CODEN [USA]: IAJPBB ISSN: 2349-7750

INDO AMERICAN JOURNAL OF
PHARMACEUTICAL SCIENCES

http://doi.org/10.5281/zenodo.3581772

Available online at: http://www.iajps.com *Research Article*

WOMEN'S PREFERENCE REGARDING PLACE OF DELIVERY

[1] Hafiz Muhammad Muzammil, [2] Muhammad Raza, [3] Tayyaba Ismail

[1] Bahawal Victoria Hospital, Bahawalpur., [2] Sheikh Zayed Hospital Rahim Yar Khan, [3] Benazir Bhutto Hospital Rawalpindi.

Article Received: October 2019 **Accepted:** November 2019 **Published:** December 2019

Abstract:

Objective: *To determine the women's preference for place of delivery among pregnant women of Bahawalpur City.*

Material and Methods: *This cross sectional study was conducted at Outpatient department of gynecology unit of Bahawal Victoria hospital, Bahawalpur and included 100 participants. Informed consent was taken from all participants. All the women in third trimester of pregnancy were included. Preformed and pretested questionnaire was used for data collection.*

Results: *Out of 100 women of reproductive age group, 84 women preferred health care outlet for the place of delivery and 16 women preferred home as a place of delivery.*

Conclusion: *Majority of women preferred H.C.O to deliver baby while only few preferred home for delivery of child. It was concluded that mostly women preferred H.C.O for safe and secure delivery and good quality of care. Those who preferred home wanted privacy, family support and family environment.*

Keywords: *Pregnancy, Preference, Delivery.*

Corresponding author:

Hafiz Muhammad Muzammil,

Bahawal Victoria Hospital, Bahawalpur.

QR code

Please cite this article in press Hafiz Muhammad Muzammil et al., ***Women's Preference Regarding Place Of Delivery.,*** *Indo Am. J. P. Sci, 2019; 06(12).*

INTRODUCTION:

Pregnancy is the period from conception to birth. After the egg is fertilized by a sperm and then implanted in the lining of the uterus, it develops into the placenta and embryo, and later into a fetus. Pregnancy usually lasts 40 weeks, beginning from the first day of the woman's last menstrual period, and is divided into three trimesters, each lasting three months. Delivery; The act or process of giving birth. Assurance of healthcare for all segments of the population with special attention given to the health needs of women and children was one of the top priorities in the Ethiopian Health Policy [1]. The endorsement of MDG 5 in the HSDPs is an indication of the commitment or political will of the government towards reducing maternal mortality across the nation. Yet, Ethiopia's health system is underdeveloped and underfinanced. While some progress has been made in providing basic health services to poor women and their children, the progress may be uneven because many people are not reached with services. [2]

Ethiopia's total health expenditure as a percentage of the gross domestic product (GDP) has remained stable at 4.3% for years. With emphasis given to publicly funded healthcare, out-of-pocket payment constitutes 42% [3].The public health sector is the main provider of primary healthcare and serves two-thirds of the population who cannot afford private healthcare . The main objective of the public sector service provision, as stated in the National Health Policy, is "*to give comprehensive and integrated primary health care services in a decentralized and equitable fashion".* [4]

Childbirth and its process are one of the most significant life events to a woman. The time of birth as well as shortly thereafter is the most dangerous period in a child's life especially in the developing world. Hence the choice of place of delivery for a pregnant woman is an important aspect of maternal healthcare. The place of delivery is an important factor often related to the quality of care received by the mother and infant for influencing maternal and child healthcare outcomes. In Addis Ababa, the capital of Ethiopia, though the private health facilities (hospitals and clinics) outnumber public clinics, only 20%of deliveries take place in the private sectors and 17% of mothers deliver at home. This study aims to systematically explore the differences and the factors that influence women's preferences for places to give birth in Addis Ababa. It is envisaged that a clear understanding of such factors is key in building a responsive maternal healthcare system and improving health outcomes in Ethiopia. [5]

Maternal Mortality remains an intractable issue, especially in developing countries, where maternal mortality ratios have scarcely fallen in the last few decades, even as other health indices have shown improvement. Most maternal deaths continue to occur at home in low resource settings against a backdrop of poverty, unskilled home deliveries, sub optimum care seeking and weak health systems. These outcomes are mainly attributed to direct obstetrical complications, i.e. hemorrhage, obstructed labor, sepsis, eclampsia and abortion mostly occurring around the time of delivery and cannot be predicted beforehand. [6] Scientific evidence suggests that skilled attendance at delivery, timely emergency obstetric care and effective postnatal care are essential in promoting maternal health. In fact increasing rates of skilled care during childbirth is widely advocated as the "single most important factor in preventing maternal deaths" and the "proportion of births attended by skilled health personnel" is one of the target indicators to measure progress toward the attainment of improving maternal health. [7]

Pakistan was among the top six high burden countries in which half of global maternal deaths occurred with an estimated maternal mortality ratio of 533 in 1993. With persistent focus through a series of initiatives, recently updated statistics show that the burden has come down to 260. Over the past years, the government of Pakistan has initiated policies to improve maternal health outcomes and among varied efforts, introduced a new cadre of community-based midwives (CMWs) to make skilled care available and accessible in low-resource settings to address the issue of skilled birth attendance. The CMWs, while trained to conduct home deliveries, are responsible for providing individualized care to the pregnant women throughout the maternity cycle and the new-born, helping her in self-care, guidance, counseling and communicating with the community for healthy habits and involving the family in preparation for childbirth and for unforeseen emergencies. However, in order to be effective, the services of the CMWs need to be utilized by the communities where they serve. [8]

According to the latest Pakistan Demographic and Health Survey 2012–13 even now, only about 48% of births take place at a health facility and 52% are attended by skilled birth providers. Hence, the intended impact in increasing skilled attendance at deliveries in rural areas of Pakistan has not been achieved. A large number of women fail to utilize the community-based services due to unidentified reasons and end up delivering without skilled supervision. A large body of evidence on factors contributing to poor delivery service utilization across the region comes from quantitative studies, which consistently report physical and financial barriers as well as low social status of women as important barriers. Other studies

emphasize traditional beliefs and socio-cultural influences on use and non-use of health care facilities in developing countries. [9]

METHODOLOGY:

Study design: Descriptive cross sectional study.
Study setting: Outpatient Department, Gynecology Unit, Bahawal Victoria Hospital, Bahawalpur.
Duration: For a period of one year
Sample size: Our study included 100 participants representing the characteristics of a sample.
Sampling technique: It was non probability convenient method.
Inclusion criteria: All the women in third trimester of pregnancy.
Exclusion criteria: High risk pregnancies and Women not willing to be included in the study.
Data collection: Preformed and pretested questionnaire was used for data collection.
Data analysis: It was done manually. Frequencies were evaluated and percentages were calculated.

RESULTS: In our study we took a sample of 100 women of reproductive age group. In the overall age distribution the respondents were divided into 6 groups. 14% (14 respondents) belong to age group of 16-20 years40% (40 respondents) were in age group of 21-25 years.31% (31 respondents) fall in the category of 26-30 years While 9% (9 respondents) belonged to age group of 31-35 years. 5% (5 respondents) were in age group of 36-40 years and 1 lady was above 40 years (in age group of 41-45 years)

In case of education, respondents were divided into 6 main groups. 28% (20 respondents) were with no formal education, 29% (29 respondents) studied up to primary level, 11% (11 respondents) studied up to middle, 10% (10 respondents) have done matriculation, 6% (6 respondents) were up to intermediate level, Only 16% (16 respondents) were graduate and above that level In case of residence of respondents, 74% (74 women) were from urban areas and 26% (26 women) were from rural side.

In case of occupation of the respondents, 89% (89 women) among total respondents were housewives and 11% (11 women) were working ladies and they belong to different fields. Grouping on the monthly family income of respondents to determine their economic status, 67% (67 women) belong to category of <20,000 and 22% (22 respondents) belong to category of 20,000 to 40,000 and 11% were above the 40,000 for their monthly income.

There were three family types in the questionnaire and 45% (45 respondents) belong to nuclear family, 55% (55 women) to extended family and no one was in the category of polygamous type.

We determined the number of living children in the questionnaire by making 4 groups. 21% of them were with no living child at that time. 51% belong to category 1-2 number of living children and 21% were having 3-4 children alive. 7% women were with 5-7 no. living children category. We calculated findings with concern to gravidity, there were 4 groups . 44% (44 women) were in the Category of 1-2. 30% within the 3-4 category. 17% were in 5-6 category and 9% in category of 7-8

DISCUSSION:

Our study depicted that majority of women preferred H.C.O. our results were very much consistent with the study conducted in Basra. According to this 83.9% of women delivered at H.C.O and 16.1% at home. [2] Same is the case in our study, 16% preferred home. Study from Ethiopia also showed that 88% preferred delivery at health care facility. [3] While discussing the reasons for health care outlet delivery safety and security comes first with 98.6%.In our study it is 82%. While in reasons fear of unskilled birth attendant at home was also 71% in our study as compared to study in Oromia regional state where fear of unskilled birth attendant was 12%. It can be due to awareness of health facility and knowledge and concerns of people about health. It can be due to low training staff available at home in our region that women have feared. [7]

73% of women of our study were having good antenatal care at H.C.O. So they preferred to deliver at H.C.O. same were the results with study done in rural community in Jos North where 74% of their study participants were attending ANC as women find themselves satisfied with the care provided at H.C.O they preferred to plan delivery at H.C.O for safe and secure delivery. [6] Education is the key determinant in health care. Our study was also showed that as the educational status increases the preference for H.C.O. increases. Illiteracy has inverse relation with choice of H.C.O. in our study all women above graduation level preferred H.C.O. those with no formal education preferred home. Similar is case with respect to socioeconomic status and monthly family income. All of women in our study who fall in > 40000 Rs category of family income, all preferred H.C.O. same facts were seen in while looking at the study done in north India, where high educational status and good jobs of their spouse were associated with H.C.O. During data collection one of the respondents said, “I have no plan about where to deliver. It may depend upon my husband whether he can afford the expenses at H.C.O. or not. [9]

Other factors like family type and total no. of family members do affect the choice for place of delivery. Women with 1-2 children mostly preferred H.C.O. 52% of women who preferred H.C.O were with 1-2 living children. Results support that of study from Entebbe, Uganda which showed that primi gravidae were mostly to deliver at H.C.O. those who were having good facility to reach H.C.O preferred to go there for delivery. 70 times was the reason of good transportation among those who preferred H.C.O. 5 of the women who preferred home were telling about bad roads and poor transportation facilities. [10]

Among the reasons for home preference, fear of interventions at H.C.O and good family support stood at the top. Asma aged 25, the respondent of our study said during interview *"No, No, doctors will go for surgery and I am afraid of that. I will prefer home and my family can take care of me at home".* So these are the reasons given by women. They are afraid of interventions at hospitals. They have a mindset that home is place where family is near and support is also available. If we compare with study of Hashemene town, about 30% was the reason that women feel comfortable at home and seek care from family. Similarly in our case, among 16 women who preferred home almost 13 women give reason of privacy and family support. Remaining consistent with the study of Pokhara city Nepal, main reasons of home delivery were convenience and ease at home (21%) financial problems and cost of care at H.C.O (11.3%). In our study some difference from that study occurred. We have financial reason at lowest may be the good financial conditions of the respondents and no are low in this respect. Comfortable environment is mainly the most uttered reason among women who preferred home delivery. [11]

In Bangladesh according to one study conducted in rural area, results show that delivery by TBAs was first preference for pregnant women. Poverty was also important among this category. In our case in BWP city among those who preferred H.C.O were mostly afraid of unskilled TBAs. This shows that there is lack in providing primary health care and poverty is not main factor for those who preferred home they just wanted family support. [14]

So our discussion comes to end with result that great % is in favor of H.C.O. Results show that people are satisfied with the care provided to them. Among those few who preferred home reason was privacy and family support.

CONCLUSION:

Majority of women preferred H.C.O to deliver baby while only few preferred home for delivery of child. It was concluded that mostly women preferred H.C.O for safe and secure delivery and good quality of care. Those who preferred home wanted privacy, family support and family environment.

REFERENCES:

1. Javed SA, Anjum MD, Imran W, Haider A, Shiraz A, Shaheen F et al. Correlates of preference for home and hospital confinement: evidence from a national survey. BMC pregnancy and child birth. 2013;13:137.
2. S.S Mahdi, O.S Habib. A study on preference and practices of women regarding place of delivery, Eastern Mediterranean Health Journal EMHJ. 2010;16(8).
3. Ababulgu F.A, Bekuma T.T. Delivery site preferences and associated factors among married women of child bearing age in Bench Maji Zone, Ethiopia. Ethiopia J health sci. Journel. 2016; 26(1).
4. Kruk M.E, Paczkowski M, Mbaruku G, Depinho H, Galea S. Women's preference for place of delivery in rural Tanzania: a population-based discrete choice experiment. American journal of public health. 2009; 99(9).
5. Tebekaw Y, Mashalla J Y, Tshweneagae G T. Factors influencing women's preference for place to give birth in Addis Ababa, Ethiopia. Hindawi Publishing Corporation 2015.
6. Envuladu EA, Agbo HA, Lasa S, Zoakah AI. Factors determining the choice of place of delivery among pregnant women in Russia village of Jos north, Nigeria, international journal of medicine and biomedical research. 2013; 2(1):23-27.
7. Abdurahmen J, Addissie A, Molla M, et al. community based cross sectional study: preference of place of delivery and birth attendants among women of Hashemene town, Oromia, international journal of technology and emerging engineering research. 2014; 2(7).
8. WHO, UNICEF and World Bank estimates: Trends in maternal mortality. Preference of place of delivery by a pregnant lady. 1990-2010.
9. Sahoo J, Vir Singh S, Gupta V K, Garg S, Kishor J. Do socio-demographic factors still predict the choice of place of delivery: A cross-sectional study in rural North India .Journal of Epidemiology and Global Health. 2015; 5: 527–S34.
10. Sreeramareddy C T, Joshi H S, Sreekumaran B V, Gi54i S, Chuni N, et al. Home delivery and newborn care practices among urban women in western Nepal: a questionnaire survey; BMC Pregnancy and Childbirth. 2006; 6 (27).
11. Zafar S, Sikander S, Ahmad I, Parveen N, Saleem S, Nawaz T, et al. Is home delivery really

preferred? A mixed-methods national study in Pakistan Zafar et al. Health Research Policy and Systems.2015; 13 (1):52.

12. Serfraz m, Tariq s, Hamid s, Iqbal n, et al. SOCIAL AND SOCIETAL BARRIERS IN UTILIZATION OF MATERNAL HEALTH CARE SERVICES IN RURAL PUNJAB, PAKISTAN J Ayub Med College Abbottabad. 2015; 27(4).
13. Simfukwe ME, the Dar-es-salaam Medical Student's Journal- DMSJ; 2011.
14. Sarker BK, Rahman M, Rahman T, Hossain J, Riechnbach L, Mitra DK, et al. . Reasons for Preference of Home Delivery with Traditional Birth Attendants (TBAs) in Rural Bangladesh: A Qualitative Exploration. PLOS ONE. 2016; 11(1).