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**PREDICTIVE INTERACTION OF SOCIO-DEMOGRAPHIC
VARIABLES ON INCIDENCE OF PRE-ECLAMPSIA AMONG
PREGNANT WOMEN ATTENDING GOVERNMENT HOSPITALS IN
IBADAN, OYO STATE NIGERIA**

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Abstract

The study examined socio-demographic factors as predictors of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State. A descriptive survey research design was adopted for this study. Simple random sampling technique was used to select 460 respondents for the study. Self-developed and validated questionnaires were used to collect data. Inferential statistics of linear regression was used to test hypotheses at 0.05 alpha level. The findings revealed that age, ($F_{(1,458)} = 3.105$; $p < 0.05$), poverty ($F_{(1,458)} = 24.386$; $p < 0.05$), heredity ($F_{(1,458)} = 50.154$; $p < 0.05$), parity ($F_{(1,458)} = 123.631$; $p < 0.05$) and sedentary lifestyle ($F_{(1,458)} = 180.903$; $p < 0.05$) contributed significantly to pre-eclampsia. It was concluded that socio-demographic variables predicted incidence of pre-eclampsia. It was suggested that health education programme in which prevention of pre-eclampsia will be prominent should be organised for pregnant women attending government hospitals in Oyo State, Nigeria.

Keywords: socio-demographic factors, pregnant women, pre-eclampsia, government hospitals

Introduction

Good health status of pregnant women is important to the achievement of national development of a country. This perhaps explains why improved maternal health featured prominently as goal five in the Millennium Development Goals (MDGs). Suffice it

to note that the United Nations Millennium Development Goals are eight goals that all 191 UN member states have agreed to try to achieve by the year 2015. The continued occurrence of complications during the period of pregnancy among Nigerian women is a clear indication that the set goal 5 is far from been achieved in the country. Therefore, deployment of multidimensional approaches to improving the maternal health is compelling.

Pregnancy period in the life of a woman is associated with health problems. Office of Women's Health identified health problems during pregnancy among pregnant mothers as depression, ectopic fetal problems, gestational diabetes, high blood pressure, hyperemesis gravidarum, miscarriages, placental previa, placenta abruption, preterm labour, anaemia and pre-eclampsia (Omiunu, 2015). Pre-eclampsia is of interest in this study. This is largely because pre-eclampsia remained a significant public health problem contributing to maternal and perinatal morbidity and mortality (WHO, 2002).

Pre-eclampsia is a pregnancy related complication occurring in the second half of pregnancy. It usually occurs after 20 weeks of gestation. Pre-eclampsia, if left unattended to medically may progress to eclampsia. Pre-eclampsia and eclampsia are not distinct disorders but the manifestation of the spectrum of clinical symptoms of the same condition. In other words, eclampsia is normally a consequence of pre-eclampsia consisting of seizure and altered level of consciousness not caused by convulsive disorders with clear indications of severe pre-eclampsia. Essentially, pre-eclampsia is indicated when a pregnant woman develops high blood pressure (two separate readings taken at least six hours apart of 140 or more in systolic blood pressure and/or 90 or more in diastolic blood pressure) and 300mg of protein in a 24-hour urine sample (proteinuria). Symptoms of pre-eclampsia may include swelling of hands and face, headache and visual disturbance. The disease causes problems in the kidneys, liver, brain and blood of a pregnant woman. It also causes blood to flow to the placental at lower rate, a condition that makes the baby to be starved of oxygen and nutrition which may affect growth negatively.

According to Warden and Euerie (2002) pre-eclampsia is the second leading cause of maternal mortality worldwide accounting for 12-18% of pregnancy related death. The incidence of pre-eclampsia, the precursor to eclampsia varies greatly worldwide.

WHO estimates the incidence of pre-eclampsia to be seven times higher in developing countries (2.8% of live births) than in developed countries (0.4%) which is due to poor health seeking behaviour, non-availability of health care facilities and personnel (Dolea and Abouzahr, 2003). According to WHO (2005) approximately 37,000 women die annually because of pre-eclampsia or eclampsia related complications. In Northern Nigeria, pre-eclampsia accounts for 40% of maternal death (Abubakar, Abdullahi, Jibri, Dauda and Popoola, 2009). While in Southern Nigeria, the prevalent rate of the disease is between 5.6 – 7.6% (Alphonsosus, 2004). Adekunle and Akinbile (2009) found 83 cases of pre-eclampsia in a six-year retrospective study conducted in the South-west of Nigeria.

In this study socio-demographic factors are the independent variables. Olusanya, Alakija and Inem (2010) identified some socio-demographics such as (level of education, marital status) and cultural underpinnings of maternal health-seeking behaviour as contributory factors to complications of pre-eclampsia. Saftlas, Olson and Franks (1990) documented that factors for developing pre-eclampsia amongst others include primigravida, inherited tendency, molar pregnancy, maternal age below 20 years or over 30 years, obesity and chronic hypertension. Population Council (2009) identified as causes of pre-eclampsia, poor access to antenatal care, past history of pregnancy induced hypertension, abject poverty, poor reproductive health care seeking behaviour, cultural perception of eclampsia and lack of access to high quality maternal services such as intrapartum care.

Heredity is a predisposing factor to pre-eclampsia. Dolea and Abouzahra (2003) corroborate this assertion when they identified pre-eclampsia history in the family, pre-pregnancy hypertension and pre-eclampsia in previous pregnancy as risk factors of the disorder. The number of children given birth to previously otherwise call parity is a risk factor to pre-eclampsia. Poor engagement in physical exercise negates pregnancy healthy lifestyle.

Keeping mothers alive and healthy is good for women, their families and the society at large. Complications during pregnancy and childbirth are among the leading causes of death and disability among women of reproductive age in Nigeria. This is against the background that miscarriages, induced abortion and other factors cause more than 40% of the pregnancies in developing countries to result in complications, illnesses or

permanent disability for the mother or the child of which Nigeria accounted for a large percentage (WHO, 2005). According to Better Health (2014) researchers are looking for ways to predict pre-eclampsia in order to further minimise the risks for susceptible mothers and their babies. The study was carried out to examine socio-demographic factors as predictors of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State Nigeria.

Statement of the Problem

Pre-eclampsia has been noted to be a leading cause of maternal mortality in Nigeria. It is the cause of high morbidity and mortality for both mother and foetus. Offsprings of affected pregnancies are likely to have an increased risk of hypertension, heart disease and diabetes. Pre-eclampsia is the commonest cause of convulsions in pregnancy and for every woman who dies of maternal causes, 15 suffer from permanent disabilities and serious impairments (Ikechebelu and Okoli, 2002). Ignorance and misconception about the disease play an important role in the effect of the disease on women; other factors are lack of utilization of antenatal care and delay at accessing skilled care during delivery (Igberase and Ebeigbe, 2000). This study examined socio-demographic factors as predictors of incident of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State Nigeria.

Objectives of the study

The broad objective of the study was to find out socio-demographic variables as predictors of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State Nigeria.

Specifically, the study examined

- (i) Social variables as predictors of pre-eclampsia among the pregnant women.
- (ii) Demographic variables as predictors of pre-eclampsia among the pregnant women.

Hypotheses

1. Age will not significantly predict incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State Nigeria.

2. Poverty will not significantly predict incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State Nigeria.
3. Heredity will not significantly predict incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State Nigeria.
4. Parity will not significantly predict incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State Nigeria.
5. Sedentary lifestyle will not significantly predict incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State Nigeria.

Methodology

Research Design

Descriptive survey research design was used for this study.

Population

The population for this study comprised all pregnant women attending government hospitals in Ibadan, Oyo State.

Sample and Sampling Techniques

Purposive sampling technique was used to select two hospitals in Ibadan. These hospitals are University College Hospital and Adeoyo Maternity Hospital. 50% of the entire population of pregnant women registered in these health institutions were selected. Two hundred and ten (210) from University College Hospital and two hundred and fifty (250) from Adeoyo Maternity Hospital were randomly selected. This makes a total sample size of 460 respondents for this study.

Government hospitals having pre-eclampsia diagnosing kit	Number of pregnant women attending government hospital that are having pre-eclampsia diagnosing kit			Number of selected patients		
University College Hospital, Ibadan	4	2	0	2	1	0
Adeoyo Maternity Hospital, Ibadan	5	0	0	2	5	0
T o t a l	9	2	0	4	6	0

Research Instrument

The research instrument for this study was modified standardised questionnaire designed according to the variables

tested in the hypotheses. The questionnaires were constructed in four sections. Section A dealt with demographic characteristics of the respondents, Section B and C were used to elicit information in line with the tested variables. Sections B (SDFPPS) and C (PES) were in a 4-point modified Likert Format of Strongly Agree (SA), Agree (A), Disagree (D) and Strongly Disagree (SD). The corrected version of the questionnaires was administered to thirty (30) pregnant women attending antenatal clinic at Oniyanrin Maternity Health centre in Ibadan, as a pilot study. To estimate the reliability of the instruments, Cronbach Alpha method was used to test the internal consistency of the questionnaire. Socio-demographic factors predicting pre-eclampsia Scale (SDFPPS) yielded a reliability coefficient value of 0.7531 and pre-eclampsia scale (PES) yielded a reliability coefficient value of 0.653.

Procedure Data for Collection

The researchers administered the questionnaires to the respondents with the support of four research assistants.

Procedure for Data Analysis

Inferential statistics of linear regression was used to test the hypotheses at 0.05 alpha levels.

Results

Hypothesis One

Age will not significantly predict incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State Nigeria.

Table 1.1: Summary of prediction of age on incidence of pre-eclampsia

Model	Sum of Squares	D	f	Mean Square	F	P	Remark
Regression	23.976	1		23.976	3.105	.019	Significant
Residual	3505.147	4	5	7.721			
Total	3529.123	4	5	9			

$R=0.082$, $R^2 = 0.007$, $Adj. R^2 = 0.005$

Table 1.2: Regression analysis showing the relative contribution of age to incidence of pre-eclampsia

Model	Unstandardised coefficient		Standardized coefficient	T	S i
	B	Std. Error	β		
Constant	7.273	.367		19.818	.000
Age	.088	.050	.082	1.762	.011

Table 1.1 shows that age is a significant predictor of incidence of pre-eclampsia, with about 0.7% of the variations accounted for the independent variable ($F_{(1,458)} = 3.105$; $R = 0.082$, $R^2 = 0.007$, $p < 0.05$). Table 1.2 further shows the relative contribution of age on incidence of pre-eclampsia ($\beta = 0.82$; $p < 0.05$). This means that age significantly predicted and contributed to incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan. Hence, the null hypothesis was rejected.

Hypothesis Two

Poverty will not significantly predict incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State, Nigeria.

Table 2.1: Summary of prediction of poverty on incidence of pre-eclampsia

Model	Sum of Squares	D	f	Mean Square	F	P	Remark
Regression	179.900	1		179.900	24.386	.000	Significant
Residual	3349.222	4	5	7.377			
Total	3529.123	4	5	9			

$R=0.226$, $R^2 = 0.051$, $Adj. R^2 = 0.049$

Table 2.2: Regression Analysis showing the relative contribution of poverty to incidence of pre-eclampsia

M o d e l	Unstandardised coefficient			Standardised coefficient	T	S i g .
	B	Std. Error	β			
Constant	6 . 2 3 7	. 3 5 6	. 2 2 6	17.538	. 0 0 0	
Poverty	. 4 4 5	. 0 9 0		4.938	. 0 0 0	

Table 2.1 reveals that poverty is a significant predictor of incidence of pre-eclampsia with about 5.1% of the variation accounted for by the independent variable ($F_{(1,458)} = 24.386$; $R = 0.226$, $R^2 = 0.051$, $p < 0.05$). Table 2.2 further shows the relative contribution of poverty to incidence of pre-eclampsia ($\beta = .226$, $P < .05$). This means that poverty significantly predicted and contributed to incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State, Nigeria. Hence the null hypothesis was rejected.

Hypothesis Three

Heredity will not significantly predict incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State, Nigeria.

Table 3.1: Summary of prediction of heredity on incidence of pre-eclampsia

M o d e l	Sum of Squares	D	f	Mean Square	F	P	Remark
Regression	351.085	1		151.085	50.154	. 0 0 0	Significant
Residual	3178.038	4 5 8		7.000			
T o t a l	3529.123	4 5 9					

$R = 0.315$, $R^2 = 0.099$, $Adj. R^2 = 0.097$

Table 3.2: Regression Analysis showing the relative contribution of heredity to incidence of pre-eclampsia

M o d e l	Unstandardised coefficient			Standardised coefficient	T	S i g .
	B	Std. Error	β			
Constant	4 . 2 5 3	. 5 2 7	. 3 1 5	8.076	. 0 0 0	
Heredity	. 2 8 6	. 0 4 0		7.082	. 0 0 0	

Table 3.1 shows that heredity is a significant predictor of incidence of pre-eclampsia with about 9.9% of the variation

accounted for by the independent variable ($F_{(1,458)} = 50.154$; $R = 0.315$, $R^2 = 0.099$, $p < 0.05$). Table 3.2 also shows the relative contribution of heredity to incidence of pre-eclampsia ($\beta = 315$, $p < 0.05$). This means that heredity significantly predicted and contributed to incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State, Nigeria. Hence the null hypothesis was rejected.

Hypothesis Four

Parity will not significantly predict incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State, Nigeria.

Table 4.1: Summary of prediction of parity on incidence of pre-eclampsia

Model	Sum of Squares	D	f	Mean Square	F	P	Remark
Regression	755.341	1		755.341			
Residual	2773.782	4	5	8	6.1110	123.631	.0000 Significant
Total	3529.123	4	5	9			

$R = 0.463$, $R^2 = 0.214$, $Adj. R^2 = 0.212$

Table 4.2: Regression Analysis showing the relative contribution of parity to incidence of pre-eclampsia

Model	Unstandardised coefficient		Standardised coefficient	T	Sig
	B	Std. Error	β		
Constant	3.472	.413	.463	8.412	.0000
Parity	.781	.070	.463	11.119	.0000

Table 4.1 shows that parity is a significant predictor of incidence of pre-eclampsia with about 21.4% of the variation accounted for by the independent variable ($F_{(1,458)} = 123.631$; $R = 0.463$, $R^2 = 0.214$, $p < 0.05$). Table 4.2 also reveals the relative contribution of parity to incidence of pre-eclampsia ($\beta = .463$, $P < 0.05$). This means that parity significantly predicted and contributed to incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State, Nigeria. Hence the null hypothesis was rejected.

Hypothesis Five

Sedentary lifestyle will not significantly predict incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State, Nigeria.

Table 5.1: Summary of prediction of sedentary lifestyle on incidence of pre-eclampsia

Model	Sum of Squares	D	f	Mean Square	F	P	Remark
Regression	1005.553	1		1005.553	180.903	.000	Significant
Residual	2523.570	4	5	8			
Total	146881.795	4	5	9			

$R = .534$, $R^2 = 0.285$, $Adj R^2 = 0.283$

Table 5.2: Regression Analysis showing the relative contribution of sedentary lifestyle to incidence of pre-eclampsia

Model	Unstandardised coefficient		Standardised coefficient	T	Sig.
	B	Std. Error	β		
Constant	3.439	.348		9.881	.000
Physical Exercise	.595	.044	.534	13.450	.000

Table 5.1 reveals that sedentary lifestyle is a significant predictor of incidence of pre-eclampsia with about 28.5% of the variation accounted for by the independent variable ($F_{(1,458)} = 180.903$; $R = 0.534$, $R^2 = 0.285$, $p < 0.05$). Table 5.2 also shows the relative contribution of sedentary lifestyle to incidence of pre-eclampsia ($\beta = .534$, $P < .05$). This means that sedentary lifestyle significantly predicted and contributed to incidence of pre-eclampsia among pregnant women attending government hospitals in Ibadan, Oyo State, Nigeria. Hence, the null hypothesis was rejected.

Discussion of the Findings

The finding from this study shows that age was a predictor of incidence of pre-eclampsia. Earlier on Singh, Ahmed, Egundu and Ikechukwu (2014) had postulated that increasing maternal age and gravid multiparity are associated with medical disorders of pregnancy especially the risk of essential hypertension. Also, poverty was established to be a predictor of incidence of pre-eclampsia. This finding is in line with Begum, Begum, Quadiar, Akhter and Shamsuddin (2004) and Brackson, (2010) who affirmed that complications such as pre-eclampsia can be detected and

treated but it is worsened by lack of decision-making power, poverty and rising cost of health care.

In this study heredity was found to be a predictor of incidence of pre-eclampsia. Meanwhile, Salafia and Shiverick (1999) found that family history of pre-eclampsia is a leading risk factor and nearly triples the risk of other indicators of pre-eclampsia. Parity contributed to incidence of pre-eclampsia in this study. The number of a time a woman experience pregnancy could affect the health of the individual. This assertion arising from the result of the study is in line with the earlier finding of Odum (1995) that multiple pregnancies is a risk factor for developing hypertension disorders in pregnancy.

It was found in this study that sedentary lifestyle contributed to incidence of pre-eclampsia. Sporting lifestyle can be beneficial to the health of the people in any situation. It follows then that regular leisure-time physical activity in early pregnancy could significantly reduce the risk of pre-eclampsia. Tracey, Weissgerber, Wolfe and Davies (2004) found that frequent walking during the workday was associated with a significantly lower risk of pre-eclampsia.

Conclusion

The period of pregnancy is associated with various degrees of complications which often led to maternal foetal as well as neonatal morbidity and mortality. Pre-eclampsia is a condition in which hypertension occurs in pregnancy. In this study it was concluded that age, poverty, heredity, parity and sedentary lifestyle predicted incidence of pre-eclampsia among pregnant women.

Recommendations

Based on the findings of this study the following recommendations are made:

1. Health education programme in which pre-eclampsia prevention will feature prominently should be organised for pregnant women attending government hospitals in Oyo State.
2. Effort should be made to sustain and even increase antenatal services in governmental hospitals in the state. This can be done by providing adequate skilled staff, equipment and facilities.

3. Reliable data pool on maternal health services should be made available in government hospitals in Nigeria.
4. Poverty alleviation programme should be organised in Oyo State.
5. Provision must be made for physical exercise equipment and facilities in government hospitals. Also, pregnant women must be encouraged to participate in physical activities.

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