

**PERSPECTIVES AND PRACTICES OF HEALTH WORKERS IN SELECTED LOCAL  
GOVERNMENT AREAS OF LAGOS STATE REGARDING FOCUSED ANTENATAL  
CARE**

**BY**

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**A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH,  
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### CERTIFICATION

This is to certify that this work was carried out by OGUNYOLUOLAYINKAOMOYENI under supervision in the Department of Community Health, College of Health Sciences, ObafemiAwolowo University, Ile-Ife, Osun State, Nigeria.

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**Date**

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## DEDICATION

I dedicate this project to God Almighty who made it possible for me to fulfil my set goal, to my loving parents and to my entire family.

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## ABBREVIATIONS

AGPMPM: Association of General AND Medical Practitioners of Nigeria.

ACNO: Assistant Chief Nursing Officer

CHEWs: Community Health Extension Workers

CHO: Community Health Officer

CNO: Chief Nursing Officer

FANC: Focused Antenatal Care.

FGD: Focused Group Discussions

GHS: Ghana Health Services

IUGR: Intra-Uterine Growth Retardation

JUTH: Jos University Teaching Hospital

LUTH: Lagos University Teaching Hospital Idi-Araba

NDHS: Nigeria Demographic and Health Survey

NYSC: National Youth Service Corps

PD: Perinatal Death

PPH: Post -Partum Haemorrhage

PHC: Primary Health Centre

RH: Reproductive Health

SBA: Skilled Birth Attendants

SDC: Socio-Demographic Characteristics

STI: Sexually Transmitted Infections

STD: Sexually Transmitted Diseases

WHO: World Health Organization

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## ABSTRACT

This study assessed the knowledge of health workers in Lagos Mainland and Mushin Local Government Areas of Lagos State about focused antenatal care (FANC) and the attitude/ beliefs of the health workers toward FANC. It further determined the acceptability and practice of FANC and the correlates of the practice of FANC among health workers in Lagos Mainland and Mushin Local Government Areas of Lagos State. This was with a view to examining the health workers' perspectives and practices regarding FANC.

The study employed both qualitative and quantitative methodologies. The quantitative survey was cross-sectional in design and was carried out with the aid of a semi-structured, self-administered questionnaire applied to 400 health workers at the selected health facilities. The qualitative design consisted of three focus group discussions (FGD) with doctors, nurses and community health workers. Quantitative data were analysed and presented using univariate, bivariate and multivariate statistical methods. Statistical significance was accepted at  $p < 0.05$ . Qualitative data were analysed using detailed content analysis and results presented with Z-Y index tables.

The results showed that 225 (56.2%) respondents were aware of FANC. Three hundred and forty-six respondents (86.5%) had no protocols on FANC, while 336 (84%) had no educational materials regarding FANC. One hundred and twenty-four (55.1%) of those aware of FANC knew that FANC visits should be carried out four times in normal pregnancy. However, only 38 (16.9%) of them knew that health workers were expected to spend approximately 46 mins with each patient during the first visit, while 46 (20.7%) knew that health workers were expected to

spend approximately 27 mins with each patient during revisits. The years of practice as a health worker was significantly and positively associated with the knowledge of FANC ( $\chi^2 = 21.048$ ;  $p < 0.005$ ). Regarding the gestational age when clients should visit, 140 (62.2%) respondents who were aware of FANC correctly reported that clients should first visit at 10-17 weeks, 143 (63.6%) correctly reported that second visit should be at 24-28 weeks and 29 (12.9%) correctly reported that third visit should be at 32 weeks. Two hundred and six respondents (91.6%) who were aware of FANC indicated that the strategy was acceptable to them. The practice of FANC was generally poor among the respondents; 321 (80.25%) were not practicing FANC in their health facilities while only 79 (19.75%) were practicing FANC. Seventy nine percent of the respondents believed that FANC is time consuming, while 76% believe that it is stressful. Overall, 51% of those aware of FANC demonstrated a positive attitude towards the practice of FANC. Respondents that had positive attitude towards FANC were 9 times more likely to practice FANC compared to those with negative attitude (OR= 9.65;  $p < 0.05$ ). Medical doctors were 14 times more likely to have good knowledge about FANC compared to other health workers (OR=14.32;  $p < 0.05$ ).

The study concluded that while significant proportions of the health workers had good knowledge of FANC, and were positively predisposed to it, the practice was poor. The major predictor of practice of FANC was the attitude of the health workers to the strategy.



## CHAPTER ONE

### INTRODUCTION

High maternal and perinatal mortality rates are particularly persistent health challenges in South Asia and sub-Saharan Africa; these two geographical areas account for nearly all such deaths globally (World Bank, 2006). Globally, of the estimated 210 million pregnancies each year, close to 60 million pregnancies end in miscarriages. (World Bank, 2006). Maternal deaths are frequently caused by such conditions such as hemorrhage, sepsis, hypertensive disorders and obstructed labour whereas perinatal deaths are usually attributed to low birth weight, infections or birth asphyxia (World Bank, 2006). However, Survey methods generally used to estimate maternal mortality in developing countries include the indirect sisterhood method and a direct variant of the sisterhood method (Graham et al, 1994).

Maternal mortality is a leading health and developmental problem in Nigeria. Significant proportions of maternal deaths in Nigeria are attributable to direct and indirect complications of prolonged and obstructed labour. Other causes of maternal deaths such as post-partum hemorrhage and puerperal sepsis are closely linked to the abnormal course of labour. Severe morbidity such as vesico-vagina fistula (VVF), chronic pelvic pain and mental retardation in children can also present from prolonged obstructed labour (Orji et al, 2002). Nigeria which has approximately two percent of the world's population contributes almost 10% of the world's maternal deaths (FMOH, 2005). Available data indicates that 59,000 women die yearly because of complications in childbirth (WHO, 2007). The Population and Housing Census conducted in Nigeria in 2006 estimates that about 65 million females exist in the country. Each year, about 6million women become pregnant, of which 5 million will result in childbirth

(WHO/UNFPA/UNICEF, 2007). The Nigerian National Reproductive Health Policy of 2001 targeted a 50% reduction in maternal mortality, from a national average of about 800 deaths to 400 deaths per 100,000 live births between 2001 and 2006. A 50% increase in access to safe blood transfusion services and emergency obstetrics care (EmOc) for woman of reproductive age. Nigeria is also a signatory to the Millennium Development Goal (MDG) of the United Nations member countries, goal 5 of which targets the reduction of maternal mortality by 75% between 1990 and 2015. The country is however not on track towards the realization of this goal. Recent estimates of the maternal mortality burden by the Federal Ministry of Health puts maternal mortality ratio at an unacceptable high figure of 545 per 100,000 live births (NPC/ICF Macro, 2009). In 2005, the World Health Organization reported maternal mortality ratio of 1100 per 100,000 live births in Nigeria (WHO, 2005). Likewise maternal mortality rate remains high in other African Countries like Sierra-Leone (2000), Afghanistan (1900), Malawi (1800), Angola (1700), Niger (1600), Tanzania (1500), Rwanda (1400) (WHO, UNICEF AND UNFPA, 2005).

Reducing maternal mortality is one of Nigeria's developmental priorities. One of the challenges in this respect is the quality of obstetric practices and access to skilled attendants (NPC/ICF Macro, 2009); poor and unavailable maternal health services and poor knowledge concerning the concept of emergency obstetrics care (EmOc) contribute to high maternal and perinatal mortality.

Ijadunola et al carried out a study at primary, secondary and tertiary health facilities (obstetrics units) in Ife central and Ife east local governments in 2010; 40% of staff reported counselling clients on complication readiness but structured observation revealed that no staff did, 9% of staff had ever been trained in life saving skills (LSS) and 70% of respondents still preferred the

strengthening of routine antenatal care services in the health facilities to the provision of access to EmOc services for all pregnant women who need it.

Utilization of maternal health services is associated with improved maternal and neonatal health outcomes. Certain factors may affect the utilization of these health services at individual, household and community levels. Babalola and Fatusi in 2009 carried out a study involving all the 36 states in Nigeria, education was identified as the only individual-level variable that is consistently a significant predictor of service utilization, while socio-economic level was also identified as the consistent significant predictor at the household level. At the community level, urban residence and community media saturation are consistently strong predictors. Economic reason also ranks strongly in the preference of some Nigerian women for TBAs as their services have been reported to be more affordable (Onah, 2003).

The concept of skilled attendant (SBA) during labour, delivery and immediate post-partum period could prevent many of maternal and perinatal deaths (Killew et al, 2007). Evidence in the literature showed high negative correlation between skilled birth attendants at birth and maternal and perinatal mortality. According to the World Health Organization(WHO), a skilled health worker (SAB) is an accredited health professional such as a doctor, nurse and midwife who had been educated and trained to proficiency in the skills necessary to manage normal (uncomplicated) pregnancies, childbirth and immediate post-delivery complications in women and newborn (WHO, 2008). Federal Ministry of Health reported that trained health personnel (skilled attendant at birth) attend 41.6% of births in Nigeria in 2001 but NDHS 2008 puts SAB at delivery at 43%.

Improved quality of obstetric practices during pregnancy and delivery is important for the health of both the mother and the baby thereby reducing maternal and perinatal mortality. The health care that a mother receives during pregnancy, at the time of delivery and soon after delivery is important for the survival and well-being of both the mother and her child. A complication that can occur during delivery and in the immediate post delivery period is post-

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