



## A Qualitative Study of Birth Preparedness and Complication Readiness among Community Members in a Rural Area

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### Abstract

*Birth preparedness and complication readiness (BP/CR) comprise a strategy to make women plan for birth, recognize common complications and encourage them to seek professional care in order to reduce poor pregnancy outcome by reducing the delays in seeking, reaching or receiving care. However, there are lacunae somewhere as the BP/CR messages do not translate to complete comprehension and full utilization of facility delivery. This qualitative study using focus group discussions (FGDs) explores the perceptions of the community on BP/CR.*

**Methods:** Six FGDs were conducted during May-June 2016. The FGDs had 10–12 participants in each group. Each group comprised older men and women and young men and women in a community in rural Maharashtra. A pretested questionnaire was used to conduct the FGDs. The topics for discussion centred around community experiences with antenatal and postnatal care services, cultural and social issues surrounding birth preparedness, recognition of maternal danger signs, and the use of traditional practices during pregnancy and childbirth.

*Qualitative content analysis was used to analyse the data.*

**Results:** The study revealed that hospital delivery was perceived to be safer than home delivery. Reasons cited for not attending the minimum requirement of four antenatal care services or two postnatal care services within the first month after delivery included distance to the health facility, poor road conditions and lack of money for transport. Findings included lack of community awareness about the danger signs during pregnancy and childbirth, that traditional birth attendants were important but that deliveries needed skilled care.

**Conclusion:** This study shows that the perceptions of the community regarding BP/CR are in favour of skilled care. The community is aware of the importance of attending ANC, saving money for buying supplies and organizing transport, but there was little awareness about recognising complications and importance of obstetric emergency care. It is important to provide information on BP/CR and schemes like JSK, JSSK through community health workers particularly during antenatal visits.

**Keywords:** Focus group discussions, perceptions, birth preparedness and complication readiness, rural Maharashtra.

### Introduction

Every pregnancy is a joyful moment for all mothers who visualize being handed a flawless “bundle of joy”.

However unpredictable complications can result in disastrous consequences. Worldwide, approximately 830 women died every single day due to complications during pregnancy or childbirth in 2015.<sup>(1)</sup> Thaddeus and Maine have

documented 'three delays' in seeking, reaching and obtaining appropriate care as the crucial factors for maternal mortality.<sup>(2)</sup>

Immediate and efficient professional care during antenatal, intra natal and post partum period can make the difference between life and death for a woman and her new born.<sup>(3)</sup>

The Maternal and Neonatal Health Program of JHPIEGO has developed the strategy of Birth preparedness and Complication readiness (BP/CR) addressing the factors that can be averted with advance preparation and rapid action, thus reducing the delays in seeking, reaching or receiving care.<sup>(3,4)</sup> Knowledge of danger signs, identifying a mode of transport, saving money, identifying a skilled attendant, identifying where to go in case of complications, and identifying a blood donor are all elements of BP/CR<sup>(5)</sup>

Reducing the global maternal mortality ratio (MMR) to less than 70 per 100 000 live births by 2030 (SDG Target 3.1) will require a global annual rate of reduction of at least 7.5%<sup>(1)</sup>. It is therefore crucially important to increase women's access to quality care before, during and after childbirth.

In developing countries women have poor knowledge of danger signs as shown in several studies.<sup>(6-9)</sup> In sub-Saharan countries studies have also found low knowledge of birth preparedness and the practice of BP/CR.<sup>(10,11)</sup> In a qualitative study on BP/CR in Tanzania by Furaha August (2015) it has been demonstrated that few women attending ANC are counselled on obstetric danger signs during their very short visits.<sup>(12)</sup> However in a study by Musa et al in Ethiopia more than half of the respondents were prepared for birth and its complications.<sup>(13)</sup>

There is evidence from India<sup>(14)</sup> Ethiopia<sup>(15)</sup> and Ghana<sup>(16)</sup> that promoting BP/CR improves knowledge about danger signs of pregnancy and childbirth and also preventive and care seeking behaviour.

Maharashtra has many remote rural areas and tribal pockets where the concept of BP/CR is not well understood. This study has been conducted in

a group of 5 villages and remote tribal areas. The primary health centre is located 10 kilometres away, government hospitals and MGM hospital at Kamothe are all located 30 kilometres away. Access to the nearby sub centre is hampered by rocky and bad roads. The sub centre does not provide 24X7 services and the quality of services are often not satisfactory. To sustain the MDG target and go on to achieve the SDG target it is necessary for the concept of BPCR to percolate to all the remote areas. However no study has been done in rural Maharashtra to explore this concept among men and women. The aim of this study was to explore the perceptions, experiences and challenges faced by the community regarding BP/CR.

## Materials and Methods

### Study design

A qualitative study design using focus group discussions (FGDs) was employed to explore the perception of the community on BP/CR. FGDs involved group interactions and were used to capture a wealth of information about these perceptions.

### Study area

The study was conducted in 5 villages in catchment area of Tara group Gram Panchayat. The total population is around 6000. The villages are a part of field practice area of Rural Health Training Centre (RHTC) of the Department of Community Medicine of MGM Medical College, Kamothe.

The FGDs were conducted in the Anganwadi centres of the 5 villages.

### Study Period

Six FGDs were conducted during May-June 2016.

### Ethical Considerations

The study protocol was reviewed and cleared by The Institutional Ethical Committee of the institution. The participants were told the aim of the study and that their participation was voluntary, that their identities would not be revealed and that the information they provided

would only be used for research purposes and would be kept confidential. Verbal consent to participate was given by each of the participants.

#### Data collection

Six FGDs were conducted during May-June 2016. The FGDs had 10–12 participants in each group. Each group comprised of older men and women and young men and women (Table 1). A pretested questionnaire was used to conduct the FGDs. The topics for discussion included knowledge about the components of birth preparedness during pregnancy and childbirth, cultural and social issues surrounding it, steps taken to prepare for pregnancy and potential complications during childbirth in the community, recognition of maternal danger signs, and the use of traditional practices during pregnancy and childbirth. (Table 2)

The focus group discussions would begin with the moderator asking the participants to talk and interact about what happens when a woman in their family is pregnant. What are the aspects they look into while preparing for childbirth and how do they propose to tackle emergency situations that may arise during pregnancy, during labour and after childbirth?

The FGDs were conducted in Marathi and were audio-recorded and lasted about 45 minutes to 1 hour. All FGDs were led by a moderator and some notes were taken by an observer.

**Table 1** FGD with participants' particulars

Participants	Age range	Average age	Number of participants	Number of FGDs
Young men	20–36	25	13	3
Young women	19–34	23	16	3
Older men	51–76	55	12	3
Older women	50–74	52	14	3

**Table: 2** Main topics included in the questionnaire used for focus group discussions

During pregnancy and Delivery	During postnatal period
Type of ANC services received	Type of PNC services received
Reasons for attending ANC services	Reasons for attending PNC services
Frequency of ANC visits	Frequency of PNC visits
Constraints of accessing ANC services	Constraints of accessing PNC services
Satisfaction for using ANC services	Satisfaction for using PNC services
Knowledge about danger signs during pregnancy and childbirth	Knowledge about danger signs during Post natal period
Fee for ANC services	Fee for PNC services
Reasons for not attending ANC services	Reasons for not attending PNC services
Reasons for using TBA services	Reasons for using TBA services
Community attitude towards health Professionals	Community attitude towards health Professionals
Family support and decision making on health services during pregnancy and labour	Family support and decision making on health services during post natal period
Traditional practices and beliefs during Pregnancy and labour	Traditional practices and beliefs during post natal period
Government schemes discussed/not discussed during ANC visits	

#### Data analysis

A qualitative content analysis approach, as described by Graneheim and Lundman, was used to analyse the data.<sup>(17)</sup> The manifest meanings expressed were looked for during the analysis. The recorded and written textual material was read several times to understand the crux of the expressed views.<sup>(12)</sup> The thematic units were configured according to relevance criteria or aim of the study. Categories and subcategories were developed. Table 3.

#### Results

During the analysis, 'Birth preparedness - important for all births', 'If complications arise then hospital care necessary', and 'Midwives and birth attendants necessary' were the manifest meanings and each of these were divided into

several subcategories. Views of some participants which emerged from the FGDs are quoted.

**Table 3** Categories and subcategories on perception of birth preparedness and complication readiness

1. <b>Birth preparedness is important for all births</b>
<ul style="list-style-type: none"> <li>• ANC important but has challenges</li> <li>• Facility delivery preferred</li> <li>• Reason for irregular ANC check up due to economic reasons/distance/poor roads.</li> </ul>
2. <b>If complications arise then hospital care necessary'</b>
<ul style="list-style-type: none"> <li>• Recognising danger signs</li> <li>• Health centre services known to be free but practically often not so</li> <li>• Men decide but in consultation</li> <li>• Traditional beliefs are given less importance than before</li> <li>• Government schemes are not discussed during ANC visits</li> </ul>
3 <b>Midwives and traditional birth attendants necessary</b>
<ul style="list-style-type: none"> <li>• Necessary in the case of home deliveries.</li> <li>• They live within the community and hence they are readily accessible.</li> </ul>

### **Birth preparedness is important for all births ANC important but has challenges**

It was discussed that it is essential to make ANC visits and preparations for delivery at the hospital, though in the past women would attend for the first time at term or if they had pregnancy or childbirth related problems. The practice now however is to attend for check-ups at the health centre/hospital and most women deliver in hospital.

### **Reasons cited for not attending ANC/PNC visits**

These reasons include distance to the health facility and lack of money for transport, bad roads, or if there was no one to tend to their children in their absence.

“We live far from the health centre and the roads are bad. I may have to deliver right here though I do not want to.” (Young woman, FGD)

“I am not sick why should I go to the midwife/health centre [after delivery]? I do not want to waste my money. My mother-in-law is old and cannot tend to my son”(A young mother, FGD)

### **Facility delivery is preferred**

Hospital delivery was perceived to be safer than home delivery. Confidence in the competency of the well-trained health workers was also expressed. They also stated that, in this community, few women deliver at home (except in the adivasipada of Banbaiwadi).

“I will feel safe if I deliver in hospital. During delivery my sister had a lot of trouble but she delivered safely in hospital.”(A 23 year old pregnant woman during FGD)

Although facility delivery is preferred, at times the intention to do so was not always followed. Traditional birth attendants (TBAs) are consulted in the case of home deliveries. They live within the community and hence they are readily accessible and can come quickly to the home. TBAs are preferred for attendance at home during pregnancy and advising instead of regular visits to health centre. This is cheaper.

“I called the village midwife because my son’s wife had some bleeding in the 4th month of pregnancy. It was cheaper to call her than to arrange for vehicle.” (Older woman, FGD)

### **If complications arise then hospital care necessary**

#### **Recognising danger signs**

The FGD participants mentioned few complications that may occur during pregnancy and childbirth like fits during pregnancy, prolonged labour, excessive vaginal bleeding after childbirth.

However many common complications were unknown to most women and they felt that such issues were not discussed during ANC visits. They stated that they could go to the health centre and the doctor would advise.

### **Health centre services known to be free but practically often not so**

Despite the fact that the community prefers to go to a health facility and know that the services are free, they reported that they are told to buy drugs and other essentials.

“Health workers often tell the pregnant woman to bring a new blade, clean clothes, gloves and thread for the delivery. If they do not they are scolded. This happened to my friend’s son?” (Older man, FGD)

### **The husband/men take the decision but in consultation**

Participants reported that the decision to go to health facility for delivery or emergency is usually made by the husband but in consultation with other older members of the family.

### **Traditional beliefs are given less importance than before**

The community explained that in the past they used to believe that eating certain foods like eggs, green leafy vegetables was detrimental to the unborn foetus but now they believe the opposite. TBAs sometimes advised to apply cow dung on the umbilical cord after delivery but most women said that this was an old custom only.

### **Government schemes are not discussed during ANC visits**

The community was not aware about schemes like JSY, JSSK which provide help in emergency situations. Studies by Mukhopadhyay et al in West Bengal reveal poor awareness about assistance provided by these government schemes.<sup>(14)</sup> According to Concurrent evaluation of NRHM (2009), 48.7% women had awareness about JSY in India.<sup>(18)</sup>

### **Strengths and limitations**

This qualitative study using different participants in terms of age, and gender was strength because this provided different perspectives of how BP/CR is discussed and used.

A possible limitation is that the participants may not have disclosed their true perceptions and have given socially correct answers as the interviews were conducted by doctors and medical staff.

Another limitation is that women are introvert by nature. However, the women participants in my

study were eager to participate and interact with one another.

### **Conclusions**

This study shows that the perceptions of the community regarding BP/CR are in favour of skilled care. The community is aware of the importance of attending ANC, saving money for buying supplies, but there was little awareness about recognising complications and importance of obstetric emergency care. This awareness could be improved by providing information on birth preparedness messages through community health workers during the routine antenatal visits.

Issues related to distance, poverty, informal costs, inability to prepare in advance hinder the realisation of the intention to use skilled care.

The community does not have a mechanism in place to help those who are in need in case of an emergency.

It is important to innovate on how the community reinforces BP/CR, such as using the schemes like JSK, JSSK.

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