autonomy, the more likely she will be to visit a doctor, rather than other traditional sources of healthcare when ill. So enhancing the autonomy of women is a laudable goal in and of itself. Determinants of poor maternal and infant outcome include poverty and cultural factor which restrict womenôs autonomy, promote early marriage and or support harmful traditional practices (Reynolds et al 2006).

Decision making on utilization of health services related to womenôs autonomy is defined as ability to make decisions in the household. Studies have indicated that in some sub-Saharan countries, men generally are decision makers regarding the location at which their spouses should give birth. Where as in East-Asia it is mostly mother in-laws who determine the location of birth. At the international conference on population and development held in

Cairo, Egypt in 1994, it was affirmed that when women are empowered to make own decisions, they would access health services more quickly. In some sub-Sahara African countries, men generally are decision makers regarding the location at which their spouses should give birth. (Ahmed et al, 2010), Kabakyenga et al (2012).

Wagle, Sabre and Nielson (2004) in their study on socio-economic and physical distance to the maternity hospital as a predictor for place of delivery, stated that most of the women narrated if they could choose, they would prefer to deliver in a health institution assisted by a professionally skilled person. Nevertheless, the decision was not simply their own, and the influence from other members of the household seemed strong especially older women in the family like mothers, grandmothers, mother in-laws and husbands. According to Furuta and Salaway(2006) earlier work in south-Asia has suggested. Inequitable gender roles and womenôs position within the households, as influencing use of services. Gender roles and relations may operate to restrict womenôs access to health care during pregnancy and at the time of delivery. These include heightened restrictions on womenôs movement because the pregnant state is considered ñshamefulò. Young womenôs lack of say within the family and the fact that pregnancy related knowledge and decision-making authority are commonly vested in older women, young womenôs lack of influence over material resources, and the exclusion of men, who are often the primary decision makers in the use of material resources from the polluting event of childbirth determine use of services

(2) Perceived Benefits/Needs

Under perceived benefits are such factors as:

Information availability, health knowledge, perceived quality of care pregnancy wanted/unwanted, antenatal care use, previous delivery service use, birth order, complications. According to Gabrysh and Campbell (2009). This category comprises factors influencing the perception of how a facility delivery with skilled attendance will benefit mother and newborn and/or how big the personal need for such care is. This perception is shaped by the general awareness of the dangers of childbirth and interventions available at health facilities by individual past experiences with pregnancy childbirth and health services, as well as by risk assessment of the index pregnancy. Factors in this category are thought to primarily affect the decision to seek care.

Information Availability: Having access to information through modern media could influence womenôs knowledge about delivery risks and availability of services. It may be

hard to disentangle access to information from possession of radio or TV and a higher socio-economic status that makes this more likely. Literacy is essential for access to written information

Health Knowledge: Specific knowledge about the risk of childbirth and the benefits of skilled attendance should increase preventive care seeking, while recognition of danger signs and knowledge about available beneficial intervention should increase care seeking for complications. Contact with a skilled attendant could increase specific knowledge on childbirth via health education. Specific knowledge may also be associated with educational level in general (Umuringi 2010).

Perceived Quality of Care: Perceived quality of care is thought to be an important influence on healthcare seeking. Assessment of quality of services largely depends on peoples own experiences with the health system and those of people they know .Elements of satisfaction cover satisfaction with the outcome, the interventions and with the service received ï including staff friendliness, availability of supplies and waiting times. In many cases, the medical culture may clash with the womanôs for example, when family members are not allowed to be present, supine birthing position is imposed or privacy not respected, this may lead to perception of poor quality (Thaddeus and Maine 1994 in Gabrysh & Campbell 2009).

Healthcare providerôs attitude is another essential component of quality of health services. According to Amankwa (2010), staff attitude remains a hindrance to accessing professional services among pregnant women in rural Tanzania (Mrisho et al., 2007) Poor healthcare providerôs attitude and fear of punishment by healthcare provider in form of abusive language, denying women service, lack of compassion and refusing to assist properly resulted in seldom decision making among the pregnant women to deliver in a health facility. Many women report dissatisfaction with rude, arrogant and neglectful behavior at health facilities and prefer the care of TBAs or relatives. (Gabrysh & Campbell 2009)

Wanted or Unwanted pregnancy

Women with unwanted pregnancies may be less likely to invest in skilled attendance at delivery than those who attach high value to the expected child. Delivery care may be sought due to the risk for the mother rather than the child.

Previous delivery service use: Women who delivered with a skilled attendant previously become more familiar with this setting, which may make them likely, use it again.

Birth Order/parity : The first birth is known to be more difficult and the women have no previous experience of delivery. Often a high value is placed on the first pregnancy and in some settings; the womanôs natal family helps her get the best care possible. Furthermore, health workers may recommend a facility delivery for primipara. By contrast women of higher parity can draw on their maternity experiences and may not feel the need to receive professional care if previous deliveries were uncomplicated. Also women with several small children may have greater difficulty in attending facilities due to the need to arrange child care. According to Amankwa (2010) Parity is another significant factor that can influence a womanôs decision to deliver with a skilled attendant He cited Bangladesh where women with lower parity are less likely to deliver at home

Ekene &Tunau (2007)in Amankwa (2010) stated that in Sokoto in Nigeria, women of high parity were found to be more likely to decide to prefer home delivery with unskilled attendants

Antenatal Care. ANC services can provide opportunities for health workers to promote a specific place of delivery or give women information on the status of their pregnancy, which in turn informs their decisions on where to deliver.

Risk assessment during ANC may explicitly recommend a place for delivery, for instance to deliver in a hospital for twin pregnancy. On the other hand women who are told their pregnancy is fine may feel encouraged to deliver without a skilled attendant.

Complications: Complications experienced during previous deliveries or loss of the newborn can make women aware of the dangers of childbirth and the benefits of skilled intervention and thus make them use skilled attendance for subsequent deliveries. Furthermore women with specific medical intervention in a previous delivery example cesareans section will be encouraged by health workers to seek skilled care for subsequent deliveries since there is an increased risk for rupture with a scarred uterus. Complications during an attempted home delivery often influence women and their families to seek professional care, even though the original intention was to deliver at home.

(3) Economic accessibility

Economic accessibility refers to the relation between financial capability of the family and cost of a facility delivery including transportation costs while directly affecting whether a woman can actually have a facility for delivery (second delay) the anticipation of a high cost will affect whether a decision for a facility delivery is made in the first place (first delay) Gabrysh & Campbell (2009). Under this group are factors such as motherôs occupation,

husbandôs occupation and other measures of ability to pay including community level poverty.

Mothers Occupation: Women who are working and earning money will be able to save and decide to spend it on facility delivery. However, in many settings women either do not earn money for their work or do not control what they earn. An increased range of movement and better access to information are suggested as reasons why formal work may promote womenôs use of health facilities for childbirth. On the other hand, working may be poverty induced and indicate resource constraints, which would make working women less likely to use health services for delivery. According to Chakraborty et al (2003) womenôs involvement in gainful employment is one of the important factors positively affecting the use of quality medical care to treat complications. This also empowered women to take part in decision making processes about health care in the family

Husband's occupation: Wives of husbands with higher status occupation could be more able to use facilities for delivery. High status occupations are associated with greater wealth, making it easier for the family to pay costs associated with skilled delivery care. Certain professions include health insurance benefits making care seeking less costly. Women whose husbands worked in business or services were most likely to be users of modern health care services to treat complications during pregnancy (Chakraborty et al., 2003)

Ability to pay: The cost of care seeking may include costs of transportation, medication and supplies, official and unofficial provider fees as well as the opportunity cost of travel time and waiting time lost from productive activities (although women in the late stages of labor are unlikely to do any production other than reproduction) where women do not travel alone, accompanying adults or children for whom no caretaker can be found increase opportunity costs, transportation costs and costs for staying over might in the town where the health facility is located. Wading et al (2009) asserts that empirical evidence has revealed that negative impact of commercialization of public health services delivery on attainment of Millenium Development Goals in Nigeria. Households on a tight budget will have great difficulties to pay their costs and therefore be less likely to use a health facility for delivery. Another reason for greater use of services is that households with higher living standard are more modern and therefore more receptive towards modern health care services on a larger scale Communities with less economic development are likely to be more traditional, give women less autonomy and have less positive attitudes towards services use. An alternative mechanism how economic status affects care seeking is that the characteristics of the health facilities serving the poor may discourage use. This may stem from inferior quality of care or

worse availability of services in poor areas thus requiring users to travel long distances. Cost and distance (from health facility) often go hand in hand as longer distances entail higher transportation costs (Thaddues and Maine 1994 in Gabrysh and Campbell 2009).

(4) Physical accessibility.

Region and place of residence: Since service and social environment are typically very different in urban and rural areas; strong urban-rural differences in use of delivery care are expected. Similar reason applies to differences between regions within a country and it can be difficult to know which factor to ascribe any differences in service use to. Place of residence may be associated with education and ability to pay.

Distance and transport: Distance to health services exerts a dual influence on use as a disincentive to seeking care in the first place and as an actual obstacle to reaching care after a decision has been made to seek it. Many pregnant women do not even attempt to reach a facility for delivery since walking many kilometers is difficult in labor and impossible if labour starts at night and transport means are unavailable. Those trying to reach a far off facility often fail and women with serious complications may die en route. (Thaddeus & Maine 2006 in Gabrysh & Campbell 2009).

Babalola &Fatusi(2009) observed that poor staffing in the health facilities particularly the primary health facilities which makes it difficult to guarantee 24hour availability of services had also been reported as a factor that discourage women in Nigeria even when they have received ANC to seek medical services when labour commence The roles of traditional and religious beliefs as well as the perception of women with regards to comparative efficacy of the medical versus traditional birth attendants may also be contributing to failure to have skilled attendants at birth .Modern (medical) and indigenous maternal health care services coexist in most African countries particularly in rural areas and women may have to choose between the two options He stated that many Nigerian women particularly those in rural areas rate the services of TBAs as being of higher quality than that of medical healthcare practitioners particularly with regards to interpersonal communications and relationship. TBAs have been reported to be more considerate and to provide more compassionate care. Mrisho, M., Schellenberg, A.J, Mushi, K.A. Obrist B., Mshi NDA, H., Tanner, M,. and Schellenberg, D,. (2007) observed that another important factor that influences quality of healthcare services is accessibility to health centre. The standard is that

every pregnant woman should have access to a health facility within less than 5km. Lack of transportation has been identified as one major contributor to many home deliveries in rural areas

Review of Related Theories

Around the world, there is significant unmet need for health care. With a better understanding of why people use or do not use these services, health care organizations can seek to improve the quality of human life by bridging the detected gaps to enhance utilization.:

Anderson's Model Of Health Services Utilization.

Andersonôs model of health services utilization was reviewed and used for this study. Anderson (1968) developed a model of healthcare utilization which looks at three categories of determinants:

1. **Predisposing characteristics**: These categories represent the proclivity to utilize health care services. According to Anderson, an individual is more or less likely to use health services based on demographics, position within the social structure and belief of health services benefit. An individual, who believes health services are useful for treatment, will likely utilize those services.
2. **Enabling characteristics**: These include resources found within the family and the community. Family resources comprise economic status and the location of residence. Community resources incorporate access to health care facilities and the availability of person for assistance.
3. **Need based characteristics**: These include the perception of need for health services, whether individual, social or clinically evaluated perception of need (Wolinsky 1988)

In the 1970ôs Andersonôs model was later expanded and refined to include the health care system. The health care system includes health policy, resources and organization as well as the changes in these over time. Resources comprise the volume and distribution of both labour and capital including education of health care personnel and available equipment. Organization refers to how a health care system manages its resources which ultimately influences access to and structure of health services. According to this level of revised model,

how an organization distributes its resources and whether or not the organization has adequate labour volume will determine if an individual uses their health services. In addition, the updated model includes recognition that consumer satisfaction reflects health care use. The model also includes the notion that there are several health services available, and both the types of service available (i.e. a hospital, dentist, laboratory or pharmacy) and the purpose of the health care service (i.e. primary or secondary) will determine the type of service utilized. Thus according to the revised model, whether or not a specific healthcare service is utilized and the frequency a service is utilized will have different determinants based on characteristics of the population and the health services (Anderson 1995, Anderson and Newman 2005 in Rehban 2008).

During the 1980ôs and 1990ôs Andersonôs model was again revised to form three components with a linear relationship;

1. Primary determinants
2. Health behaviors
3. Health outcomes

Primary determinants: are noted as the direct cause of health behavior. These determinants include characteristics of the population (Demographics) Health care system (resources and organization), external environment (political physical and economic influence on utilization).

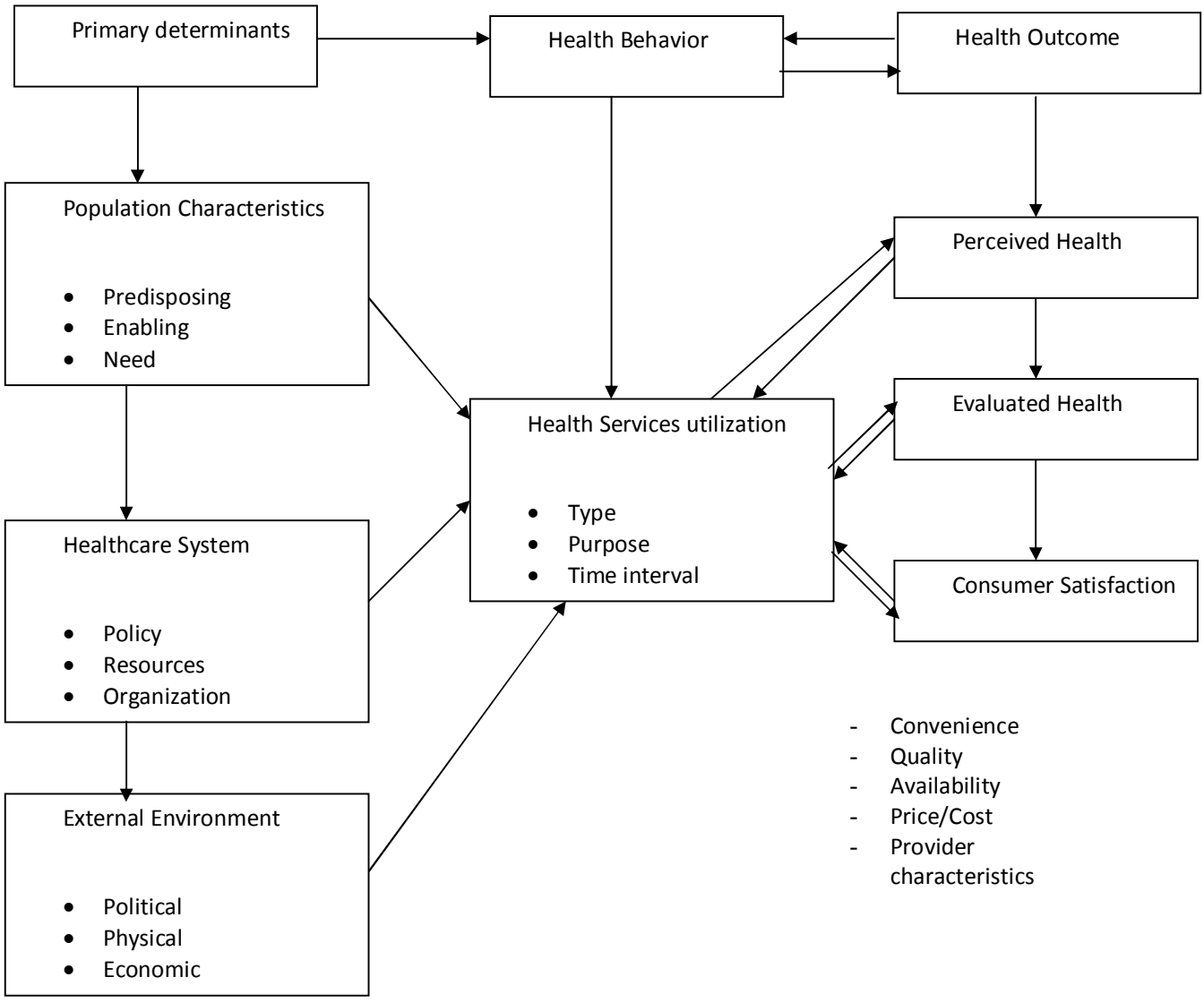
Health behaviour

The model explains that health behaviors are the direct cause of health outcomes

Health behaviours include; personal health characteristics, use of health services

Health outcomes includes: perceived health status, evaluated health status, and consumer satisfaction (Anderson **1995).**

Consumer satisfaction: include convenience of using the services, quality of the services provided, availability of the needed service, price or cost of the service, provider characteristics attitude, skills, proficiency etc. this will lead to the use of both preventive and emergency services.



Phase 3: Anderson's model of health services utilization. (Anderson 2005)

Relating the theoretical framework to this work:

Primary determinants:

Population characteristics: which include?

Predisposing characteristics example- age,

Age is often presented as a proxy. Older women may be told to deliver in the health facility since older age is a biological risk factor. Older women are also more influential in household decision making than younger women and adolescents in particular making them to have power of deciding where to deliver On the other hand, older women may belong to more traditional cohorts and thus be less likely to use modern health facilities than younger women. Young women on the other hand might have enhanced knowledge of modern

healthcare services because of their schooling. This will make them place more value on modern health services and use it. Young women may be unmarried and lack social support and this may make them unable and unwilling to use maternal health services.

Enabling characteristics eg : Income

Income can affect the type of health care provider to be utilized by an individual or family. Income determines the ability of an individual to pay. If the income is low one may decide to use traditional birth attendants, be assisted by family members or even deliver unassisted instead of going to a health facility just because of lack of funds. On the other hand one may prefer to use health care services with highly skilled personnel no matter how costly it may be if the fund is available.

Need Characteristics: If one perceives labour and delivery as a serious problem, need for advanced care arises, she will look for a skilled health care provider. Also if a mother develops an illness or is diagnosed of any abnormality during pregnancy a need arises and it might make her choose to use a skilled healthcare provider based in a functional health facility during delivery. If the mother does not have any problem nor perceive labour as a serious problem she will not see need to use a skilled health care provider.

Health system

Under health system we have policy, resources and organization.

Policy: The type of policy run by a health system will determine whether it should be used or not. If the policy is favourable the populace will like to use it, if not nobody will choose it.

Resources: The resources available in a particular health system eg human resources. Qualified doctors, nurses, midwives etc. available equipments, facilities for blood transfusion , incubators tests etc. will determine whether one will choose it or not. Volume and distribution of labour in an organization also is a determinant

Organisation: The organization of health services eg 24hours service. How resources are managed and the structure of health services also will determine whether one will choose this health system for delivery or not.

Health services This includes type, purpose and time interval. The type of health services rendered by a healthcare provider or health system e.g ANC, post natal services, family planning, paediatric services, immunization, pharmacy, etc will make one choose or not to choose it.

Purpose: purpose include whether it is preventive or curative, primary or secondary health facility. This will make one to choose it or not depending on the need

Time interval: These include how often these services are rendered whether it is regularly available or not. If it is not always available at those intervals it will discourage clients from coming even when it is available.

External environment

Under external environment, we have political, physical and economic health. Political can be situation of health facilities eg some health services suffer non utilization due to political situation. It will not be available for the community if it is situated on problem land or because of lack of political will, it will not be equipped or the road to it will not be graded or tarred, this will bring about non utilization of the facility and the skilled care provider in it

Physical: This has to do with distance; if healthcare facility is far, it will involve paying transport. Some women with serious complications may die on the way thus discouraging clients. Very sick clients with emergency situations will not use it because there may be delay and death; also poor clients are discouraged because of lack of transport.

All the above primary determinants lead to health behavior. (Use of health services)

Health Behaviour

Health behavior here includes choice and use of health services.

The primary determinants will determine whether one will use healthcare services or not, the type of healthcare provider to choose during delivery, and purpose of choosing such healthcare provider. Choice and use of healthcare services leads to health outcome

Health Outcome

Use of health services determine health outcome. Under health outcome are

- Perceived health status
- Evaluated health status
- Consumer satisfaction.

Perceived health status- If a client use health services, she will be able to evaluate self from past experiences or from knowledge gained through health education given at the health facilities. This will make client to use health services promptly to avoid complications e.g a mother who attends ANC will be educated on danger signs of pregnancy and this will make her seek help early enough to avoid further complications and death whenever she sees the sign of complication; because she will perceive the complication as a danger to her health and that of her baby.

Evaluated health status: When one uses health services she will be able to benefit from evaluation of her health status by health care providers and be advised properly on what to do and the best place for her delivery. If any complication is detected, she will be informed earlier to enable her choose the appropriate healthcare provider during delivery.

Consumer satisfaction: Consumer satisfaction is very important for choice of health care provider. It is measured by such factors as

- Providerôs characteristics which include: whether providers are polite, well trained, proficient etc.
- convenience of using the health care services,-
- quality of care given by the provider,
- Time spent in the process of getting care from the provider etc.

When all of the above are met for any client, the client will choose the health care provider again and also recommend it to others; while if the consumer is not satisfied with the services of a particular healthcare provider, she will not choose the healthcare provider again and will not recommend it to anybody. The client will even discourage others from utilizing the services. In fact consumer satisfaction is a very important factor in health service utilization. Health outcome determine whether a client will choose a particular healthcare provider again or not. Health outcome determines health behavior, (choice of healthcare provider and use of health services) and health behavior determines health outcome.(wellness, early intervention in cases of complications, maternal wellbeing and reduction in maternal and infant mortality)

Empirical Review

Gabrysh & Campbell (2009) in their review of determinants of delivery service use, searched electronic databases to identify reviewed articles on determinants of delivery services use. They used already written articles from researchers to ascertain relevant studies on determinants of delivery service use. They identified twenty determinants and grouped these determinants into four themes

1. Socio-cultural
2. Perceived benefits/needs of skilled attendance
3. Economic accessibility
4. Physical accessibility

Using the review articles and over 80 original articles, they described the findings in more detail and from the result of their review, there is ample evidence that higher maternal age, education, household wealth, lower parity and urban residence increase use. Facility use in the previous delivery and antenatal care use are highly predictive of high facility use for the index delivery, though this may be due to confounding by service availability and other factors.

Obstetric complications also increase use. Quality care is judged to be essential in qualitative studies but is not easily measured in surveys. In their review, distance to health facility decrease use. From their study, they observed that studies of determinants of skilled attendance concentrate on socio cultural and economic accessibility variables and neglect variables of perceived benefit/need and physical accessibility. They finally concluded that it is important to consider as many influential factors as possible in any analysis of delivery service use.

In a study on determinants of use of maternal health services in Bangladesh, Chakraborty et al (2003) used random sampling to select 993 pregnant women out of 1020 who had one antenatal follow up , they attempted to examine the factors associated with the use of maternal health care services on the basis of data from the survey of maternal morbidity in Bangladesh conducted by Bangladesh Institute of Research for promotion of essential and reproductive health and technology. The results from both the bivariate and multivariate analysis confirmed the importance of mothersô education in explaining the utilization of healthcare service. They found out that independent of other womenôs background characteristics, household socioeconomic status and access to health care services, female education retain a net effect on maternal health service use.

In another study by Singh Rai, Alagarajan and Singh (2011) on services utilization among married adolescents in rural India, they used data from National family health survey (2005 ï 2006) available in public domain for use by researchers to examine the factors associated with the utilization of maternal healthcare among married adolescents women (aged 15 ï 19yrs) in rural India to measure their components of maternal health services utilization: full antenatal care, safe delivery and postnatal care within 42 days of delivery in the last five years preceding the survey. Findings of their analysis indicate significant difference in selected maternal healthcare utilization by educational attainment, economic status and

region of residence. It was also found out that Muslim women and women who belonged to scheduled castes, and other backward classes are less likely to avail safe delivery services. Also adolescent women from southern region utilize the highest maternal healthcare services than other regions showing regional differences. Thus they concluded that socio economic and cultural factors affect the utilization of maternal health services among rural adolescent women in India. Based on this they recommended that healthcare programs should start targeting households with married adolescent women belonging to poor and specific sub-groups of the population in rural areas to address the needs for maternal care services use.

Aremu, Lawoko and Dahlal (2011) in the study of neighborhood socio-economic disadvantage, individual wealth status and pattern of delivery care utilization in Nigeria, used a population-based multi level discrete choice analysis. This was performed using the most recent population based Nigerian demographic and Health survey data of women aged 15 and 29years .The analysis was restricted to 15,162 ever married women from 888 communities across the 36 states of the federation including the Federal Capital Territory Abuja. Result showed that the choice of place of delivery vary across the socio-economic strata. The multi level discrete choice models used indicates that with every other factor controlled for the household wealth status, womenôs occupation, womenôs and partnerôs high level of education attainment and possession of health insurance were associated with the use of private and government health facilities for childbirth relative to home birth. The results also show that higher birth order and young maternal age were associated with use of home delivery compared to the patronage of government health facilities

Adelaja (2011) studied home delivery and newborn care practices among women in a suburban area of western Nigeria. He carried out a cross sectional survey in the immunization clinic of Shagamu local government. A total of 300 mothers were interviewed using a semi structured questionnaire. Findings showed that, 66.7% of births occur at home were planned while. 33.3% were unplanned. Only 13.4% of deliveries had a skilled birth attendant present and (15.7%) gave birth alone.

A compiled data from national surveys from all continents done by Shanton et al(2006) showed that in all continents low parity women were more likely to seek skilled birth attendance. High birth order was found to be a predisposing factor of home delivery by Thind in India. Gabrysh and Campbell (2009) in their review of the determinants of delivery

service, searched PubMed and Ovid data base for review and ascertained relevant articles from these and other sources. . They found out 20 determinants of the use of health facility delivery or skilled attendant. Factors most consistently associated with receiving skilled care in their multivariate analysis are higher maternal age, low parity, maternal education, and higher household economic resources. According to their review, facility use for previous delivery and ANC use are also nearly always highly predictive of health facility use for the index delivery.

Wegle, Sabroe and Nielson (2004) in their study of socio-economic and physical distance to the maternity hospital as predictors for place of delivery in Nepal used a cross-sectional design to carry out a study between January 2001 and June 2002 in rural parts of Kathmandu and Dhading Districts of Nepal. They interviewed 308 women who delivered within 45days of date of the interview. With a pretested structured questionnaire. Findings showed that a distance of more than one hour to the maternity hospital, low amenity score status, low education, multi-parity and not seeking antenatal care in the present pregnancy were statistically significantly associated with an increased risk of home delivery. Ethnicity, obstetric history, age of mother, ritual observances of menarche, type and size of family and who is head of household were not statistically significantly associated with the place of delivery.

Babalola & Fatusi (2009) in the study of determinants of maternal health services utilization in Nigeria with a focus on household, community and state level factors. An interviewer administered nationally representative survey were analyzed to identify individual, household and community factors that were significantly associated with utilization of maternal care services among 2 148 women who had a baby during the five years preceding the survey. (2005) national HIV/AIDS survey. They analyzed an interviewer administered. Findings showed that approximately three fifths (60.3%) of the mothers in their study used antenatal services at least once during their most recent pregnancy while 43.5% had skilled attendants at delivery and 41.2% received postnatal care. It was also found out that education is the only individual level variable that is consistently a significant predictor of service utilization, while socio-economic level is a consistent significant predictor at the household level. At the community level urban residence and community media saturation are consistently strong predictors.

Selejeskog, Sundby and Chimango (2006)carried an explorative study in the Magochi area of Malawi on factors influencing womenôs choice of place of delivery with the aim of investigating individual, community and health facility factors influencing womenôs choice of place of delivery. In dept interviews and non-participating observation were the method s used. Findings showed that factors fall into three major categories : firstly, sub-optimal quality of care including communication, attitude and cooperation within the healthcare system was identified as a main factor. Secondly, cultural factors such as influence from decision makers, perceptions of danger signs and traditional views on pregnancy and delivery. Finally an unsatisfactory availability of skilled delivery care in terms of distance, transport and cost were also implicated.

Amankwa (2010) studied the determinants of skilled birth attendants in Bolgatanga Ghana. In assessing the determinants of skilled birth attendance, a descriptive cross-sectional survey was used over the period from July to October, 2008. The study involved interviews to a random sample of women (aged 15 to 49 years) who had given birth not more than a year prior to the survey. The survey instruments were pre-tested in two communities. The data collection tools included structured questionnaire (with open and closed ended questions), focus group discussion guide, and in-depth interview schedule. The study populations were women (aged 15 to 49 years) who had given birth within one year prior to the survey, their in-laws and husbands, and the traditional birth attendants (TBAs) in the study area. The following determinants were found to be significantly associated with delivery at health facility; the number of ANC visits, level of education. Religion. Distance to reproductive health facility, Duration of first ANC visit and level of awareness of pregnancy and labour danger signs. The findings also showed that parity is significantly associated with delivery at health facility

(Mahfuzar Shahidur &Syeda 2008) Onah et al (2006) also found in Enugu South eastern Nigeria, that there was statistically significant association between choice of institutional or non institutional deliveries among pregnant women and parity. They found out that primiparous women are more likely to use health services for delivery than multiparous women. Shanton et al in a study using data from several developing countries found out that women with higher parity were more likely to receive assistance from unskilled birth attendants. .

Yanagisawa (2005) on study of determinants of birth attendantôs choice of women in rural areas of Cambodia performed a population based survey on skilled attendant choice. By women in rural Cambodia to identify determinants of birth attendant choice, with contact with birth attendant as an exposure factor. Subjects were women aged 15-49years who had delivered babies during three months prior to the survey. Of the 980 included in the analysis, 19.8% had skilled attendants present at the birth. The determinants of facility delivery choice were different from skilled attendantôs choice in home birth and contact with birth attendants worked differently on the choices. For facility delivery choice, contact with skilled attendant through antenatal care was a significant determinant. For home births, the choice of skilled and unskilled attendants at the preceding delivery was a significant determinant. For community based programs, women who once chose unskilled attendants were five to seven times less likely to choose skilled attendants in the following delivery than primiparas.

In another study on womenôs preference for place of delivery in rural Tanzania by Kruk et al (2009), they fielded a population-based discrete choice experiment (DCE) in rural Western Tanzania, where only one third of women deliver children in a health facility, to evaluate health-system factors that influence women's delivery decisions. Women were shown choice cards that described 2 hypothetical health centres by means of 6 attributes (distance, cost, type of provider, attitude of provider, drugs and equipment, free transport). The women were then asked to indicate which of the 2 facilities they would prefer to use for a future delivery. They used a hierarchical Bayes procedure to estimate individual and mean utility parameters. A total of 1203 women completed the DCE. The model showed good predictive validity for actual facility choice. They found out cost and distance having a negative effect on over all utility. The most important positive facility attributes were a respectful provider attitude and availability of drugs and medical equipment.

Iyaniwura and Yussuf (2009) on their study on utilization of antenatal care and delivery services in Shagamu south western Nigeria found out that majority of the women received antenatal care (84.6%) during their last pregnancy, four fifth of those who received ANC first attended the clinic during the second trimester (79.6%). The places of delivery were government facilities (54.8%) private hospital (24.5%) traditional birth attendants (13%) spiritual healing homes 5.6%. Higher educational status and higher level of income positively affected the pattern of use of these services. Perceived quality of service influenced the choice of facility or obstetric care. According to Iyaniwure and Yusuf (2009), the increased

proportion of the deliveries at TBA homes may also be associated with the prevalent supernatural concept of disease in many African communities. Twenty nine percent (29%) of ANC attendees in Equatorial Guinea expressed that TBAs were better than orthodox practitioners in some respects because TBAs possess spiritual powers and can intervene in certain situations where medical interventions cannot help.

Ogunleshi (2004) in his study of the pattern of utilization of prenatal and delivery services in Ilesha Nigeria, found that out of the 260 women studied churches were most commonly patronized for prenatal care (98.3%) and delivery (92.35.4%) mostly for religious and financial reasons A considerable proportion of those who used traditional brth attendants (36.1%) used it to please their husbands A study carried out by é

Itina in(1997) conducted a study on a group of 52 TBAs in Offot clan in the South eastern Nigeria to help develop effective programmes for TBAs in the safe delivery and early referral of women with complications to hospitals; findings showed that the majority of TBAs were illiterates and had no previous experience or training, even informal training, when they took on the TBA role. Ignorance about maternal complications during childbirth and the appropriate treatment was evidence for most of the groups. A small number of the group relied solely on divine revelation for guidance in the management of childbearing women. In this study, TBAs reported that they managed problems in pregnancy primarily with fasting, prayers, herbal medicine, or enema. They were generally uninformed about the causes of/and management of antepartum and postpartum heamorrhages ï a major cause of maternal mortality.

Zelek and Orantia (2007) in their study on factors affecting where women chose to give birth in Marathon-Canada revealed that the most important factor is being close to home, being where it was easy for a partner to be present, and being where it was easy for a coach to be present. The least important were availability of epidural analgesia, care in a place that did a high number of deliveries and cost.

Idris and Gwarzo (2003) carried out a study on determination of place of delivery among women in semi-urban settlement in Zaria, Northern Nigeria used pretested interviewer questionnaire to interview and collect data from 496 women who had delivered at least once. Findings showed that there is high rate of home deliveries and deliveries not supervised by skilled attendants of 70% and 75% respectively, mothers educational level, husbands

occupation and age at the first pregnancy were the main determinants of place of delivery service use. Amoti ï Kaguna & Nuwaha (2000) in their study on factors that influence choice of delivery sites in Rakai implicated access to maternity services, social influence from spouse and other relatives, TBAs and health workers efficacy habit (from previous experience) and the concept of normal versus abnormal delivery (pre-existing condition), attitude, belief towards various delivery sites; and also that attendance to ANC may discourage delivery in health units if the mothers are told that the pregnancy is normal.

Anyait et al (2012) found in their study of predictors for health facility delivery in Busia district Uganda that out of 500 women interviewed 227 (45.4%) delivered in health facility while 288(58%) of the 227 who delivered at health facility 159(70%) delivered in public health facility and 68(20%) in private health facility. Of the 273 that delivered outside the health facility, 249(91.2%) were at the respondents home 20(7.3%) at the home of TBA and 4(1.5%) on the way to the facility.

In a study on reasons for preference of delivery in spiritual church based clinics by women of South South Nigeria, Udoma , Ekanam, Abastattai and Bassey studied 263 pregnant women who were regular attendants of 47 spiritual church based clinics in South South Nigeria. The study was carried out between 1st February 2003 and 31st July2003. Reasons given by the women include: protection against satanic attacks and safe delivery (36.8%) lack of funds (30.5%) harsh attitude of healthcare workers (12.1%) convenience (10.3) faith in God and previous delivery in church(4.0%), help and good care (2.35%).

Azuh Dominic (2013) conducted a study on Socio demographic factors influencing Health Programs usage by pregnant mothers in Nigeria.

The study covers five (5) rural wards of Ado-Odo/Ota Local Government Area in Ogun State, Nigeria. The study used face-to-face structured interview and focus group discussion (FGD) In-depth interviews were held with specific stakeholders in the community, some officials of the five primary health care u nits in the wards selected and staff of the only general hospital residing in the Local Government of the study area. A stratified sampling technique was adopted in selecting the respondents who were ever married women in child bearing age (15-49) years who had at least one live-birth in the last two years preceding the survey. On the whole, 260 female respondents were randomly selected from five wards out of the sixteen wards in the local government area. They were interviewed through a face-to-

face approach and focus group discussion with a two-level analytical approach capturing both the qualitative data and information from the discussion segment.

The result show that the educational attainment of the respondents is very
poor with slightly above half of the population having only secondary education (55.5%). Respondents with no schooling, those having primary level account for 22.7 and 18.2 per cent respectively. Nevertheless, a negligible number of the respondents had attained above secondary level education (3.6 %).

Distance to the health facility is also a major retarding factor in accessing health services among the five wards in the study area. While 68% of the respondents have health facility within two kilometres distance from their homes, a reasonable proportion (32%) of these respondents has to walk beyond three kilometres distance to access health services. (73%) of the respondents stated that it is their husbands who decide when and where to go for treatment and equally pay for the treatment costs. On awareness of place of antenatal care (ANC), overwhelming proportion of the respondents admitted knowledge of place of ANC treatment (93%). However, the common reasons hindering attendance or registration for antenatal care is high cost of ANC service. Only one-tenth (10.5%) of the respondents agreed that what they spend at health centres is convenient (cheap) for them. However, 51.8 per cent and 37.7 per cent stated moderate and expensive charges respectively. Cost may reduce womenôs use of maternal health services from having hospital ï based deliveries or seeking care even when complications arise. Information gathered through in-depth interview revealed that even when formal fees are low, other informal costs such as buying complete delivery items, drugs, food, etc pose barrier to utilisation of available health services. The assistants during pregnancy and child birth were identified to be nurses/midwives (56.8%), doctors (20%); and traditional birth attendants (17.7%) and relatives (5.5%).

Olufunke and Akinlujoye (2012) on why mothers prefer TBAs include that TBAs have adequate knowledge and skills, to care for them, their services are cheaper. more culturally acceptable in many environments, closer to their houses than hospital, they provide more compassionate care than orthordox workers and some said it is the only maternity service they know.

Summary of Literature Review

Literature on choice of birth place and birth attendants during delivery. was reviewed under the following: Conceptual review which showed different concepts of birth attendants . Empirical review showed other peopleôs work on this topic. Theories related to the topic were also reviewed. Andersonôs model of health service utilization of 1968, 70ôs and 1995 were all reviewed .The theoretical review for this study was taken from Andersonôs model of health care utilization of 1995 (phase 3) which used primary determinants, Health behavior and health outcome to further show inter relatedness between demographic factors, enabling factors, need factors, healthcare system, health behavior (use of health services), and health outcome . From the literature reviewed, mothers level of education, previous use of health facility, attitude of healthcare provider, motherôs age and distance to health facility are all factors that influenced the choice of birth place and use of birth attendants during delivery. The review of literature further showed that no known study has been carried out on choice of birth place and use of birth attendants during delivery and factors that influence the choices in the area of study and Abia state as a whole. Hence this study intends to bridge the gap.

CHAPTER THREE
METHODOLOGY

Introduction

This chapter is discussed under the following: study design, setting/area of study, target population, sample, sampling procedure, instrument for data collection, validity of instrument, reliability of instrument, ethical consideration, procedure for data collection and method of data analysis.

Research Design

The study adopted a cross-sectional descriptive design. This design is concerned with the present and tells how people feel or react to phenomenon under investigation. The purpose of the design is to provide a picture of a situation as it naturally occurs. Cross-sectional descriptive design is considered appropriate for this study because it takes place at a single point in time and allows the researcher to look at numerous things at once (age , income, education, parity, autonomy etc) as they naturally affect the study population .

Area of study

The area of study was Akanu community in Ohafia L.G.A of Abia State.

Akanu is one of the villages in Ohafia. It is an Igbo speaking community. Akanu is the largest village in Ohafia; the population of which was estimated by Philip Nsugbe (1974.) in the mid sixties to be around 12,000. Akanu Ohafia is the largest single community in terms of population and land mass in the eastern part of Nigeria (Tochi Okereke Akanu Ohafia .com E-Zine 2014).

Akanu is bounded in the North by Abia community, East by Ndi Uduma Awoke, South by Ebem community and West by Asaga. Akanu community has people of all professions ï teachers, nurses, doctors, lawyers etc. They also have artisans and farmers. They are mainly Christians. They have primary and secondary schools both governments owned and private. In their health centers, they have both Nurses/midwives and chews as healthcare providers to women during delivery. Akanu is made up of four sub-communities **Ekelogo, Amafor, Ndiodo, and** Utughaokoko. These four communities are made up of 26 compounds. Each compound is made up of about 20 households bringing the total households to about 520.

Target population

The population for this study were women of childbearing age (15 ï 49yrs) in Akanu community; 313 number of women who gave birth between Jan-Dec 2012 were used for the study. (Source: BCG immunization registers of Ania & Akanu Ukwu health centers) for Jan. to Dec. 2012.

Sample

No sampling was carried out. Entire populations recorded were all used for the study.

Inclusion criteria:

1. Women of childbearing age who delivered between January and December 2012 in the four sub communities of Akanu.
2. Willingness to participate.
3. Availability

Instrument for data collection

The instrument for data collection was a researcher developed questionnaire generated from reviewed literature. The questions were formulated according to the research objectives stated. It has two sections and contained 24 items.

Section A Is concerned with the respondentsô demographic data.

Section B contained items designed to elicit responses on choice of birth place and use of birth attendants during delivery among child bearing women in Akanu, Ohafia. The questionnaire was made up of closed and open ended items. The closed ended questions contained options to choose. While the open ended questions gave room for the respondents to write in their opinion on topic.

Validity of Instrument

The questionnaire was submitted to the researcherôs supervisor and two other senior lecturers in the department of nursing sciences for face validity. The items were scrutinized and modifications were made where possible. All the inputs were used to effect corrections in the final copy of the questionnaire which was presented to the supervisor for signing before use.

Reliability of Instrument:

The questionnaire was used for pilot study in a smaller but similar population to test for clarity and reliability. 20 copies of the questionnaire were administered to 20 women in another community which was similar to the sample studied. Split half method was used and Pearsonôs Product moment correlation statistics was applied and a correlation coefficient of 0.89 was obtained which was considered appropriate for use in the study.

Ethical Consideration

Written administrative permission was obtained from the community leader of Akanu Ukwu Autonomous community after explaining the purpose of the study to him. Summary of the research proposal was also submitted to the ethical review Board of Federal Medical centre Umuahia and approval was given for the data collection, permission was also obtained from the women leader. The purpose of the study was explained to her. Respondentsô consent was also obtained and the need for the study explained to them to gain their co-operation, confidentiality and anonymity of information was guaranteed. Respondents were not forced to participate in the study and were not prevented from backing out if they wanted.

Procedure for data collection

Written administrative permission to carry out the study had already been obtained from the traditional ruler of Akanu Ukwu Autonomous community. Permission was also obtained from the women leader. The town crier was paid to disseminate the information to all the members of the community which he did. The researcher and research assistants went from house to house in each sub community collecting data from all available mothers who met the inclusion criteria. Data were collected in the morning and evening hours between 9am-12noon and 3pm-6pm respectively till the number for that sub-community was reached. Data collection lasted for five weeks.

Method of data analysis:

Data analysis was done with the statistical Package for Social Sciences (SPSS) version 17.0. Data were analyzed using descriptive statistics namely frequencies and percentages for objectives 1 ï 4. Inferential statistics involving chi-square, fisher's exact-test and correlational coefficient was used to test the two hypotheses stated for the study

CHAPTER FOUR
PRESENTATION OF RESULTS

This chapter presents the results of the data analysis on choice of birth place and use of birth attendants among childbearing women in Akanu community and reasons for their choice. Three hundred and thirteen (313) questionnaires were distributed to the respondents; all of the questionnaires were filled correctly and returned giving the return rate of (100%). This is because questionnaires were administered in an interview format

Socio- demographic characteristics of the respondents

Table 1 showing the socio-demographic profile of the respondents

N = **313**

Variables	Frequency	Percentage
Age range		
< 20 years	49	15.7%
20 -29 years	128	40.9%
30 -39 years	90	28.8%
40 ï 49 years	46	14.7%
Mean age X —	**28.7**	
SD	**4.49years**	
Marital status		
Single	81	25.9%
Married	232	74.1%
Religion		
Christianity	311	99.4%
African Traditional Religion	2	0.6%
Respondent's Level of education		
No formal education	4	1.3%
Primary	51	16.3%
Secondary	249	79.6%
Tertiary. Education	9	2.9%
Husband's level of education		
No formal education	81	25 9%
Primary education	26	8.3%
Secondary education	195	62.3%
Tertiary education	11	3.5%
Respondent's occupation		
Trading	89	28.4%
Farming	69	22.0%
Seamstress	26	8.3%
Government worker	14	4.5%
Jobless	83	26.5%
Others	32	10.2%
Parity		
Primiparous	101	32.3%
Multiparous	212	67.7%
Place of ANC		
Hospital /Health centre	276	88.2%
TBA'S place	19	6 1%
Church/ spiritual home	6	1.9%
Home	1	0.3%
No ANC received	11	3.5%
Who decided on place of ANC		
Self	143	45.7%
Husband	101	32.3%
Mother	52	16.6%
Others	10	3.2%
No response	7	2.2%
Decision maker on place of delivery		
Self	138	44.%
Husband	87	27.8%
Mother	39	23.0%
Mother in-law	3	1.9%
Sister	2	1.0%
Pastor	1	0.6%
Brother	5	1.6%

Table 1 shows the demographic characteristics of the respondents. Out of the 313 respondents involved in this study, 49 (15.7%) of them were less than 20years, 128 (40.9%) were 20-29years, 90 (28.8%) were 30-39years, while 46 (14.7%) of them were 40-49years. Their marital status showed that 81 (25.9%) of the respondents were single, while 232 (74.1%) of them were married. Their ethnicity showed that 304 (97.1%) of the respondents were Ibos, while 9 (2.9%) were from other ethnic groups. Religion showed that 311 (99.4%) were Christians while 2(0.6) were of African traditional religion. The respondentsô level of education showed that 4 (1.3%) had no formal education, 51 (16.3%) had primary education, 249 (79.6%) had secondary education, while 9 (2.9%) of them had tertiary education. The respondents husbandsô highest level of education showed that 81 (25.9%) had no formal education, 26 (8.3%) had primary education, 195 (62.3%) had secondary education, while 11 (3.5%) had tertiary education. As regards respondentsô occupation, Table 1 showed that 89 (28.4%) of them were traders, 69 (22.0%) were farmers, 26 (8.3%) were seamstress, 14 (4.5%) were government workers, 83 (26.5%) were jobless, while 32 (10.2%) of them belong to other occupational groups such as-apprentice, caterers, hair dressers, interior decoration, teaching, school leavers, students, housewife. The parity of the respondents showed that 101(32.3%) were primiparous, while 212 (67.7%) were multiparous.

As regards where respondents received ANC, the result showed that more than three quarters 276 (88.2%) of the respondents received their ANC in their last pregnancy at the hospital/ health centre A few 19(6.1%) received ANC at TBAôs place while 6(1.9%) a small proportion received at the church/spiritual homes. Only 1 person 1(0.3%) received from home. Six 11 (3.5%) received no ANC at all. On who decided where the respondents went for ANC, Majority 143 (45.7%) said they decided where to receive ANC by themselves, 101(32.3%) said that their spouses took the decision on where they received ANC in their last pregnancy while 52(16.6%) indicated that their mother decided for them where they received ANC. Others indicated in this decision making were aunty 2(0.6%)ô brother 2(0.6%). .Father of my child 4(1.3) and a relative 2(0.6) The result on the final decision on where the respondents delivered the last baby showed that, 138(44.1%) said they made the decision by themselves while 87(27.8%) said it was their husbandôs decision, 72(23.0%) said it was their mother, while 6 (1.9%) said the decision was made by their mother in-law . Other people implicated were sister 3(1.0%), pastor 2(0.6%), Aunty 3(1.0%) and brother 2(0.6%)

Objective One: To determine respondent's choice of birthplace.

Table 2: Where the respondents had their last baby.

N= 313

Place of delivery	Frequency	Percentage
Hospital/health centre	211	67.6%
TBAôS place	43	13.7%
Church/spiritual home	32	10.2%
Home	27	8.6%
Total	313	100%

From the result on Table 2 above, more than half of the respondents 211 (65.6%) had their last baby delivered at the hospital/health centre, 43 (13.7%) had their last baby delivered at TBAôs place, 32 (10.2%) delivered at the church/spiritual home and 27 (8.6%) delivered at home.

Objective Two

To elicit reasons for womenôs choice of birth place.

Table 3: Responses on reasons for womenôs choice of birth places.

Reasons	**Hospital/ Healthcentre n=221**	**TBA's Place n=43**	**Church/Spiritual home n= 32**	**Home n=27**
They are always available	189(85.5%)	41(95.8%)	26(%)	0(0.0%)
They took good care of me	144(65.2%)	32(75%)	0(0.0%)	0(0.0%)
I was told at ANC to deliver here	96(43.4%)	0(0.0%)	0(0.0%)	0(0.0%)
They have equipment and drugs	96(43.4%)	0(0.0%)	0(0.0%)	00.0%)
Their services are convenient to use	96(43.4%)	35(83.3%)	19(58.8%)	(0.0%)
It is near my house	84(37.8%)	35(83.3%)	17(52.9%)	0(0.0%)
I had problem in my last delivery and was told to deliver here	10(4.5%)	0(0.0%)	9(29.4%)	0(0.0%)
They give traditional medicine	0(0.0)	18(41.6%)	0(0.0%)	0(0.0%)
They charge low (no cost)	0(0.0)	38(87.5%)	26(82.3%)	22(80.0%)
Labour started at night	0(0.0)	7(12.5%)	4(11.7%)	9(33.3%)
Labour was too short	0(0.0)	4(8.3%)	0(0.0)	7(26%)
Protection from demonic attacks	0(0.0)	0(0.0)	32(100%)	0(0.0%)
They pray for people	0(0.0)	0(0.0)	32(100%)	0(0.0)

***Responses not exclusive**

The result on Table 3 showed responses on why they preferred to deliver their last baby in the place they specified. The result showed that out of 211 that delivered their last baby at the hospital/healthcare, the major reasons were that ó They are always availableò (85.5%), ñThey took good care of meò (65.2%), ñThey run 24hours serviceò (62.6 %) and òThey have qualified staff (52.1%) . Other reasons indicated here were ó I was told at ANC to deliver hereô(43.4%). óThey have equipment and drugs(43.4%)ô óTheir services are convenient to use(43,4%)ò and óHad problem in my last delivery and was told to deliver here (43.4%)ô Out of the 43 respondents that delivered their last baby in TBAsô place, the major reasons were that ñ They are always available 41 (95.8.0%) , ñThey charge lowò 38(87.5%,

ñTheir services are convenient to use 35 (83.3%) The place is near my houseò35 (83.3%),andñThey took good care of meò32(75%) . Others were they give traditional medicine 18(41.6%), Labour started at night 7(16.6%),It was raining 5(12.5%) and ólabour was too shortôô4(8.3%). Out of the 32 respondents that delivered in the church/spiritual home, the major reasons were ñòProtection from demonic attacksôô32(100%), They pray for people (32(100%), cost (I will not pay money 26(82.3%) and óHad problem in my last delivery and was told to deliver hereô 17(52.9%). Other reasons indicated here include ï nearness 9(29.4%) and labour started at night 4(11.7%) Out of the 27 respondents that delivered at home, the major reasons given were cost 22(80.0%) and ñ labour started at night 11 (40.7%), and labour was too short 7(26%)

Objective Three: To identify the personel that attended their delivery.

Table 4: Responses on who took the delivery of the last baby

N= 313

Response	Frequency	Percentage
Nurse/Midwife	221	70.6%
TBA	47	15.0%
Pastor/Spiritual Woman of God	38	12.1%
Doctor	2	0.6%
Others mothers, mother in-law and sister in-law	5	1.6%
Total	313	100%

The result on Table 7 shows the responses on who took the delivery of the last baby. Majority 221(70.6%) of the deliveries were conducted by nurse/midwives.; 47(15.0%) were taken by TBAs; 38(12.1%) by pastor/spiritual woman of God; 2(0.6%) by a doctor and 5(1.6%) were taken by others which include: mother 1(0.3%); mother in-law 2(0.6%); and sister in-law 2(0.6%)

Objective four: To elicit the factors that influence women's use of birth attendants during delivery.

Table 5: **Factors that influence women's use of birth attendants during delivery.**

Factors	**Nurse/Midwife 221**	**TBA 47**	**Pastor/Spiritual woman of God 38**	**Doctors 2**
I used this healthcare provider in my last baby.	80(36.2%)	19(40.4%)	3(7.9%)	2(100%
The provider lives near me.	51(23.1%)	34(72.3%)	13(34.2%)	2(100%)
The provider charges low.	113(51.1%)	43(91.5.%)	26(68.4%)	2(100%)
The provider knows the work.	194(87.8%)	34(72.3%)	30(78.9%)	2(100%)
Provideriswell qualified to do the work	(190(86.0.%)	1(2.3%)	1(2.6 %)	2(100%)
Provider treats people with respect.	152(72.0%)	35(74.0%)	32(84.2%)	2(100%)
Provider is always available.	183(82.8%)	37(78.7.0%)	32(84.2%)	2(100%)
The provider knows our tradition.	0(0.0%)	26(55.3%)	16(42.1%)	0(0.0%)
Gives traditional medicine	0(0.0%)	26(55.3%)	(0.0.0%)	0(0.0%)
Sees vision	0(0.0%)	0(0.0%)	38(100%)	0(0.0%)
Prays for people	0(0.0%)	0(0.0%)	38(100%)	0(0.0%)

***Responses not exclusive**

The result on Table 5 showed the factors that influence women to use specific birth attendants during their last delivery. The result showed that that had the delivery of their last babies through nurse/midwife, their reasons in order of preference when allowed to pick more than one option showed that more than three quarters 194(87.8%) said the provider knows her workô a similar number 197(87.8%), said ñ The provider is well qualified to do the jobò 190(86.0%) said óShe is always availableô while 183(82.8%) said they used her because óShe treats people with respectô. From the 47 respondents that had the delivery of their last baby through TBA, when allowed to pick more than one option showed that majority (91.5%) said óshe charges lowô, more than three quarters (78.7%) said ñShe is always availableôô (74.5%) said óProvider treats people with respect and (72.3%) said the provider knows the work. From the 38 respondents that had the delivery of their last baby through

Pastor/Spiritual woman of God, All the respondents 38(100%) said she sees vision, a similar number 38(100%) said óShe prays for them. Other reasons given by the respondents include provider is always available 32 (84.2%), ñShe treats people with respectò 32(84.2%)and óProvider knows he workôõ30 (78 9%).

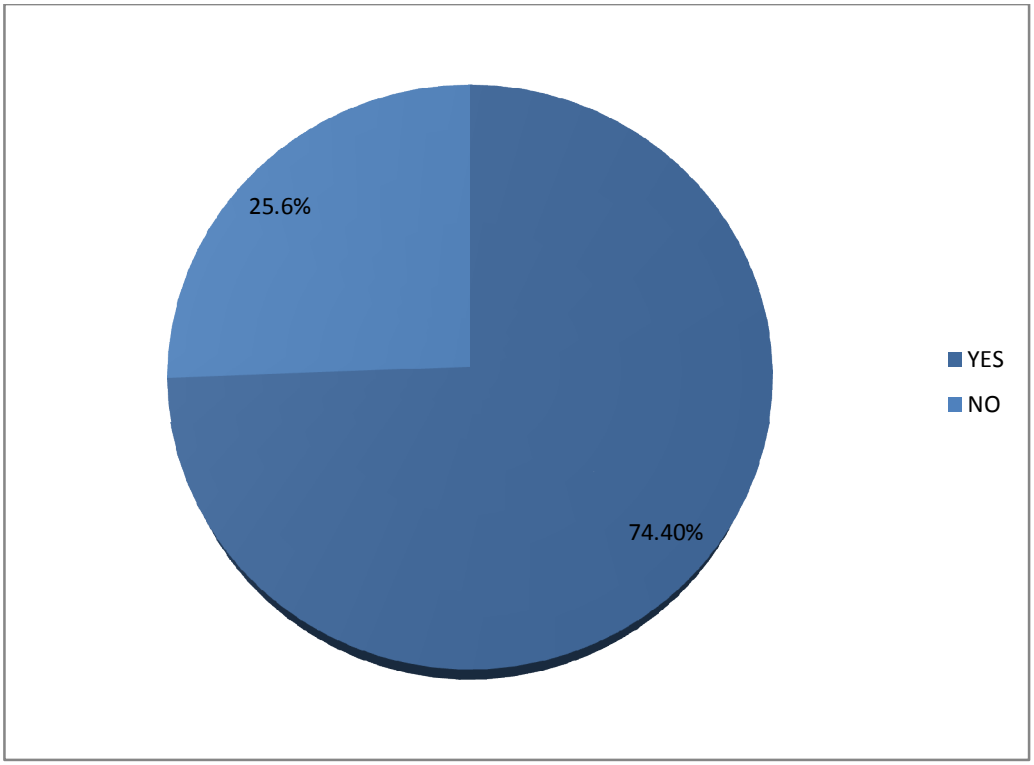


Figure 1 on whether the respondents will want to use the same birth place in future.

The responses on whether the respondents will want to use the same birth place for delivery in future showed that 233(74.4%) said yes while 80(25.6%) said no.

Table 6: Reasons for wanting to use the same birth place for delivery in future.

n= 233

Reasons	Frequency	Percentage
Staff efficiency and good care	107	46 .0%
Availability of equipment/ facility/drugs	93	39.8%
They are always available	51	21.9%
They charge low	40	17.1%
It is convenient to use	36	15.6%
I always use it/previous use	30	13.2%
They pray for people	29	12.5%
They have qualified staff	25	10.9%

***Responses not exclusive**

Findings on respondentsô reasons for wanting to use the same birthplace in future delivery showed that out of the 223(74.4%) of respondents that said yes, 107(46.0%) said it was because of "Staff efficiency /good care ò;more than one quarter 93(39.8%) of the respondents said they will use it in future because of ñAvailability of equipment and drugs while 51(21.9%) of the respondents said ñ They are always availableò40 (17.1%) said they charge lowò while 36(15.4%) of the respondents said that òTheir services are convenient to useò. Another 30(13.2%) of the respondents said it is because ñ I always use itò (previous use). A similar number 29(12.5%)said ñThey pray for peopleò. Fourteen 25(10.9%) it is because ñThey have qualified staffò.

Table 7: Reasons for not wanting to use the same birth place for delivery in future. **n =80**

Reasons	Frequency	Percentage
No qualified health personnel	36	45.4%
Not enough equipment /drugs	34	43.1%
No proper care/treatment	31	38.6%
Not convenient to use	9	11.3%
They are not always available	7	9.0%
Their charges are high	4	4.5%

***Responses not exclusive**

Findings on respondentsô reasons for not wanting to deliver in the same birth place in future showed that out of the (25.6%) of the respondents who said they will not deliver in the same birthplace, a little below half 36(45.4%)of the respondents said it is because ñThey donôt have qualified health personnelôò;34(43.1%) of the respondents said it is because ñThey donôt have enough equipment/drugsò while 31(38.6%) of the respondents said ñThey donôt give proper care/treatmentò. Five 9(11.3%) of respondents said the place is not convenient to useò, while 7(9.0%) of the respondents said it is because ñThey are not always availableò and 4(4.5%) said ñTheir charges are highò.

Test of Hypotheses

Hypothesis 1: There is no significant difference in the use of birth attendants between primiparous and multiparous women.

Questions number 8 grouped and 17 were cross tabulated to test this hypothesis.

Table 8: Relationship between primiparous and multiparous women in the use of birth attendants during delivery.

	Primiparous	Multiparous	Fisherôs Exact	P-value
Nurse/Midwife	85(84.2%)	135(64.2%)		
Doctor	0 (0.0%)	2 (0.9%)		
TBA	5 (5.4%)	44 (19.8%)	15.85	0.001
Pastor/Spiritual Woman of God	10 (9.9%)	27 (13.2%)		
Others	1 (1.0%)	4 (1.9%)		
Total	101 (100%)	212(100%)		

From the result of the hypothesis, since there are some of the expected values that are less than 5, Fisherôs exact is more reliable than Chi-square. Since the P-value < 0.05, the hypothesis is rejected and thus, there is significant difference in the use of birth attendants between primiparous and multiparous women. This implies that greater percentage of primiparous women delivered their baby by nurse /midwife, while greater percentage of multiparous women delivered their baby by TBA.

Hypothesis 2: There is no significant difference in the choice of birth place and some socio-demographic characteristics of women (age, marital status educational level of respondents and parity).

Table 9: Age cross tabulated with place of delivery

	<20yrs	20-29yrs	30-39yrs	40-49yrs	Fisherôs Exact	P-value
Hospital/Healthcare	40(81.6%)	91(71.1.%)	47(52.2.%)	21(45.7.%)		
Church	0(0.0%)	5(3.9%)	5(10.0%)	10(21.7%)		
TBAôs place	5(10.2%)	9(7.0%)	18(20.0%)	10(21.7%)	73.376	0.000
Home	0(0.0%)	12(9.4.%)	10(11.1%)	5(10.9%)		
Private hospital	0(0.0%)	10(7.8%)	2(2.2%)	0(0.0%)		
Spiritual home	4(8.2%)	0(0.0%)	4(4.4%)	0(0.0%)		
Others	0(0.0%)	1(0.8%)	0(0.0%)	0(0.0%)		
Total	49(100%)	128(100%)	90(100%)	46(100%)		

From the result of the hypothesis, since there are some of the expected values that are less than 5, Fisherôs exact is more reliable than Chi-square. Since the P-value < 0.05, the hypothesis is rejected and thus, there is significant difference in the place of delivery according to age group. This implies that the younger the women, the more they delivered in the hospital/healthcare.

Table 10: Place of delivery cross tabulated with marital status

	Single	Married	Fisherôs Exact	P-value
Hospital/Healthcare	63(77.8%)	135(58.3%)		
Church	2(2.2%)	22(9.4%)	11.644	0.045
TBAôs place	7(8.9%)	36(15.7%)		
Home	5(4.4%)	24(10.2%)		
Private hospital	0(0.0%)	11(4.7%)		
Spiritual home	4(4.4%)	4(1.6%)		
Others	2(2.2%)	0(0.0%)		
Total	81(100%)	232(100%)		

From the result of the hypothesis, since there are some of the expected values that are less than 5, Fisherôs exact is more reliable than Chi-square. Since the P-value is < 0.05, the hypothesis is rejected and thus, there is significant difference in the place of delivery between single and married women. This implies that greater percentage of single women delivered their baby in the hospital/health centre while greater percentage of married women delivered their baby in the church, TBA or home than single women.

Table 11: Level of education cross tabulated with place of delivery

	No formal education	Primary	Secondary	Tertiary	Fisherôs Exact	P-value
Hospital/Healthcare	0(0.0%)	28(54.9%)	166(66.7%)	5(55.6.%)		
Church	0(0.0%)	2(3.9%)	20(8.0%)	2(22.2.%)		
TBAôs place	2(50.0%)	7(13.7%)	33(13.3%)	0(0.0%)	25.496	0.152
Home	2(50.0%)	8(15.7%)	17(6.8%)	0(0.0%)		
Private hospital	0(0.0%)	2(3.9%)	8(3.2.%)	2(22.2%)		
Spiritual home	0(0.0%)	4(7.8%)	4(1.6%)	0(0.0%)		
Others	0(0.0%)	0(0.0%)	1(0.4%)	0(0.0%)		
Total	4(100%)	51(100%)	249(100%)	9(100%)		

From the result of the hypothesis, since there are some of the expected values that are less than 5, Fisherôs exact is more reliable than Chi-square. Since the P-value is > 0.05, the hypothesis is accepted and thus, there is no significant difference in the place of delivery according to respondentôs level of education.

Table 12:Parity of respondents crosstabulated with place of delivery

	Primiparous	Multiparous	Fisherôs Exact	P-value
Hospital/Healthcare	79(76.8%)	120(56.9%)	14.105	0.015
Church	2(2.0%)	22(10.3%)		
TBAôs place	4(7.1%)	35(17.2%)		
Home	5(8.9%)	19(8.6%)		
Private hospital	0(0.0%)	12(5.2%)		
Spiritual home	2(3.6%)	4(1.7%)		
Others	1(1.8%)	0(0.0%)		
Total	101(100%)	212(100%)		

From the result of the hypothesis, since there are some of the expected values that are less than 5, Fisherôs exact is more reliable than Chi-square. Since the P-value is < 0.05, the hypothesis is rejected and thus, there is significant difference in the place of delivery between primiparous and multiparous women. This implies that greater percentage of primiparous women delivered their baby in the hospital/healthcare, while greater percentage of multiparous women delivered their baby in the church or by TBA.

Summary of Findings

8. Findings showed that more than half of the respondents delivered at the Health centre/hospital.

9. A little bit below three quarter 221(70.6%) used nurse/midwives as their birth attendants during their last delivery**.**

10. On decision making, majority of the respondents (more than half) decided by themselves on where they went for ANC and delivery of their last baby.

11. The findings also showed that TBAS took the deliveries for substantial number of the respondents.

12. On reasons for their choice, the respondents gave different reasons for choice of different birth places and birth attendants. The most common reasons that appeared in all choices of birth places and birth attendants is ócostô; others are: availability of

care providers, good care, convenience, availability of equipment, drugs, knowledge/skill of care provider protection from demonic attacks and praying for people.

13. The findings generally showed that choice of birth place and use of birth attendants during delivery is a multi-factorial issue since so many factors interact to guide a mother and her family in choosing where to deliver and who should take the delivery

14. Findings on the hypothesis tested showed a significant relationship between some socio-demographic characteristics (age, marital status, parity and choice of birth places. There is also significant relationship between parity and use of birth attendants.

CHAPTER FIVE

DISCUSSION OF FINDINGS

The discussion of the findings is presented in this chapter. Discussion was done based on the objectives set for the study. Also the limitation of the study, implication of the findings, recommendations and suggestions for further studies were all presented.

Objective one: To determine respondentsô choice of birthplace.

The results shows that majority of the respondents delivered their last baby at the hospital/health centre. This is in contrast to the findings of Umurungi (2010), Aremu (2011) and Adelaja (2011) that most deliveries took place at home or in other non hospital settings. The increased use of health facilities for delivery may be attributed to the constant awareness campaign that is going on in the Nation and States on improving care in the area of maternal and child health to achieve the 5th millennium development goal. The government is also providing support and services to mother and child in rural communities through subsidy reinvestment and empowerment program SURE-P. S U R E ï P MCH, is an intervention programme where they give incentives to mothers for attending ANC during pregnancy and using skilled attendants in health facilities during delivery. Midwives service scheme (MSS) and other free medical treatment programmes that mothers can utilize have also been provided to all the rural communities in the country including Abia State. Added to these are the provisions of health facilities in all communities all over the states and federation for easy access. Ado (2013) stated that the federal government deployed 6,500 midwives to 1,500 health facilities to ensure the presence of skilled attendants during childbirth, particularly in rural areas. This result agrees with Iyaniwure and Yusuf,(2009)which reported that greater percentage of their study population used government facilities followed by private hospitals for delivery.

The findings that a reasonable proportion of the respondents used the TBAôs home is still worrisome to maternal and child health advocates. In spite of the campaigns and sensitizations going on in our rural communities to encourage women to deliver in the hospital/health centres, many women still use the TBAôs place for delivery as found out in this study. Iyaniwure and Yusuf (2009), observed that the increased proportion of deliveries at TBA homes may also be associated with the prevalent supernatural concept of disease in many African communities. Twenty nine percent (29%) of ANC attendees in Equatorial Guinea expressed that TBAs were better than orthodox practitioners in some respects because

TBAs possess spiritual powers and can intervene in certain situations where medical interventions cannot help.

On use of church / spiritual homes for delivery it was found out that 10.2% of the of the respondents used church/spiritual homes during their last delivery . This finding is in line with Ogunleshi (2004) who found out in his study that 33.3% of respondents who took prenatal care in the teaching hospitals deflated into churches for delivery. 8.7% of respondents delivered at home. This is still substantial going by the amount of sensitization and awareness being created by both federal states and local government on the need for women to deliver at the health facilities to avert maternal morbidity and mortality. This finding agrees with the findings of Titaly,Hunter and Debley (2010), Umurugi, (2010), Aremu, (2011) and Adelaja, (2011),Teigingan, Amalray and Dahkal (2011). They reported that women deliver at home in spite of a relatively easy access to institutional maternity service. Home delivery is usually the cheapest option but is associated with lack of available equipment should complication occurs. (Umurungi 2010).

Objective two

Reasons for women's choice of these birth places.

Findings on reasons for womenôs choice of birth place showed that out of the (67.6%) that chose health facility , three quarters gave the reason for their choice as ñavailability of health services.ò Women are always frustrated when they come to a health facility during labour and the place is not open for them. They will be discouraged and may not go there again This is in line with Selejescog Sandby and Chimago (2006) who found unavailability as a factor deterring women from delivering in health facilities. The next reason is ñgood careò which denotes consumer satisfaction from previous use by a particular user or his/her relative. This supports the findings of Amankwa (2010) that individualôs past experience with pregnancy, child birth and health services affect the decision to seek care. More than half of the respondents said they used the place because they run 24 hours service followed by less than half who chose the place because of availability of qualified staff . These findings agree with Pearl &Joseph (2011) who reported that reasons for delivery in a health facility include availability of various cadre of professionals and specialists, availability of drugs and equipment to handle emergencies and availability of doctors and nurses. Poor staffing in a health facility especially in primary health facility makes it difficult to guarantee 24hours availability of services. This is a factor that can discourage women from seeking medical

services when labour commences even when they received ANC at the health facility asserts Babalola and Fatusi (2009), Gabrysh & Campbell (2009) Other reasons mentioned here are being advised at ANC to deliver at the health facility, equipment and drugs , convenience, nearness, and problem in the clientôs last delivery.

On reasons for womenôs choice of TBAôs place for delivery, results showed that out of the 13.7% of the study population that used TBAôs place for delivery , almost all of them 95.8% gave their reasons as óavailability of services.

More than three quarters indicated ñlow chargeôô, more than half indicated convenience and similar number indicated nearness and . Women patronise the TBA because of the above reasons. The TBAS live in the midst of the people and can be accessed at any point in time. They are equally more convenient to use in terms of distance from homes, finance, time spent, and so forth.

Cost of service can hinder a woman from seeking care in orthodox health facility if she has no support or any means of raising money to pay for the services. Nearness of health facility to residence is important because it determines the distance a woman in labour will walk before accessing care. Other reasons given by these mothers for using the TBAôS place include the fact TBAS ñgive traditional medicineò, Labour started at night, ñit was rainingò and ñLabour was too shortô. These findings support the findings of Olfunke & Akintujo (2012) that the reasons for using TBA services are because they are cheaper, more culturally acceptable, closer to the homes than hospital services, and provide more compassionate care than orthodox health workers

On reasons for choice of church /spiritual homes for delivery , the result showed that all the respondents that chose church said they went there for óprotection from demonic attacksôô, more than three quarters said ót is because they prayed for peopleô and more than two thirds said they will not pay money (cost).More than half said they used the place because óIt is convenient for themô. Other reasons implicated here include nearness to residence, problem in last delivery and labour started at night. These findings are in congruence with findings of Udomo, Ekanem Abasiatta,& Bassey (2008) that protection from evil attacks, cost and good care make women to deliver in the church. Ogunleshi (2004) also found that churches were mostly patronised for prenatal care and delivery for religious reasons.

Findings on reasons why women choose to deliver at home showed that more than three quarters of all the respondents that delivered at home said their reason for delivering at

home was cost, less than half said ólabour started at nightô, and less than one quarter said labour was too short. These findings are in line with Gabrysh and Campbell (2009) Sychaneun et al (2012) who also found that labour starting at night, quick progressive labour, (precipitate labour) were also given for reasons for home delivery in their study.

Objective Three

To determine womenôs use of health care provider during delivery.

The findings showed that the highest number of deliveries taken in the community were by nurses/ midwives.(70.3%). This can be attributed to the level of awareness of the respondents on the need to use skilled attendants during delivery to reduce maternal death. Majority of the respondents are also empowered through education since majority had education up to secondary school level and above, this encourages the use of health services.

The above findings can also be attributed to the federal governmentôs institution and implementation of programmes like the midwives service scheme and making provision for mothers through SURES-P to make available skilled health care providers during delivery in all communities in the country.

Recently, Abia State government in collaboration withé Shell BP gave scholarships to practising nurses who have not done their midwifery programme to read midwifery ,this is to ensure the availability of skilled midwives in the health facilities in the state especially the primary health facilities. The findings above are in agreement with Azuh (2013) who found out in his study that assistants during pregnancy and delivery were identified to be nurse/midwives (56.8%), doctors (20%), traditional birth attendants (17.7%) and relatives (5.5%) Also WHO (2013) stated that midwife initiatives have made it possible for a personnel to be at the health care system always, hence women may determine to utilize their services. The second highest birth attendants indicated here is the TBA which was fifteen percent (15.0%.) . Many Nigerian women particularly in the rural areas rate the services of the TBAôs as being of higher quality than that of the medical health practitioners particularly with regards to interpersonal communications and relationships. TBA has been reported to be more considerate and to provide more compassionate care. This supports the findings of Iyaniwure and Yusuf (2009) that many women for several reasons ranging from skill, proximity, cost etc patronise the TBAS in spite of skilled health care providers made available by both the government and the private sectors. The result of Abia state, health statistics of (2010) showed that TBAS attend up to (80%) of births and skilled midwives

(20%.) The continual use of TBAS despite mass campaign and awareness on the need for mothers to use skilled birth attendants can also be connected to the recognition and training by some state government which make women regard the TBAS as approved birth attendants during delivery. From the result above, there is a reduction from the (2010) report that 80% of women use TBAõS, this may be due to increased awareness and sensitisation to use skilled birth attendants in order to reduce maternal morbidity and mortality.

Another birth attendant implicated are the pastors/ spiritual women of God (11.6%). Although the percentage of those using these birth attendants have been reduced, substantial number of women are still using them and this is detrimental to maternal and child health if nothing is done to stop them or train them to improve their services.

Objective four

To elicit the factors that influence womenõs use of birth attendants during delivery. Findings on factors that influence the use of birth attendants during delivery showed that out of 70.6% that chose nurse midwives, more than three quarters said they used the provider because" she knows the job " A similar number said õThe provider is well qualified to do the job" The above findings show that a provider is visited over and over again if she knows her work. If a provider is proficient, and there is positive outcome in her services, there is the tendency that the consumer will use that provider again and also recommend her to others. This is in agreement with the findings of Apmooti-Kaguna (2000) that health workers and TBAs proficiency are factors influencing use of delivery sites in Rakai. More than half of the respondents said they used the provider because "she is always available", like birth place, availability of healthcare provider in all health facilities determines whether a client should use it or not.

If health facilities are provided everywhere without health workers to give the needed services, mothers will not use it. The findings agrees with Anderson and Newman (2005) which states that the resources (qualified doctors, nurses/midwives, available equipment etc) available in a facility will determine whether one will use him/her or not. More than half of the respondents said they used the place because the provider is well qualified to do the job. Due to current sensitization on use of skilled birth attendant during. delivery, many mothers go to qualified care providers since they now know that they are trained. This is in agreement with UNFPA (2004) that skilled health attendants refers to " people with midwifery skills for

example (doctors, nurses and midwives.) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer obstetric complications. Other reasons indicated for using the nurse/midwife include "she is caring and kind", treated me well in the last delivery and treated me with respect.

On use of TBA's as healthcare provider during delivery; out of the 15.0% that used the TBA more than three quarters of the respondents said they used the TBA because of cost "she charges low" followed by "availability", "she treats people with respect " knows the workò and "nearness". Cost of health services is another reason that deter women from using skilled healthcare provider during delivery. Inability to pay for services rendered to clients is a very important factor to be considered when making decisions on where to deliver and who the healthcare provider should be. In many government institutions, women deliver but due to their inability to pay bills, they are kept in the hospital for months until their relations come up and pay. Some stay for months and are not opportuned to lie on the bed with their babies. This brings down the ego of the client and this explains why some of them prefer the TBA's where they can pay gradually or even in kind. In considering cost, it is not only the cost of health services rendered that matters. Cost of seeking care includes cost of transportation; medications, supplies, official and unofficial fees, provider fees and opportunity cost of travelling time and waiting time lost during this period. Cost of having assistance to accompany the woman, who and how to care for the other children at home are all considered. When women cannot put up with all these costs, they choose to deliver with the TBA's. These findings are in agreement with the findings of Gabrysh and Campell (2009) and Kruk et all (2009) .TBAs may offer more convenient user charges, that allow payment to be spread over a period of time or be made in kind (Iyaniwure and Yusuf 2009). The second reason for use of TBA for delivery is availability. The TBA lives in the community in the midst of the people unlike the health facilities which are located away from the compounds where the people live. The TBA can be assessed at any time.

On the third reason, ñshe treats people with respect". 74% said she treats people with respect and 57.4%said "She lives near me". Respect is very important for maintenance of human dignity. Respect for client irrespective of her status, colour or tribe goes a long way in the development of trust and confidence between the care provider and her client. This is in agreement with Selejescog et al (2006,) Gabrysh & Campbell (2009) that quality of care is one of the determinants of use of healthcare provider and respect is part of quality of care .

On nearness, findings show that 57.4% said they chose the provider because "She lives near themò. Women tend to use a care provider which is near for convenience. This is because it will reduce the travelling time and distance the woman will walk if labour starts. World Health Organization standard is that every woman should have access to health facility which should not be more than 30 minutes walking distance or less than 5 kilometers. Distance exerts a dual influence since walking many kilometres is difficult for a woman in labour and impossible if labour starts at night and there is no means of transport. Women may deliver on the road and develop complications which may claim their lives or that of their baby .Traditional birth attendants live in the midst of the villagers and may be the most likely care provider to take the delivery under this situation. This support the work of Kurk (2004), Selejescog , Wagle and Sabroe (2004) that cost and distance have negative effects on utilization and a distance of more than one hour to maternity hospital increase risk of home delivery

Reasons for use of pastor /spiritual woman of God showed that all the respondents indicated "She sees vision", a similar number said ósshe charges lowô or óno charge at all" while more than three quarters said she prays for them. Other factors indicated here are: protection from evil attack and she knows the job. These findings support the findings of Udoma and Ekanem (2008) that spiritual protection against satanic attacks, safe delivery, lack of funds, harsh attitude of healthcare providers ,faith in God, previous use, help and good care are reasons for preference for delivery in spiritual church based clinic by women of South South in Nigeria .

Findings on whether the respondents will want to use the same birth place in future showed that 74.4% said yes while 25.6% said no. Future choice of place of delivery depends on the previous experience of the chooser with health system. Findings showed that majority said they will use the place because of staff efficiency/good care, more than half said they will use it because of availability of equipment and facilities, and availability of healthcare provider in the birth place. Other factors indicated are ó$They charge lowô, ó$Their services are convenient to useô, ó$They pray for people. ó$I have always used itô; ó$They have qualified staffô. The last 0.8% said they will use because they went for ANC there and their people recommended it respectively.

Findings on respondentôs reasons for not wanting to use the same birth place in future, shows that respondents implicated such factors as the place not having enough equipment /drugs, not giving proper /adequate care, and not having qualified staff. Other reasons given were that the place was not convenient to use, not always available and their charges are high. These reasons denote consumer satisfaction with services rendered. Consumer satisfaction is measured by such factors as; providers characteristics which include whether the provider is polite, well trained, proficient, respectful and so forth. These findings agree with Umurungi (2010),Gabrysh and Campbell(2009). If the consumer of health services is satisfied with the previous services used, there is the tendency to use it again and recommend it to others but if not satisfied, the mother will neither use nor recommend it to others.(Anderson and Newman, 2005)..

Relationship between primiparous and multiparous women in the use of healthcare provider.

The study showed that there was a statistical significant difference in the use of healthcare provider during delivery between primiparous and multiparous women. The result shows that greater percentage of primiparous women deliver their babies by nurse/midwives while greater percentage of multiparuos women deliver their babies by TBAs. This is in agreement with Umurungi (2010) who said that often a high value is placed on the first pregnancy and in some settings; the womanôs natal family helps her get the best care possible. Furthermore, health workers may recommend a facility delivery for primipara. By contrast women of higher parity can draw on their maternity experiences and may not feel the need to receive professional care if previous deliveries were uncomplicated. Also women with several small children may have greater difficulty in attending facilities due to the need to arrange child care. Amankwa (2010) also reported that parity is another significant factor that can influence a womanôs decision to deliver with a skilled attendant. He cited Bangladesh where women with lower parity are less likely to deliver at home.

Ekene &Tunau (2007)in Amankwa (2010) observed that in Sokoto in Nigeria,
women of high parity were found to be more likely to decide to prefer home delivery with unskilled attendants

The Relationship between some socio-demographic characteristics age, marital status, educational level of respondents and parity, on choice of birth place.

The result shows that there is significant difference in the place of delivery according to age group. This implies that the younger the women the more they delivered at the hospital/healthcentre. Age is often presented as a proxy for use of health services. Older women many belong to more traditional cohorts and thus be less likely to use modern facilities than young women. On the other hand older women may be told to deliver in the health facility since older age is a biological risk factor (Gabrysh and Cambell 2009). Young women may be single and may be supported by their parents and this may make them deliver at the health facility. Age is also related to parity and it may be the first pregnancy making young women to seek facility delivery more.

Findings on relationship between marital status and choice of birth place showed that there is significant difference in the choice of place of delivery between single and married women . Result shows that greater percentage of single women delivered their babies at the hospital/health centre while greater percentage of married women delivered at the church, TBAs. or home. Marital status may influence the choice of delivery place, probably via its influence on female autonomy and status through financial resources. Single or divorced women may be poorer but enjoy greater autonomy than those currently married. Young single mothers may be cared for by their natal families which may encourage skilled attendance especially for a first birth Umurungi (2010)

Result on relationship between respondentôs level of education and choice of place of delivery shows that there is no significant difference in the place of delivery according to educational level of respondents. Women deliver at the health facility irrespective of their level of education. The finding is so because of the constant sensitizations carried out in the communities on utilization of maternal health services as a strategy for reducing maternal mortality. Rural women are now more aware of health services than before, they are empowered in so many other ways even when they are not educated up to secondary school level. This women empowerment has brought autonomy and decision making power to rural women thereby influencing choice of birth place. Furthermore women attend ANC and receive health information through health education in their own dialect on risk factors of childbirth and the benefits of skill attendance. Added to these is the provision of health

facilities very close to the members of the community with skilled health care provider to attend to mothers in need.

On parity the result showed that there is significant relationship between motherôs parity and place of delivery. Greater percentage of primiparous women delivered their babies in the hospital/health centre and greater percentage of multiparous delivered theirs at IBAs place, church and home. This is in agreement with Umurungi (2010) that the first birth is known to be more difficult and women have no previous experience of delivery. Often a high value is placed on the first pregnancy and in some settings; the womenôs natal family helps her to get the best care possible. Furthermore, the health workers may recommend a facility delivery for prinipara. By contrast, women of higher party can draw on their maternity experiences and may not feel the need to receive professional care if previous deliverances are uncomplicated.

Conclusion

Choice of birthplace and use of birth attendants during delivery have important influence on maternal and child health and wellbeing in Nigeria. The study has identified where women deliver their babies, who takes the deliveries and factors influencing these choices in the area of study. Among these factors include : cost of health services, availability of health services and birth attendants, qualified staff equipment, and drugs. Good care, respect for client,convenience and problem in last delivery.

It was also found that no single factor can be implicated alone. These factors interact to bring about choice of health services during delivery. Without available and accessible healthcare that is less costly, all other efforts to reduce maternal mortality will be in vain.

Nursing implication

The findings of this study provide an overall picture of the choice of birth place and use of birth attendants during delivery and reasons for their choices. The findings will inform healthcare providers of where women prefer to deliver their babies, who they mostly use for this deliveries and why they took these decisions. This will help the nurse managers to plan services in such a way that it will provide 24 hours availability of service for consumers and at a reduced cost too. Nurses or care providers in the communities should intensify their campaign on need to use health facilities.

Reproductive health education should be intensified by health wokers. It will help midwives in the communities avoid those characteristics that scare consumers from the health facilities eg. Unavailability, lack of respect for consumers, high cost of services and so forth. Nurses

who work in communities should try to establish good rapport with their clients and family to build confidence and enhance use. Health workers should apply more empathy in their relationship with clents and there should be good communication between the provider and consumer.

Recommendations

- Since the government alone cannot provide health services and the TBAS are aways used by rural women, some training should be given to the TBAS on care during delivery and need for early referal to prevent maternal morbidity and mortality.
- Because of the level of poverty in the country that discourage mothers on the use of health facilities, health services should be subsidised and made available to women of child bearing ages if the MDGôS will be achieved since cost is one of the major deterents from choosing health care facility.
- It is true that the government has done much in terms of trainning of healthcare providers and provision of health facilities; the healthcare providers posted to rural health facilities should be encouraged to stay in their health facilities by being provided with the necessary amenities like ï security,light,water,and some monitary incentives eg rural allowance to motivate them to stay in rural areas .
- They should also be monitored to avoid abandonment of facilities and their work to unskilled attendants
- For protection of human dignity, government facilities should off-set the bills of the very poor ones after they have paid the little they can afford to avoid the degrading situation of keeping a woman in the hospital for months in an inhuman condition for not being able to pay
- Women should be given incentives in all the states for using government health facilities and skilled providers during (ANC) and delivery to courage use.
- Education of the girl child up to secondary school level is very important to empower them on the use of the media and in understanding health messages which will make them increase use.

Limitations of the study

There were some limitations in the course of this study which include: The terrain in some places in the community is confussing and this brought about the use of two research assistants as the local guides. Dearth of current data on population of Akanu as a whole and data on women of reproductive age in Akanu.

A weakness to this study was the use of self report regarding palce of deliery and birth attendants. This could not be verified since there are not records available immediately to use to really authenticate the report. Mothers may deliver at home or other palces and say they delivered in a health facility since it can not be verified further to authenticate the infroamtion. however, previous reprots have found verbal interviews a reliable way of assessing womenôs palce of delviery and the time lag is not much for women to have forgotten the right inforamtion. Inspite of the above limitations, this study contributes to the knowlede about choice of birth palces and use of birth attendants during delivery and factors influencing these choices.

Suggestions for further studies.

The scope of this study was limited to only one community, similar studies can be conducted using a wider population for example the entire state and other locations in Nigeria.

Research should also be conducted on the coverage of skilled healthcare provider in our rural communities.

Summary

The study investigated choice of birthplace and use of birth attendants among child beraing in Akanu, Ohafia local Government area of Abia State and also the factors that influence their choices. The reasearch was prompted by observation of the researcher that women attend ANC but do not use health facility for delivery. Four research objectives and two hypotheses were formulated. The theory which was reviewed for this study was Andresonôs model of healthcare utilization which was used for analysing the choice of birth place and use of birth attendants during delivery. 313 respondents were used for the study. Researcher developed questionaire was used for data collection. This was administered to respondents in an interview format for about 10-20 minutes but a good number of women completed their questionnaire by themselves. An important observation of this study is that in contrast to the findings of so many studies that majority of their study population used other birth places and unorthodox birth attendants during delivery, the researcherôs findings showed that majority of the studied population used the health facilities for delivery and used

nurse/midwife as birth attendents during delivery. On reasons for choice, the study implicated reasons like availability of healthcarebirth attendants, availability of equipment, good care, knowledge of the work (skill of birth attendants) respect for health services consumers, convinience and cost. Cost of healthcare and availability of services consistently appeared as factors that influence choice of birthplace and use of birth attendants during delivery.

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APPENDIX 1

Statistics of (ANC) attendance and attendance during delivery in the three comprehensive health centres in Ohafia

ANIA HEALTH CENTRE

Year	Anc Attendance	Delivery
2007	163	45
2008	164	43
2009	73	38
2010	72	39
2011(JAN ï AUG)	72	20

Source: Delivery register Ania health centre

OHAFOR HEALTH CENTRE ASAGA

Year	Anc Attendance	Delivery
2007	79	No data
2008	36	No data
2009	49	No data
2010	75	47
2011	124	66

Source: ANC & Delivery register Ohafor health centre

ISIAMA HEALTH CENTRE EBEM OHAFIA

Year	Anc Attendance	Delivery
2007	400	150
2008	385	I52
2009	405	160
2010	370	145
2011(JAN-AUG)	309	112

Source: Isiama Health centre ANC/Delivery register

APPENDIX 11

The sub- communities that make up Akanu-Ukwu autonomous community in Ohafia LGA

Ekelogo	**Amafor**	**Utugha Okoko**	**Ndi Odo**
Ndi Uma	Ndi Agboke	Ndi Uka	Ndi Agwu Odo
Ezi Ukwu	Ndi Ulu	Ndi Uche	Ndi Awa Nta Odo
Ndi Okoro	Ndi Ikpo	Ndi Ulu Agboke	Ndi Odo Ukpai
Ndi Agwunta	Ndi Alulu	Ndi Agwu	Ndi Edum
Ndi Udo	Ndi Ezera Uka	Ndi Mba	Ndi Anya
Ndi Akamandu	Ndi Ogbu	Ndi Ijere	
Ndi Ibe	Ndi Ekele	Ndi Uda	

APPENDIX 1V

Department of Nursing sciences,
Faculty of Health Science & Technology.
University of Nigeria
Enugu campus
Enugu.

Dear Respondent,

I am an MSc student of the above named institution conducting a research on choice of birth place and healthcare provider during delivery among women of childbearing age (15 - 49)yrs in Akanu Ohafia community of Abia state.

I solicit your sincere impute as all information given will be treated confidentially
Thank you.

Nwokoro, U. I.
(Researcher)

APPENDIX 1V

Department of Nursing sciences,
Faculty of Health Science &Technology.
University of Nigeria
Enugu campus
Enugu.

15 th January 2013.

The Chairman ,
Health Research and Ethic Committee,
Federal medical Centre
Umuahia

Through:
The head of department,
Department of Nursing Sciences,
University of Nigeria ,
Enugu campus.

APPLICATION FOR ETHICAL APPROVAL

I humbly apply for ethical clearance to conduct a study on choice of birth place and healthcare provider during delivery among women of childbearing age in Akanu community of Ohafia LGA.

I am a post graduate student of the Department of Nursing Sciences , University of Nigeria, Enugu Campus. The subjects of the study are childbearing women aged (15 ï 49years) in Akanu Ukwu autonomous community of Ohafia LGA state.

Participation in will be voluntary and no risk is anticipated as no aspect of the study is invasive. All information shall be confidential and used only for academic purposes
Thanks.

Yours faithfully,

Nwokoro, U.

Appendix V

QUESTIONNAIRE ON CHOICE OF BIRTHPLACE AND USE OF BIRTH ATTENDANTS AMONG CHILD BEARING WOMEN IN AKANU, OHAFIA LOCAL GOVERNMENT AREA, ABIA STATE NIGERIA

SECTION A

1. Age in years
   - < 20 years [ ]
   - 20-29 years [ ]
   - 30-39 years [ ]
   - 40-49 years [ ]

2. Marital status:
   - Single [ ]
   - Married [ ]
   - Divorced [ ]
   - Widow [ ]

3 Religion: [ ]
   - Christianity [ ]
   - Islam [ ]
   - African traditional [ ]

4. Highest level of education of respondent:
   - Formal education [ ]
   - Primary [ ]
   - Secondary [ ]
   - Tertiary [ ]

5. Occupation of respondent:
   - Farming [ ]
   - Trading [ ]
   - Seamstress [ ]
   - Government worker [ ]
   - please specify [ ]

6. Parity:
   - 1 [ ]
   - 2 [ ]
   - 3 [ ]
   - 4 [ ]
   - 6 and above. [ ]

7 Place of (ANC) Antenatal care in your last pregnancy?

Hospital/health centre	[ ]
TBAôs place	[ ]
Church/Spiritual Healing home	[ ]
Home	[ ]
Others please specify	[ ]

8 Who decided where you went for ANC during your last pregnancy?

Self	[ ]
Husband	[ ]
Mother	[ ]
Mother-in law	[ ]
Pastor	[ ]
Others please specify	[ ]

9 Who had the final decision on where you delivered your last baby?

Self	[ ]
Husband	[ ]
Mother	[ ]
Mother- in law	[ ]
Pastor	[ ]
Others please specify	[ ]

SECTION B
CHOICE OF BIRTHPLACE AND BIRTH ATTENDANTS DURING DELIVERY

10 Where did you deliver you last baby?

Hospital/health centre	[ ]
TBAôs place	[ ]
Church/spiritual home	[ ]
Home	[ ]
Others please specify	[ ]

11 If you delivered at the hospital, why did you prefer to deliver your baby there?

i) The place is near my house	[ ]
ii) I was told at ANC to deliver here	[ ]
iii) I had problem in my last delivery and was told to deliver here	[ ]
iv) Labour started at night	[ ]
v) They have equipment /drugs	[ ]
vi)They charge low	[ ]
vii)They are always available	[ ]
viii)They have qualified staff	[ ]
ix)They run 24hour service	[ ]
x)Their services are convenient to use	[ ]

12. If you delivered at the TBAôs place, why did you choose to deliver there?(tick)

i) The place is near my house. [ ]
ii) Labour started at night. [ ]
iii) They charge low [ ]
iv) Their services are convenient to use [ ]
v) They are always available [ ]
vi) Labour was too short [ ]
vii) They give traditional medicine [ ]

13. If you delivered at the church, why did you prefer to deliver there? (tick)
i)The place is near my house [ ]
ii)I had problem in my last delivery and I was told to deliver here [ ]
iii) Labour started at night. [ ]
iv)They see vision . [ ]
v)They pray for people. [ ]
vi) Protection from demonic attack [ ]
vii) Convenience [ ]
viii) Cost [ ]

14 .if you delivered at home, why did you prefer to deliver at home? (tick)
No money to pay for hospital bill [ ]
Labour started at night [ ]
Labour was too short(precipitate labour) [ ]
It was raining [ ]

15. Who took the delivery of your last baby?
a) Nurse/midwife [ ]
b) Doctor [ ]
c) TBA [ ]
d) Pastor /Spiritual woman of God [ ]
e) Others please specify----------

16. What were your reasons for choosing nurse/midwife to take your delivery:

She is always available [ ]
She is well qualified to do the job [ ]
She is caring and kind [ ]
She respects people [ ]
She treated me well in the last delivery [ ]

17) What were your reasons for choosing a TBA in your last delivery?
She knows the job [ ]
Treats people with respect [ ]
She lives near me [ ]
She is always available [ ]
She gives traditional medicine. [ ]
She knows our tradition [ ]
She charges low [ ]

18) What were your reasons for choosing pastor/Spiritual woman during your last delivery?

She prays for me [ ]
She sees vision [ ]
She knows the job [ ]
She can prevent evil attacks [ ]
She does not charge me [ ]

19) Why did you choose the doctor during your last delivery?
She knows the job [ ]
Well qualified to do the job. [ ]
Can do operation [ ]
I had problem in my last delivery. [ ]

20) What were your reasons for choosing any other healthcare provider specified here (mother, mother in law, sister, friend)
It is more convenient [ ]
I will not pay any money [ ]
She will take care of me [ ]
She is my mother [ ]
She knows the job

21) In future, do you hope to use the same birthplace?
Yes b. No

22) If yes, give reasons for your answer

---

23) If no give reasons for your answer

---

24) In future, would you want to use the same healthcare provider?
Yes b. No

25) If yes give reasons for your answer

---

26) If no give reasons for your answer
