

## Birth Preparedness and Complication Readiness among Pregnant Women in Okpatu Community, Enugu State, Nigeria

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**ABSTRACT:** Every pregnant woman faces risk of life-threatening obstetric complications. A birth-preparedness package promotes active preparation and assists in decision-making for healthcare seeking in case of such complications. This paper seeks to investigate how pregnant women in Okpatu Community prepare for delivery and in the event of complication. A Qualitative phenomenological type of study was conducted; and analyzed using thematic analysis. Respondents consisting of 87 pregnant women were used for the study. Focus group consisted of 5-10 women during each session of 45 minutes interview. Results shows that majority of the participants do not visit any health care facility until their third trimester, where as the TBAs places are mostly visit. Also majority of the participants do not engage in any form of preparation until after delivery. Participants noted that they will invite their mothers to assist them with domestic chores and care of the new baby. However they seem not to have any formal preparation for other siblings. The status of birth preparedness and complication readiness was low in Okpatu community. Socio demographic, economic, knowledge of key danger signs, attitude toward antenatal care use were identified as associated factors hindering birth preparedness in this community. The husbands are not committed to their wives' needs in preparing for delivery as deduced from some of the responses by the women. The women do not prepare until they are about to deliver.

**KEYWORDS:** Birth preparedness, complications readiness, pregnant, women, Traditional Birth Attendants.

### 1 BACKGROUND

Childbirth is said to be a highly joyful experience <sup>[1]</sup>, yet for many women, child bearing is experienced not as the joyful event as it should be <sup>[2]</sup>. Maternal mortality is a global public health challenge, with more than 500,000 women dying each year due to pregnancy and childbirth-related complications. Maternal mortality in Nigeria is second only to that of India <sup>[3]</sup>. Nigeria accounts for only 2% of the world population but accounts for up to 10% of the maternal mortality rates <sup>[4]</sup>. Nigeria is also a leading contributor to the maternal death figure in sub-Saharan Africa not only because of the hugeness of her population but also because of her high maternal mortality ratio <sup>[5]</sup>.

Birth preparedness is a comprehensive strategy to improve the use of skilled providers at birth and the key intervention to decrease maternal mortality. Birth preparedness and complication readiness (BP/CR) is the process of planning for normal birth and anticipating actions needed in case of emergency. The elements of birth preparedness includes: knowing danger signs, planning for birth attendants and birth location, arranging transportation, identifying a blood donor and saving money in case of an obstetrics complication and attending antenatal clinic <sup>[6]</sup>. Pregnant women should have a written plan for birth and for dealing with unexpected adverse events that may occur in pregnancy, delivery or immediate postpartum period. This plan can be written in the birth preparedness card and reviewed with a skilled attendant at each antenatal assessment <sup>[7, 8, 9]</sup>.

According to a group of researchers; birth preparedness include selecting a birth location, identifying a skilled provider and making the necessary plans to receive skilled care for normal births and preparing for rapid action in the event of an obstetric emergency <sup>[10]</sup>. It is therefore an essential component of the safe motherhood program. They opined that the most recent demographic and health survey in Nigeria reported that only 39% of births were attended by skilled birth attendants. They equally observed that complication readiness facilitates urgent skilled attention when an obstetric emergency occurs. An emergency plan include identifying the nearest functional 24hours emergency obstetric care facility, means of transportation in emergency, suitable blood donors, sources of emergency funds, designation of a person to make decisions on the woman's behalf and a person to care for her family while she is away <sup>[10]</sup>.

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According to a study on birth preparedness and complication readiness of pregnant women attending the three levels of health facilities in Ife central local government, it was discovered that majority (79.4%) of respondents have not identified a blood donor, while many respondents (72.8%) had identified someone who can make decisions on their behalf in case they are unable to make them. About 65% of respondents had identified the source of emergency funds and majority of respondents 81.9% had identified an emergency means of transport. A total of 240(60.8%) respondents had identified a health facility around them for emergency services, while most of the respondents 91.2% had identified a way of communication in case of an emergency <sup>[11]</sup>.

Birth preparedness and complication readiness (BP/CR) is a safe motherhood strategy which addresses delays that could increase the risk of dying in pregnancy, child birth and the immediate postpartum period. The strategy has not been effectively implemented in Nigeria hence maternal mortality remains unacceptably high.

The principle and practice of birth preparedness and complication readiness in developing countries like Nigeria are prevailing illiteracy, inefficient infrastructure, poor transport system, and unpredictable access to skilled care providers have the potential of reducing the existing high maternal and neonatal morbidity and mortality.

This situation informed the researchers' choice of the topic; "Birth Preparedness and Complication Readiness" to ascertain what women do in Okpatu community in preparation for delivery; with the following objectives:

- Ascertain the gestational age at which they start preparing for delivery.
- Identify their choice of birth facility.
- Identify their choice of birth attendant.
- Assess their level of financial commitment.
- Identify their level of preparedness in cases of emergencies.

The purpose of the study is to find out how pregnant women in Okpatu community prepare for delivery and in the event of complication. It is expected that findings from the study will help to ascertain lapses in the ways women prepare for birth, serve as a useful guide for policy makers in decision towards improving the standard of the health facility and also add to the existing body of knowledge as well as serve as a reference point for other researchers who will carry out studies in related topic.

## **2 MATERIAL AND METHODS**

### **2.1 RESEARCH DESIGN**

A qualitative study was done which is a phenomenon necessary in laying foundation for subsequence research.

### **2.2 AREA OF STUDY**

The study was carried out between 1<sup>st</sup> July and 13<sup>th</sup> August 2013 in Okpatu, a rural community located in Udi Local Government Area, Enugu State. The Okpatu Community is made up of two autonomous communities comprising of 12 villages namely; Umeleme, Amegbu, Umuchime, Amagu, Amaukwu, Eziam, Amorka, Amani, Amachalla, Umuene, Obiagu and Amaolugbu. The main ethnic group in the community is Ibo and the common language is Ibo. The major occupation of the community is farming and petty trading while the predominant religion is Christianity.

### **2.3 POPULATION OF STUDY**

The population of study were pregnant women.

### **2.4 SAMPLING TECHNIQUES**

Purposeful sampling method was used, in which women who were pregnant were selected from the population for the study. Convenient sampling was used to meet a total of 87 women used.

#### **2.4.1 INCLUSION CRITERIA**

- Must be within the child bearing age of 15- 49 years.
- Must be pregnant within the period of study.
- Must live in Okpatu community.
- Must be willing to participate in the study.

### **2.5 INSTRUMENT FOR DATA COLLECTION**

The Instruments for data collection was structured in- depth interview guide. The structured interview guide consisting two sections: section A consists of participants' demographic data, and section B consists the research questions. The instruments consist of 12 open ended questions. The questions were translated in Igbo for easy understanding by the participants.

### **2.6 METHOD OF DATA COLLECTION**

Data was collected using focus group discussion and in-depth interview approaches to obtain information from the participants, and each focus group ranged from 5-10 in numbers. In some villages the turnout was poor and the number available was used. A total of 12 focus groups were used. On the average each discussion lasted for 45 minutes. There are three researchers in the group, one of the researchers acted as a facilitator while the second and third researchers played the role of note takers in every interview session. The discussions were taped and taken down on note. The tape version of the discussion was transcribed and the analysis of the content made. The data were categorized according to research objectives and the categories examined for relationship among different categories.

### **2.7 ETHICAL CONSIDERATION**

The researchers used the first week for familiarization tour to the various communities. The Igwe, the local government chairman and the head of department of health in the local government were informed about the proposed study and their consents were obtained. The researchers entered into the communities through the chairman of health committee. The chairman of health committee also assisted in organising the mobilizers and a warm reception given to the researchers while the purpose of the exercise was clearly explained. With the aid of a facilitator during each visit, the researchers were able to assess all the communities. The participants were made to understand the purpose of the study and they willingly gave their consent.

### 3 RESULT

Data were collected and processed following the sequence, transcribing and sorting, organising and ordering of data. The material collected were listened to and gone through over and over again. Coding and tagging of section of collected data and subsequent development of themes or categories. Final analysis was done thematically.

After going through the above stages in our study, the following themes were generated:-

#### 3.1 GREATER PERCENTAGE OF THE PARTICIPANTS START VISITING THE TBAs AT THE THIRD TRIMESTER OF PREGNANCY WHICH THEY ATTRIBUTED TO BE THE TIME THEY CAN TRULY SAY THEY ARE PREGNANT

Majority of the participants responded that they do not go to any health care facility until when they are in their third trimester and this was attributed to the fact that that is the time they know that they are pregnant. Comments like *"watin I won go hospital for wen I no no how whether na real pregnancy"*. *"That place no good oh, them they do only operation"*. *"Those maternity (TBAs) beta because them fit pray for somebody wen somtin bad one happen and the e go beta, and the person go deliver"*.

#### 3.2 A GREATER PERCENTAGE OF THE WOMEN HAVE NO FORM OF BIRTH PREPAREDNESS BEFORE DELIVERY

Majority of the participants responded that they do not engage in any form of preparation until after delivery. For instant most of them claimed that they do not prepare until they are sure of the baby's sex. For example, a participant was asked how do you prepare your house in anticipation of the coming baby answered *"ah! there is no special preparation, is it not normal thing?"* and another person asked if they should build a new house to welcome the baby.

#### 3.3 THE ITEMS NEEDED FOR DELIVERY ARE NOT BOUGHT UNTIL THE BABY IS BORN

Majority of the participants responded that they do not buy their babies' items until after delivery. This can be inferred from their answers when asked when they start to buy their babies' items. For instant a participant answered *"I buy my baby's things when I'm in the last month of pregnancy."* Another participant said *"I no dey buy my baby's items until after I born."* and another one said : *"my husband does not give money for the baby's items until after the baby is born"*.

#### 3.4 THE MEN ARE NOT SUPPORTIVE DURING PREGNANCY; THERE SEEM TO BE NO DIFFERENCE BETWEEN WHEN THEIR WIVES ARE PREGNANT AND WHEN THEY ARE NOT

A good number of participants claimed that their husbands do not give any special care when they are pregnant compare to when they are not. For instance, a participant when asked, does your husband help in the house chores when you are pregnant? Said he doesn't really care if am pregnant or not, he will tell me that I am not carrying the baby on the legs or hands. Another when asked how her husband relates with her during pregnancy said he does not have any special regards.

#### 3.5 MAJORITY OF THE PARTICIPANTS DO NOT HAVE ANY FORM OF PREPARATION TOWARDS EMERGENCY BLOOD TRANSFUSION, EMERGENCY TRANSPORTATION AND EMERGENCY FINANCIAL ARRANGEMENT, THEY BELIEVE THAT GOD SHALL NOT ALLOW SUCH NEEDS TO ARISE

This can be deduced from their responses when asked about their preparation towards emergency blood transfusion, emergency transportation and emergency financial arrangement. One participant said: *"my God is faithful and shall not allow such to happen to me."*

Another woman said: *"God forbid, is not my portion"*. Another one said *"I do not pray for that but when it happens, there are always people around that will assist"*.

#### 3.6 A GOOD NUMBER OF PARTICIPANTS PLAN TO INVITE THEIR MOTHERS TO ASSIST THEM IN THE CARE OF THE BABY AND OTHER HOME CHORES AFTER DELIVERY

Participants noted that they will invite their mothers to assist them with domestic chores and care of the new baby. However they seem not to have any formal preparation for other siblings. Home arrangement remains the same for welcoming the new born. Responds like *"my mama go come take care of me and the pikin"*. Another said *"which*

preparation? we no go build house for the pikinna". As regards the other siblings, their responds were like "them don old na".

### **3.7 A GREATER PERCENTAGE OF PARTICIPANTS SEEM NOT TO HAVE DIFFERENCE IN WHAT THEY EAT BEFORE AND DURING PREGNANCY**

Majority of the participants don't have any special food. As they said, they eat any food available. However, there are some food taboos prohibiting the pregnant women from eating snail, grass cutter, squirrel, and bitter cola.

## **4 DISCUSSION**

It was discovered that majority of our respondents do not register their pregnancies in the health facility rather they visit the TBAs and at third trimester. This is in line with the findings of study conducted by Hailu, Gebremariam, Alemseged, and Deribe mail (2011), on birth Preparedness and Complication Readiness among Pregnant Women in Southern Ethiopia. BP/CR practice in Okpatu community was found to be low. While few community members identified the hospital and skilled attendants as their preferred source of delivery care, in practice the majority of women rely on TBAs, who are more accessible. The cost of TBAs is relatively low and payment options are flexible. Moreover, TBAs are available night and day and transport is generally not required. Many study respondents indicated that while they would prefer to deliver at a health facility, they did not even consider this a realistic option due to issues concerning cost, distance and transport. The timing of the onset of labour also appears to play a crucial role in determining where women deliver. If labour begins at night, there simply is no transport available to enable her to reach a health facility. In other words, the "decision" to deliver at home or with a TBA may simply be a reflection of the fact that there is no alternative in many of these communities. Effort to increase BP/CR should focus on availing antenatal care services.

The TBAs was also found to be the choice of respondents where majority prefer to have their ANC and even deliver there. This is in line with the findings of study conducted by Hailu, Gebremariam, Alemseged, and Deribe mail (2011), on birth Preparedness and Complication Readiness among Pregnant Women in Southern Ethiopia where majority of the respondents reported that they intended to deliver at home, and only few planned to deliver at health facilities.

Majority of the participants do not have any form of preparation towards emergency blood transfusion, emergency transportation and emergency financial arrangement. This is in contrast to Abioye, *et al.* (2011), in their study on birth preparedness and complication readiness of pregnant women attending the three levels of health facilities in Ife central local government, Where Majority of respondents have not identified a blood donor, but many respondents had identified someone who can make decisions on their behalf in case they are unable to make them, had identified the source of emergency funds, had identified an emergency means of transport, had identified a health facility around them for emergency services and had identified a way of communication in case of an emergency.

Lack of money and transportation is a barrier to seeking care as well as identifying and reaching medical facilities (Thaddeus and Maine 2004). Money saved by the woman or her family may not pay for health services and supplies, transport, or other costs. If the woman can afford to pay for these costs, she is more likely to seek care. The woman herself may not be the person saving money; rather, the money may be part of a common household pot. There is little empirical evidence to know if it is important for the woman to have saved the money versus having access to household savings. There is also little evidence to suggest what sum of money may be effective in improving health outcomes in different circumstances. Many factors including the severity of a complication, distance to a health facility and cost of healthcare services will determine the amount of money needed. This indicator measures whether the woman or her family put aside any money at all, even if it may be too little money to make a difference. With future research, it may be possible to develop recommendations for amounts of money to save in specific settings.

## **5 CONCLUSION**

The status of birth preparedness and complication readiness was low in Okpatu community. Socio demographic, economic, knowledge of key danger signs, attitude toward antenatal care use were identified as associated factors hindering birth preparedness in this community. The husbands are not committed to their wives' needs in preparing for delivery as deduced from some of the responses by the women. The women do not prepare until they are about to deliver, the implication of this is that obstetric emergencies are not detected early which portends danger. Therefore, Responsibility for Birth preparedness must be shared among all safe motherhood stakeholders namely; policymakers, facility managers, providers, communities, families, and women as a coordinated effort is relevant in reducing the delays that contribute to maternal and new-born deaths. Adequate number of health workers should be trained and sent to the only health facility in

the community to ensure proper coverage of the shifts and availability of skilled health care providers; as this will improve antenatal care (ANC), giving special emphasis to knowledge of key danger signs, BP and CR during health education and ANC counseling as a short term solution, while women education, job and income generating activities to raise the socio-economic status of the women are recommended as long term interventions. Addressing the cultural beliefs and practices, improving health care provider-client relationship and sensitizing male partners on complications associated with pregnancy and child birth can go a long way in promoting male partner involvement in promoting deliveries by skilled attendants.

## REFERENCES

- [1]. P.F.J.A. Amedee, *Pain Management for Women in Labour: An Overview of Systematic Reviews: RHL Commentary*. The WHO Reproductive Health Library; Geneva: World Health Organization. last revised: 1 March 2013
- [2]. M. Hailu, A. Gebremariam, F. Alemseged, and K. Deribe, *Birth Preparedness and Complication Readiness among Pregnant Women in Southern Ethiopia*. PLoS ONE; (6)6: 2011, e21432.
- [3]. U. C. Emma-Ukaegbu, H. I. Nwokeukwu, and B.S.C Uzochukwu. *An Assessment Of Birth Preparedness And Complication Readiness In Antenatal Women In Umuahia North Local Government Area, Abia State, Nigeria*. IOSR Journal of Dental and Medical Sciences:(13)1 2014, 90-94
- [4]. Federal Ministry of Health (FMOH) [Nigeria]. *Road Map for Accelerating the Attainment of the Millennium Development Goals Related to Maternal and Newborn Health In Nigeria*. Abuja, FMOH; 2005. 38
- [5]. K. Hill, K. Thomas, C. Abouzahr, N. Walker, L. Say, M. Inoue, and E. Suzuki, *Estimates of Maternal Mortality Worldwide Between 1990 and 2005: An Assessment Of Available Data*. Lancet. 370(9595): 2007, 1311–1319.
- [6]. I. A. Ibrahim, G. I. O. Owoeye, and V. Wagbatsoma, *The Concept of Birth Preparedness in the Niger Delta of Nigeria*. Greener Journal of Medical Sciences, 3 (1), 2013, 001-007.
- [7]. WHO (2006). *Standard For Maternal and Neonatal Care. Birth and Emergency Preparedness in antenatal care. Integrated Management of Pregnancy and Childbirth (impact)*,
- [8]. K. Muhammedawel, and A. Mesfin, *Birth Preparedness and Complication Readiness in Robe Woreda, Arsi Zone, Oromia Region, Central Ethiopia: A Cross-Sectional Study*, Reproductive Health, (11)55, 2014, 2-12
- [9]. D. Markos, and D. Bogale, *Birth preparedness and complication readiness among women of child bearing age group in Gobaworeda, Oromia region, Ethiopia*, BMC Pregnancy and Childbirth, 14(282), 2014,1186-1196.
- [10]. E. A. Kuteyi, J. O. Kutu, I. C. Lateef, J. A. Ogundipe, T. Mogbeyteren, T. and M. A. Banjo, *Birth Preparedness and complication Readiness of Pregnant Women attending the Three levels of Health Facilities in Ife central Local Government Nigeria*. Journal of Community Medicine & Primary Health Care, 23 (1&2), 2011, 54-59.
- [11]. Abioye, Kuteyi, Okutu, Lateef, Ogundipe, Mogbeyteren and Banjo, *Birth Preparedness and Complication Readiness of Pregnant Women Attending the Three Levels of Health Facilities in Ife Central Local Government*, Journal Of Community Medicine & Primary Health Care, 27(4), 2011, 55-59.