

## Perceptions and practices among married women of child bearing age regarding obstetric danger signs in rural Islamabad: A qualitative study

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### Abstract

**Objective:** To explore women's perceptions regarding obstetric danger signs and their practices to deal with them in their cultural context.

**Methods:** The exploratory qualitative study was conducted in Moorian, Jagiot and Kurri, three rural areas around Islamabad, Pakistan, from June to September, 2016. Data about understanding and practices regarding obstetric danger signs was collected from married women of reproductive age through focus group discussions. Data analysis was done manually using the content analysis approach.

**Results:** There were 85 women with a mean age  $32\pm 6.80$  years who participated in a total of 12 focus group discussions in batches of 6-8 subjects each. Majority of women 64(75%) were unaware of key obstetric danger signs and symptoms. Traditional practices and several home remedies were commonly used to manage complications in pregnancy before seeking medical care, which was only done when the condition became unmanageable at home. However, mostly women 78(92%) preferred hospital for antenatal care services, especially private health facilities, due to perceived better quality of services.

**Conclusion:** Cultural practices were found to be deep-rooted in rural population.

**Keywords:** Perceptions, Practices, Married women, Reproductive age, Obstetric danger signs. (JPMA 68: 1496; 2018)

### Introduction

Nearly 66,000 women die annually from preventable causes related to pregnancy in our region, mainly due to avoidable complications of pregnancy and childbirth. Almost all of these deaths occur in low-resource settings.<sup>1</sup> Given that such a big percentage of maternal mortalities and morbidities are attributed to the period of pregnancy, it becomes necessary to comprehensively investigate those factors that contribute to such figures.

Most women of reproductive age experience the normal physiological process of pregnancy at some stage in their life. However, some may experience problems and complications that are potentially life-threatening to the mother and the foetus. Evidence shows that 75% of maternal deaths are due to direct obstetric complications, such as haemorrhage, sepsis, hypertensive disorders of pregnancy, obstructed and prolonged labour and unsafe abortion.<sup>1-5</sup> Women need to be able to recognise the early signs of danger during pregnancy and delivery in order to get expert obstetric care. Poor understanding of risk factors and complications in pregnancy is identified as one of the primary factors leading to delays in seeking expert care.<sup>6</sup>

In Pakistan, where the maternal mortality rate (MMR) is

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178/100,000 live births,<sup>7</sup> antenatal care coverage from skilled provider is 73.1%, but only 37.1% complete their 4 antenatal visits, 48.2% deliveries take place in health facilities and only 52% deliver with a skilled provider.<sup>8</sup> This low utilisation of skilled health services could be due to lack of understanding of obstetric danger signs or staunch adherence to cultural beliefs and practices. In order to promote greater use of skilled maternal care, there is a need to understand women's beliefs regarding skilled care during pregnancy, based on which behaviour change messages can be designed to increase utilisation of healthcare services by pregnant women, especially in rural areas. The current study was planned to explore rural women's perceptions and practices regarding recognition and management of obstetric danger signs.

### Subjects and Methods

The exploratory qualitative study was conducted in Jagiot, Moorian and Kuri, three adjacent rural communities around Islamabad capital territory (ICT), Pakistan, from June to September, 2016. The population of these villages ranges from 4000 to 6000 respectively. Healthcare services are provided through a single basic health unit (BHU) in Jagiot, also catering to Moorian and Kuri. In the absence of any other government or private health facilities in these villages, timely access to health services for routine and emergency care is challenging. Beside the BHU, 09 lady health workers (LHWs) and 01 lady health visitor (LHV) also provide community-based

primary healthcare services.

The target population comprised married women of reproductive age (MWRA), including women who were currently pregnant, or in postpartum period and women who had children less than 5 years of age. In terms of educational background, mostly women 22(26%) had no formal schooling, some 58(68%) had received formal schooling till primary or middle. Very few 12(14%) had education till secondary or higher secondary level and only one participant had graduated from a university.

A framework was developed as the guiding tool for FGDs (Figure) which also helped in summarising the results.

Invitation to participate was extended to all eligible participants through local LHWs, and all those who consented were included. Approval for the study was obtained from the ethics committee of the Health Services Academy, Islamabad. Discussions were conducted in the local language. Question guide was pilot-tested for repeatability, duration and cultural sensitivity. Necessary changes were then made in FGD guide after pilot-testing. Topics to be explored in FGDs were noted (Table-1).

In each of the three villages, 4 FGDs were conducted. During the FGDs, vignettes were used. Vignette describes an event, happening, circumstance, or other scenario, the wording of which often is experimentally controlled by the researcher and at least one of the different versions of the vignette is randomly assigned to different subsets of respondents.<sup>1</sup> Vignettes related to key obstetric danger signs, including bleeding (haemorrhage), fever(sepsis), swollen hand and feet(pre-eclampsia) and fits (eclampsia). They were used in story and pictorial form to help the respondents in identifying the problem and share opinion more openly and clearly.

All the FGDs were audio-recorded, translated and transcribed later. The transcribing process involved repeated review of transcripts and audiotapes. Transcribed data was analysed by using content analysis approach. Data was reduced while preserving the core meaning. Meaning units were identified, condensed and then coded. Codes were then clustered together and sub-

categories followed by categories were created. Related categories were merged and a main theme was identified.

## Results

There were 85 women with a mean age  $32\pm 6.80$  years. The village women had a very poor understanding of obstetric danger signs and this affected their approach for seeking timely care. Managing complications at home with traditional remedies before seeking healthcare was very common practice. Their understanding was mostly based on either experiential learning of elders and relatives or their own experiences (Table-2).

The main theme extracted from all the discussion showed a very strong influence of cultural beliefs and practices regarding maternal healthcare and ultimately on care seeking behaviour in case of complications.

"Our grandmother's experience is not less than doctors. They told the due time for delivery by looking at the woman and when anyone experiences any problem she tells home remedies for this. She cures obstetric problems with traditional methods which provide quick relief". (MWRA: Kurri)

The main theme was supported by the following sub-themes.

The first sub-theme was 'cultural practices related to pregnancy and maternity care'. Almost all the women had knowledge about the early signs and symptoms of pregnancy such as missing periods, nausea, fatigue and vomiting. Majority of women reported using urine dipstick to confirm pregnancy.

Regarding self-care, women mentioned practices of eating more than normal, not bearing heavy weight,

**Table-1:** Topic explored in FGDs.

◆ Pregnancy diagnosis
◆ Knowledge on danger signs
◆ Source of information about pregnancy and delivery
◆ Cultural practices and perceptions regarding obstetric complications and their management.
◆ Choice of place for delivery
◆ Health seeking behaviour in pregnancy

**Table-2:** Results.

Theme	Sub-themes	Categories
Traditional health care practices - essential part of rural cultural life	Cultural practices related to pregnancy and maternity care Obstetric danger signs - Perceptions and practices	Routine practices for pregnancy care Decision making patterns for seeking care Understanding of obstetric danger signs Cultural care practices for ODSs

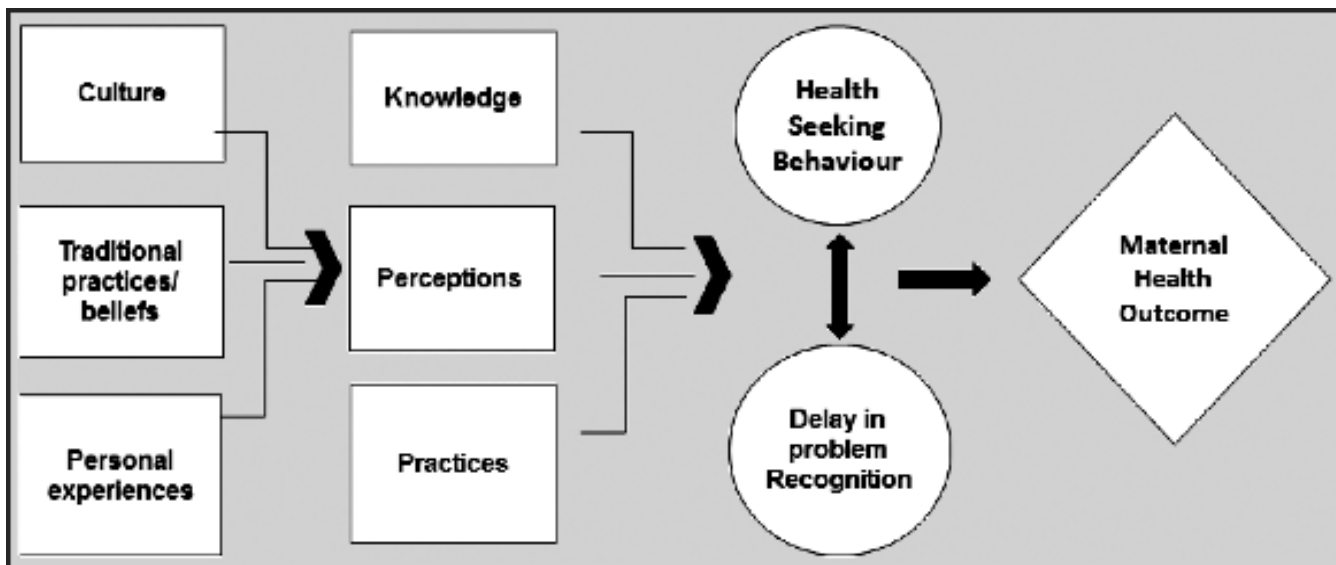


Figure: Framework for Focus Group Discussions (FGDs).

avoid squatting and putting weight on legs, and avoiding stress. But multiparous women, based on their experiences, had opposing views regarding these precautions in pregnancy.

"It all depends upon fate. Some women do all types of work but they do not have any problem and some women are on bed all the time but they face serious problems and miscarriages. It is upon Allah, not in the control of humans". (MWRA, multiparous: Moorian).

However, there were women in the discussion groups who did not practise any type of dietary restrictions. The concept of use and effect of 'hot' and 'cold' food was adhered to very strictly in these villages. Traditional belief is that 'hot' foods are thermo genic and, hence, should be taken in cool weather or when the body needs energy. Similarly, 'cold' foods should be taken in hot weather to regulate body temperatures. Pregnancy is considered a 'hot' condition and, hence, the belief that consuming too much 'hot' food in pregnancy will lead to bleeding or abortion and excess of 'cold' foods will cause backache. Similarly, some specific foods, like eggs, rice and some vegetables, were also prohibited in pregnancy and even during the postpartum period to avoid any harm to both mother and the foetus/newborn.

"We encourage a pregnant woman to eat whatever she wants. But to avoid trouble to the foetus, she should avoid hot foods because if woman eats hot food during pregnancy she has abortion. In our village, women also do not eat eggs in pregnancy because it hardens the body of

pregnant women like the shell of egg due to which child delivery becomes difficult". (MWRA: Jagiot)

The second sub-theme was, 'decision-making patterns for seeking care'. All women in FGDs had the unanimous view that a health facility was the best place to seek antenatal care (ANC) and they went to a doctor for antenatal check-up. The majority 78(92%) preferred to go to private clinics or secondary-level government hospital. A significant number of women 7(8%) never went to a healthcare provider for ANC, especially those who preferred home delivery and trusted traditional birth attendant (TBA) or faith-healer or were under the influence of mother or mother-in-law and did not believe in seeking care from a skilled birth attendant (SBA) unless they experienced any problem.

Majority of women 74(87%) shared that deciding the place for delivery is women's own choice and that their family members also support the decision of institutional delivery. Some women 32(38%) were of the view that in hospitals, doctors only do delivery by a Caesarean section (CS) so they felt afraid to go to a hospital for delivery.

Women who were educated or had previous bad experience of home delivery preferred hospital while others considered home delivery favourable if their antenatal period was safe and they felt no danger.

"If a pregnant woman experiences any problem in pregnancy, she must go to hospital for delivery but if she has a normal pregnancy which can be managed at home then she should deliver at home. I have 5 kids and 3 were

born at home and 2 at hospital. Honestly speaking, my first daughter was born at home very easily without any problem but in my next pregnancy my liquor was less, so doctor referred me to hospital but I was ignored there. My children who were born at home are healthier than those who were born in hospital. I think in hospital proper care is not given to patient and that is why home delivery is better because woman gets at least proper care from family". (MWRA: Kuri).

The third theme was 'understanding of obstetric danger signs (ODSs)'. FGDs results highlighted that cultural perceptions about ODSs determined the management of issues. Mostly women 64(75%) were not aware of key danger signs in pregnancy, especially newly-married, primigravida women. Some women had knowledge due to their personal experiences and their information was based on symptoms and medical diagnosis, shared by the doctor. This included issues such as insufficient amniotic fluid, breach presentation of baby, and high blood pressure.

Although women preferred to go seek treatment in a hospital in case of any problem, they were unable to recognise the danger signs in time for which care should be taken immediately; rather they took them as normal part of pregnancy and tried to manage them at home with traditional remedies or self-medications. Abnormal swelling of hands and feet, considered a cardinal sign for pre-eclampsia, was discussed within three FGD groups but surprisingly none of the women considered it dangerous or showed concern about it. All had the opinion that it is normal and essential part of pregnancy and most of the women experience this problem so there was no need to seek treatment for it.

"We do not go to hospital for every problem in pregnancy. Some problems can be managed at home. I had this problem (of swollen hands and feet) and severe headache in all my pregnancies. I took rest and used Brufen syrup and tablet throughout pregnancy without prescription because I felt relief after taking it. I did not seek treatment for it. My mother-in-law gave me raw coconut in milk and dry fruits to relieve pain so that my brain gets energy and prevent such things". (MWRA; Moorian)

Participants were not aware of the reason for eclampsia or eclamptic fits in pregnancy and neither were they aware of associated signs and symptoms of severe headache, apprehension, swollen hands or feet and jerky movements of body; rather they related it with weakness, impure diet, workload or mental stress in pregnancy, but they considered it dangerous for both mother and foetus.

Their opinion was that such conditions cannot be managed at home and they preferred hospital for seeking care. However, several women 46(54%) related obstetric complications with 'evil eye', 'evil spirits' and they preferred to seek spiritual care from faith-healers, specifically for fever and obstructive labour.

The final sub-theme was 'cultural care practices for ODSs'. Women had very strong faith on traditional cultural practices and using them was an essential part of their pregnancy care routine. The LHWs from the local community also favoured the use of traditional remedies and rituals for some of the health issues in pregnancy.

Each village community had their specific rituals, with specific explanations, which they followed in pregnancy. Most of their rituals were to avoid or cure the complication which occurred in pregnancy. Common rituals included use of raw eggs or clarified butter (desi ghee) to relieve backache in pregnancy; drinking castor oil in warm milk to induce labour, especially near term. The practice of squatting while cleaning floor, especially in the last month of pregnancy, was also common and pregnant women were encouraged to do so.

With reference to bleeding in pregnancy, a common practice was use of a starch based drink, prepared at home.

"Bleeding occurs in pregnancy when internal heat increases and a woman should eat cold thing to stop it. We use starch (nashasta) for this problem which we prepare at home and almost all women know this. Wheat is soaked in water for 3 to 4 days. When wheat grains absorb water and grow in size then we grind them in juicer and that paste is dried which comes into powder form. If any pregnant woman complains of bleeding or spotting, that powder is mixed in cold water and given to the women for drinking so her problem is relieved". (LHW; FGD Moorian)

The women of study area also mentioned the practice of eating dirt from a local Sufi saint's (Bari Imam, the patron saint of Islamabad and Pothohar region) shrine at LoiDandi for curing common ailments and illnesses. The practice of giving holy water (ZamZam water) during fever was also very common.

In the discussions, the women were asked about the issue of obstructed labour and how do they identify it. The local belief was that the women who have some marital problems face such problems and these women should try to resolve the issues with their husband so that she can deliver the baby easily; some families also had a specific ritual for that.

"If a woman has difficult delivery and baby is not coming out during delivery, it means her husband is not happy with her. So that women washes her husband's feet and drink that water. This makes delivery easy for her". FGD Women: Kurri).

## Discussion

This study qualitatively explored the understanding of rural women regarding maternal healthcare, especially during pregnancy, understanding of ODSs, their practices and care-seeking behaviour relevant to the cultural context. It is generally believed that since pregnancy is a natural process of women's reproductive functions, therefore problems or complications arising during pregnancy are natural to it.<sup>9-11</sup> Such beliefs contribute to delay in decision of seeking care which in turn leads to lack of utilisation of medical services and consequently increased maternal morbidity and mortality rate. The current study highlighted that age, education, parity, presence of complications, occupation and attending antenatal clinics were important factors which helped for better and right understanding of ODSs. Researchers reported that women who had secondary education or more were better aware, and primigravida women need more consideration when giving knowledge about ODSs.<sup>12-14</sup>

In rural areas, low literacy and limited sources of information contribute to the decision-making process. In this study, the major and primary source of information were family members, especially mothers, mothers-in-law or elder sisters, who transferred the traditional knowledge, handed down from elders; a generation-by-generation transfer of knowledge based on personal experiences and experiments. Most of these enforce use of multiple sources of care including herbalist, biomedical and spiritual care. Reliance on similar modes of care are found prevalent in several developing countries.<sup>14,15</sup>

Research evidence suggests that community health workers can successfully change community practices when trained effectively and properly supervised.<sup>16,17</sup> In the study area,<sup>9</sup> LHWs were providing primary healthcare services but still people had poor awareness of ODSs. It maybe that the LHWs own acceptance of traditional beliefs about ODSs. Their views regarding ODSs and their management matched those of the lay women of community. This showed the strong influence of cultural beliefs in the study area and gaps in training of LHWs. This might be due to LHWs own poor understanding and hence their reinforcement of community's beliefs and practices. Those women who preferred home delivery had negative perceptions about institutional delivery,

mainly due to fear of CS and delay in care at the hospital. Others believed that if labour starts at home, then it is a better place due to better care provision by the family members. Those women who had previous bad experience of home delivery were more likely to deliver at health facility.<sup>18,19</sup> The most commonly stated danger sign by the women who had comparatively better understanding was intrapartum bleeding or spotting. However, the practice of using oral starch solutions for the purpose was not reported by any published literature.

Study results also show that all the traditional practices during pregnancy were not wrong or harmful. The practice of squatting position during the last trimester of pregnancy helps strengthen pelvic floor muscles and makes delivery quick and easy.<sup>20-22</sup> However, the use of clarified butter (desi ghee) which was a widely common practice during the last trimester of pregnancy, is not recommended and supported by literature.<sup>23-25</sup>

Most of the women did not consider signs of pre-eclampsia (swelling of hands and feet, headaches) as symptoms of a disease. They took it as a normal part of pregnancy. Although women were not aware of the reasons for fits in pregnancy, they knew women can develop high blood pressure in pregnancy. Stress and weakness was the commonly believed cause for high blood pressure in pregnancy.<sup>26,27</sup>

The results highlighted that women of the study area had culturally dominant beliefs and practices and were influenced by the traditions. They had lack of access to accurate information which also contributed to poor perceptions and malpractices.

Community-based participatory health education strategies are highly recommended to address the poor perceptions and malpractices about ODSs. For this purpose, regular trainings and supervision of community health workers (CHWs), including lady health supervisors (LHSs), LHV and LHWs, is crucial.

## Conclusion

Women living in rural areas around Islamabad had poor understanding of ODSs despite geographical proximity to the urban area and adequate coverage by LHWs. Source of information and cultural influence were the main contributors for poor perceptions and practices. Accurate perception of ODSs is a critical step in minimising the high levels of maternal morbidity and mortality in Pakistan.

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