Factors Associated with First Delay to Seek Emergency Obstetric Care Services among the Mother of Matsari VDC of Rautahat District

[1]Navin Kumar Jha
[1]School of Health and Allied Sciences, Pokhara University, Kaski, Nepal

ABSTRACT

Pregnancy is a physiological process but also a period of potential risk leading to complications during labor, delivery, and postnatal period. The provision of care for women during pregnancy and childbirth is essential to ensure a healthy and successful outcome of pregnancy for the mother and her newborn. About 15 percent of pregnancies and childbirths need emergency obstetric care because of risks that are difficult to predict. Most life-threatening complications occur during labor and delivery, and these all can't be predicted. This community based descriptive study was carried out among the mothers having one year from December-April 2011. All the mothers (105) of VDC having one-year children were taken as unit of study. Purposive sampling was used with self-administered questionnaire to collect the related data and information. Majority of the respondents (61 percent) were housewife, 53.3 percent respondents were illiterate, and 76 percent women had knowledge about clean delivery practices. Only 9.5 percent respondents could take decision about their health problems. Transport vehicle were not available (88) at need and incase of referral and major mode of transportation was rickshaw (36 percent). EOC services were free and staff behavior was good. The study concludes that husband had major role in decision-making. Negligence of severity and socio-culture factors had also high prevalence in study area. EOC services were free but there was little cost of transportation, commodities and food cost of visitors and patients.

Key words: *Emergency Obstetric care (EOC), Mother, Decision Making, Delay, Maternal Mortality.*

Corresponding address: *Navin Kumar Jha, School of Health and Allied Sciences, Pokhara University, Kaski, Nepal. E-mail: urs.nabin@gmail.com*

INTRODUCTION

Pregnancy is a physiological process but also a period of potential risk leading to complications during labor, delivery, and postnatal period. The provision of care for women during pregnancy and childbirth is essential to ensure a healthy and successful outcome of pregnancy for the mother and her newborn. Maternal mortality is a global burden, many women dying due to pregnancy and childbirth-related complications. Birth-preparedness and complication readiness is a comprehensive strategy to improve the use of skilled providers at birth, the key intervention to decrease maternal mortality.[1] All pregnant women are at risk of obstetric complications. About 15 percent of pregnancies and childbirths need emergency obstetric care because of risks that are difficult to predict. Most life-threatening complications occur during labor and delivery, and these all can't be predicted. Every pregnant woman needs access to facilities with capabilities to provide emergency obstetric care (EOC) services. Neither effective prenatal care nor identifying risk will help women, if EOC is not available, not accessible, or not utilized.[2]

Emergency obstetric care refers to the care of women and newborns during pregnancy, delivery and the time after delivery. There are two types of emergency obstetric care, basic EOC and Comprehensive EOC. Functions used to define Basic EOC services: administer parenteral antibiotics, parenteral oxytoxic drugs, parenteral sedatives/ anticonvulsants, perform manual removal of placenta, and assisted vaginal delivery and resuscitation of newborn and referral. Functions used to define Comprehensive EOC services are all of those used in Basic EOC services and anesthesia, surgery (e.g. caesarean section, curettage) and blood transfusion.[3]

There are three main delays in utilization of emergency obstetric care. Delay in seeking medical care, delay in reaching health services and delay in receiving medical care. Delay in seeking appropriate medical help for an obstetric emergency for reasons of cost, lack of recognition of an emergency, poor education, lack of access to information and gender inequality. Delay in seeking care plays a vital role in maternal mortality. It increases the time of other two delays. We can prevent more than ninety percent of maternal death by reducing the time of first delay.[4]

Maternal Mortality Ratio (MMR) for Nepal is very high with 281 deaths per 100,000 live births and the needs for treatment of women with obstetric complications are in adequately met.[5] Obstacle to utilize the maternal health care in Nepal is geography, limited infrastructure and lack and cost of transport provide major physical and logistic barriers to accessing health services. Lack of the time due to heavy work burden restricts women's health care seeking and cultural preference and beliefs regarding care practices may influence women to seek care outside the formal sector. Women's low social status, lack of knowledge about illness and general lack of awareness about obstetric / gynecological danger signs, as well as the low value given to their lives, also delay their health care seeking. Discrimination of low caste women by provider, lack of privacy, and absence of female health care provider and rude behavior of service provider

prevent them for accessing care. A culture of silence or opposition from family member, particularly mother in law leads to often-fatal delay in seeking care.[6] The main objective of the study was to describe the factors related with first delay to seek EOC services among the mothers having one year of children of Matsari VDC.

MATERIAL AND METHODS

The study was community based descriptive type conducted among the mothers having one-year children of Matsari VDC of Rautahat district from December-April, 2011. VDC was selected purposively. All the women (105) having one year children were interview in the study using semi-structured questionnaire. Data were processed in SPSS software and analyzed using frequency table and graph. Women were refused to give consent and mentally disable women were excluded in the study.

RESULTS

Regarding socio-demographic characteristics maximum number of respondent were in (49.5 percent) in 26-35 year, entire of the respondents (105) were from Hindu religion. Majority of the respondents (61 percent) were homemaker, 23 percent farmer, 8.6 percent labor, 5.7 percent jobholder, 1.8 percent in other occupation. 53.3 percent respondents were illiterate followed by 20 percent primary level, 19 percent secondary level, 6.7 percent higher secondary level and one percent had completed above higher secondary. Regarding educational status of respondent's husband, illiterate 30.5 percent followed by 28.6 percent secondary level, 20 percent primary level, 17.1 percent higher secondary level and 3.8 percent had completed above higher secondary. Only 76 percent women had knowledge about clean delivery practices and 24 had not idea about it.

Table 1: Distribution of the respondent by the response about decision regarding health problem

Can you take decision about your health problem	Frequency (N=105)	Percent
Yes	10	9.5
No	95	90.5
Who decide about your health problem	Frequency (N=95)	Percent
Father in law	33	31.4
Mother in law	14	13.3
Husband	42	40
Other(community people)	6	5.7

Only 9.5 percent respondents could take decision about their health problem remaining 90.5 percent could not take decision about their health problem. Among 95, who couldn't take decision about their health problems, 40 percent respondent's decision was made by husband, 31.4 percent by father in law, 13.3 percent by mother in law and 5.7 percent by other (community people).

About 17 percent respondent had detected complications during ANC visit and 28 percent had experienced complications during delivery. Minimum distance from health facility was 1 km and maximum 7 km, most of the population (33.3 percent) was in distance of 2 km. and staff behavior was good (66 percent). It was found that respondents who were completed secondary class (27 percent) and engaged in job (6 percent) can take decision herself (9 percent) and husband (42 percent) and other elder person(father in law-33 percent, mother in law 14 percent) had major role to take decision. Cultural beliefs had high prevalence (100 percent) in study area. About 17 percent respondent had complication during ANC and 28 percent during delivery. Most of the respondent was staying within the distance of 2-4 km from health center providing BEOC services. Transport vehicle were not available (88) at need and incase of referral and major mode of transportation was rickshaw (36 percent). EOC services were free and staff behavior was good.

It was found that respondents who were completed secondary class (27 percent) and engaged in job (6 percent) can take decision herself (9 percent) and husband (42 percent) and other elder person(father in law-33 percent, mother in law 14 percent) had major role to take decision.

About 17 percent respondent had detected complications during ANC visit and 28 percent had experienced complications during delivery. Minimum distance from health facility was 1 km and maximum 7 km, most of the population (33.3 percent) was in distance of 2 km. and staff behavior was good (66 percent).

Regarding the question did any socio-culture factors affects in seeking EOC services majority of the responses 71.4 percent answered privacy followed by 68.6 percent shyness (service provider is male), 56.2 percent prolong labour is considered as normal phenomena and 51.4 percent delivered first baby in home.

DISCUSSION

The study describes the socio-demographic characteristics, knowledge related factors, and IEC related factors and factors related to delay to seek care. In this study 105 respondents were interviewed with the help of pretested semi structured questionnaire.

This study showed that only11 percent respondent had knowledge about all five-danger signs. Only 9.5 percent respondent could take self-decision about their health problem, most of the decision was taken by husband. Minimum distance from health facility was one kilometer and maximum 7 kilometer, most of the population (33.3 percent) was in distance of 2 kilometer. only 16 percent respondent had told that ambulance was available at need and 89 percent had told that service was free. The entire respondent had replied that socio-culture factors were main obstacle to decide to seek care. According to Panth and Shrestha "A case study of the EOC service user in Baglung hospital" 15 percent of the mothers was able to recall five major obstetric complications (good knowledge).

Husband has a significant role in decision-making, traditional healers were the first contact person in 51.5 percent cases. Only assess to hospital was by walking one hour plus or

minus and other means. The knowledge about danger signs of obstetric complications, husband role in family decision-making and their educational status, unavailability of transport at need has influenced the decision to seek care. The value system, norms, beliefs and tradition were also the major factors related seek EOC services. In this study decision making and recall of five dangers sings decreased because majority of respondents were illiterate.[7]

According to survey done by institute of medicine in September-2004, "Utilization of Emergency Obstetric Care (EmOC) in Selected Districts of Nepal" traditional harmful beliefs lead to complacency and delay in seeking care. Some other harmful traditional practices, fear of costs and lack of financial preparedness for such an eventuality lead to delay to seek care.[8] Only two percent of the mother had made decision themselves, for 83 percent male members of the family, for 10 percent mother in-law. In this study service, cost had not any role in decision making because EOC services are free now.

According to Josephine Borghi, Veronique Filippi *et. al.,* "Overview of the costs of obstetric care and the economic and social consequences for households" obstetric care costs in hospitals were showed to be significant.[9] The official user charges interact with unofficial costs, transport costs and time costs resulting in catastrophic expenditures and debt, particularly in the event of complications. Finding a source of financial protection for poor women is essential as they suffer the greatest impact of payments, and are more likely to be deterred from seeking care. This study showed that EOC service was free but other indirect cost like transportation, feeding cost of patient and visitors influence to seek care.

According to the NDHS survey-2006, about one in two women expressed concern that there may not be a health provider or female health provider available so they did not want to go alone, and expressed concern about security. Concerns about money, transport and distance were cited about two or in five women. Few women perceived getting permission from someone else as barrier to seeking health care for themselves. Not surprisingly, rural women, women with no education, and those from poorest households were more likely to state that accessing health care for any reasons was a big problem.[10] In this study also showed that educational status, transportation, decision making capacity of women and privacy were the major factors but getting permission and distance were not found as a barrier because study was carried out in Terai region.

According to a survey done by Safe Motherhood Innovation Project (SMIP) in 2004 -2007 in Nepal, women in the country, particularly in the rural areas, are dying due to poor maternal health system suffering from modestly trained staff, staff absenteeism, shortfalls in equipment and drugs, limited support to community based staff, a poor referral system, and cultural and geographical barriers. Decision-making: Overall 32.6 percent of the respondents reported that they had taken decision on their own about their health care.[11] This study also supports all above factor. Study was carried out in Teria of Nepal so geographical distribution was not found as major factors in delay to seek EOC services. Most of the respondents were staying near the health facility about distance of 2-4 kilometer.

According to Shane Duffy, "obstetric haemorrhage in Gimbie, Ethopia" delay in seeking and reaching appropriate care relates directly to the issue of access. It encompasses factors within the family and in the community, including a woman's status, knowledge of life threatening pregnancy complications. This study also showed that women status had a major role in deciding to seek care. Female having completed higher secondary (6.7 percent), women in job (5.7 percent) could take decision herself (9.5 percent).

CONCLUSION

Finding indicate that respondents who were completed secondary class (27 percent) and engaged in job (6 percent) can take decision herself (9 percent), husband had major role in decision making . Most of the respondent was staying within the distance of 2-4 km from health center providing BEOC services. Transport vehicle were not available (88 percent) cases at need and major mode of transportation was rickshaw (36 percent). EOC services were free and staff behavior was good. Negligence of severity and socio-culture factors had also high prevalence (100 percent) in study area. EOC services were free but there was little cost of transportation, commodities and food cost of visitors and patients.

ACKNOWLEDGEMENT

I would like to express my deep gratitude to Dr. Nadira Mehariban and Dr. Zia Mamoom assistant professor and Prof. Dr. Manowar Ahmad Tarafdar Northern University Bangladesh, for their academic guidance during my study. I am also very much thankful to Village Health Worker and FCHVs of Matsari Sub Health Post and all the respondents of the respondents of this study.

REFERENCES

1. Tuladhar H, Khanal R, Kayastha S, Giri A. Complications of home delivery: Our experience at Nepal Medical College Teaching Hospital. JNCTH 2009;11(3):164-169.
2. May P. Preventing Maternal Mortality through Emergency Obstetric Care. USA: SARA Issues Paper 1997.
3. Monitoring EOC a handbook. Geneva: WHO 2009. Available from: http://www.scribd.com/doc/35149397/EmOC-Monitoring
4. Annual report. Kathmandu: Ministry of Health and Population; 2008/2009.
5. Hunt P, Bueno J. Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health. New York: UNFPA; 2009.
6. Nepal maternal mortality and morbidity study. Kathmandu: Ministry of health and population, Family Health Division; 2008/2009.
7. Panth NP, Shrestha B. Factors related to the utilization of EOC service: A case study of EOC service users in Baglung Hospital. JNHRC. 2004; 11(3):5.
8. Institute of Medicine. Study on Utilization of Emergency Obstetric Care (EmOC) in Selected Districts of Nepal. Kathmandu: IOM; 2004.
9. Borghi1 J, Tagmatarchi SK. Overview of the costs of obstetric care and the economic and social consequences for households Studies in HSO&P; 2008.
10. Nepal Demographic and Health Survey. Kathmandu: MOHP, DOHS. 2007;154.
11. Safe Motherhood Innovation Project. End line Survey Report. Nepal: ADRA Nepal; 2004 -2007.