



Birth Preparedness: An Essential Part of ANC Counselling

Information for the Facilitator

Birth preparedness—i.e. advance planning and preparation for delivery—can do much to improve maternal health outcomes. Birth preparedness helps ensure that women can reach professional delivery care when labour begins. In addition, birth preparedness can help reduce the delays that occur when women experience obstetric complications, such as recognising the complication and deciding to seek care, reaching a facility where skilled care is available and receiving care from qualified providers at the facility. Key elements of birth preparedness include:

- Attending antenatal care at least four times during pregnancy;
- Identifying a skilled provider and making a plan for reaching the facility during labour;
- Setting aside personal funds to cover the costs of travelling to and delivering with a skilled provider and any required supplies;
- Recognising signs of complications;
- Knowing what community resources — emergency transport, funds, communications, etc. — are available in case of emergencies;
- Having a plan for emergencies — i.e. knowing what transport can be used to get to the hospital, setting aside funds; identifying person(s) to accompany to the hospital and/or to stay at home with family; and identifying a blood donor.

Because life-threatening complications can occur during the early postpartum period, birth preparedness also includes preparing/planning for accessing postpartum care during the first week after delivery and at six weeks after delivery.

Birth preparedness involves not only the pregnant woman, but also her family, community and available health staff. The support and involvement of these persons can be critical in ensuring that a woman can adequately prepare for delivery and carry out a birth plan.

Objectives

By the end of this 60-minute session of the Life-Saving Skills course the participant will be able to:

1. Define birth preparedness and name specific elements of culturally appropriate delivery preparations that can enable women to reach skilled delivery care.
2. Identify key counselling and problem-solving skills that can assist clients in identifying essential preparations for delivery and developing a plan for making these preparations.

Preparation

During preparation for the Life-Saving Skills course:

1. Review background notes on birth preparedness.
2. Review available qualitative research findings on communities' attitudes and practices related to preparing for normal delivery and for emergency complications.

Prior to the Birth Preparedness (ANC) session:

1. Make copies of the following handouts for participants:
 - Resource A: Birth Preparedness Information Needs
 - Resource B: Birth Preparedness Counselling Chart
 - Resource C: Community Perspectives on Preparing for Delivery
2. Write the following information on poster paper or newsprint:
 - Objectives
 - Copy left-hand column from **Resource B: Birth Preparedness Counselling Chart** onto newsprint or poster paper

Time: 60 minutes.

Lesson Plan (60 MINUTES)

Life Skills Training				
Birth Preparedness Module				
<p>Objectives: By the end of this 60-minute part of the Life-Saving Skills course, the participant will be able to:</p> <ol style="list-style-type: none"> 1. Define birth preparedness and name specific elements of culturally appropriate delivery preparations that enable women to reach skilled delivery care. 2. Identify key counselling and problem-solving skills that assist clients in identifying essential preparations for delivery and developing a plan for making these preparations. 				
Time	Topic	Teaching Methods	Resources	Evaluation
5 mins.	Introduction to Session	Facilitator provides overview of session objectives and invites participants' questions. Objectives are posted on the wall for reference.	-Session objectives written on newsprint/ poster paper.	
10 mins.	What is birth preparedness?	<p>Ask participants to brainstorm what the term “birth preparedness” means. Note down their responses on newsprint or poster paper and then work with the group to synthesise their comments and the above definition into a concise description of the term.</p> <p>Once everyone understands what the term means, ask participants to name the specific areas of birth preparedness they currently address in counselling antenatal clients (i.e. advising women to prepare for delivery in their current counselling and health education/outreach activities). Note down all responses on newsprint or poster paper.</p>	<ul style="list-style-type: none"> - 2 markers - large newsprint - easel (or masking tape to hang paper on walls) <p>-Definition of birth preparedness posted on wall for reference.</p> <p>-The list of current birth preparedness counselling topics is also hanging in the room as a reference for participants.</p>	<p>Participants can give a definition of birth preparedness.</p> <p>Participants have a common list of elements of birth preparedness.</p>
15 mins.	What barriers to use of skilled care could be addressed through birth preparedness?	<u>Brainstorm and Discussion:</u> Ask participants to share their perspectives on why all women do not seek delivery care at health facilities. Ask participants to brainstorm a list of reasons women are not using available delivery care.	<ul style="list-style-type: none"> - 2 markers - large newsprint - easel (or masking tape to hang paper on walls) 	Participants can name the barriers to use of skilled care that can be addressed through improved birth

		<p>Once participants develop a full list, ask them to review it and identify the factors or barriers that could be addressed through better/more effective birth preparedness. Note this shorter list down on newsprint or poster paper.</p> <p>Examples could include:</p> <ul style="list-style-type: none"> • Uncertainty about expected due date. • Lack of knowledge about costs of transport to health facility (during day and during night hours). • Lack of information about the costs of delivery care at health facilities. • Lack of information/knowledge about when plans should be made. • Concerns that planning for delivery or preparing for an emergency may invite misfortune. • Taboos against buying items for a baby that has not been born. • Lack of knowledge about the specific items that will be needed during delivery or where to obtain them. 		preparedness.
	What barriers to use of skilled care could be addressed through birth preparedness? (continued)	Ask the group to look at the shorter list of reasons for non-use of skilled delivery care, and compare it to the list of the topics they currently address during birth preparedness counselling. Point out the gaps between their current counselling topics and the information women and families need to better prepare for delivery.		Participants can name gaps in current counselling on birth preparedness.
25	Counselling on birth	Developing a Birth Preparedness Counselling	- 2 markers	Participants can

mins.	preparedness	<p>Chart: Remind the group that birth is a difficult event to prepare for because the onset of labour is unpredictable. For communities that are poor and lack means of transport, it is especially difficult—though all the more essential—to adequately prepare for delivery. Explain to the group that effective counselling on birth preparedness equips women and their families with problem-solving skills so they can better anticipate the problems they may encounter and identify ways to overcome them. Emphasise that to be useful and practical, this counselling has to be tailored to each woman’s individual circumstances and be sensitive to the prevailing cultural norms and beliefs.</p>	<ul style="list-style-type: none"> - large newsprint - easel (or masking tape to hang paper on walls) 	<p>identify ten essential points women/families need to know to prepare for delivery.</p> <p>Participants can help woman/family members explore potential challenges and strategies to overcome them.</p>
		<p>Explain to the group that you will jointly develop a Birth Preparedness Counselling Chart that they can use to ensure they help women anticipate the difficulties of reaching skilled care during delivery and generate plans for overcoming these hurdles.</p> <p>Post the prepared newsprint with the left-hand column of the Birth Preparedness Counselling Chart (see Resource B) where everyone can see it. Explain that there is ten essential points that women and their families need to know to adequately prepare for birth. Distribute copies of Resource A: Birth Preparedness Information Needs to participants so they can refer to it during the activity. Explain what each of the ten points means (drawing on the explanations provided in Resource A) and ask participants to brainstorm what specific issues need to be explored with the woman to help her identify the steps needed to prepare for delivery. Supplement with the questions provided in Resource B as needed.</p>	<p>-Copies of Resource A for participants</p>	

5 mins.	Wrap-up	<p>After completing the counselling chart, ask participants if there are any other information needs or issues that should be explored with the woman. Note down their additions on newsprint or poster paper.</p> <p>Wrap-up the session by handing out copies of Resource B and Resource C. Remind participants that the problem-solving skills and approaches they are learning during the LSS training can be shared with antenatal clients to help them prepare for delivery. Emphasise that cultural norms and beliefs can strongly influence patterns of birth preparation and that understanding their clients' beliefs is essential for providing them with useful counselling and advice (refer them to Resource C: Community Perspectives on Birth Preparedness).</p> <p>Urge participants to use a problem-solving approach when they counsel women about birth preparedness and to help women explore the challenges and difficulties they may face and how to overcome them.</p>	<p>-Copies of Resource B for participants</p> <p>-Copies of Resource C for participants</p>	<p>Participants have an awareness of cultural dimensions of birth preparedness that must be addressed through counselling.</p>
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Key implications for birth preparedness:

- Communities perceive pregnancy and childbirth as risky—a perception that may help motivate them to prepare for delivery.
- Aspects of formal antenatal care services that are valued by community members, like learning due date, knowing foetal presentation and detection of complications can serve as a starting point for birth preparedness counselling.
- There are no rigid taboos that restrict family discussion or dialogue about pregnancy or delivery, and while husbands and mothers-in-law exert a strong influence over these decisions, the woman herself is usually involved or consulted.
- Cultural norms and beliefs support certain types of preparations, such as saving funds; however, making purchases for the baby is perceived as inadvisable and risky given that the outcome of the pregnancy cannot be known and such preparations may invite misfortune.
- Although community beliefs and norms generally support putting aside money for delivery, in practice families find it difficult to save funds due to poverty as well as beliefs regarding the impossibility of planning for an event that is unpredictable.
- When complications arise, considerable and life-threatening delays occur as families try to mobilise funds and reach a facility where care is available.
- Among women who experienced a complication, many first sought care at inappropriate facilities where no treatment was available, indicating that better advice and counselling is needed to ensure that families can go directly to an appropriate facility.
- Use of postpartum care in the first two weeks after delivery is low and generally perceived as unnecessary if the woman is not experiencing a problem.

Facilitator's Notes

Introduction

Facilitator introduces him/herself and gives an overview of the session:

- Objectives
- Definition of birth preparedness
- Addressing barriers to skilled care through birth preparedness
- Counselling on birth preparedness
- Overview of birth preparedness handouts

Objectives

Facilitator shares objectives with participants. The facilitator places a large piece of newsprint (or overhead or PowerPoint, etc.) with objectives on the wall and reads (or has a participant read) the objectives to the group. Facilitator then asks participants if they have questions about the objectives, which are to:

1. Define birth preparedness and name specific elements of culturally appropriate delivery preparations that can enable women to reach skilled delivery care.
2. Identify key counselling and problem-solving skills that can assist clients in identifying essential preparations for delivery and developing a plan for making these preparations.

Topic A: What is "birth preparedness"?

Time—5 mins.

Defining Terms

Facilitator asks participants for a definition of birth preparedness and records participants' responses on large poster paper. After recording and briefly discussing the responses, the facilitator reads the following definition:

Birth preparedness is advance planning and preparation for delivery. Birth preparedness helps ensure that women can reach professional delivery care when labour begins and can also help reduce the delays that occur when women experience obstetric complications.

Time—10 mins.

Facilitator asks participants to name specific areas of birth preparedness they currently address when counselling antenatal clients and writes responses on large poster paper.

Topic B: What care-seeking barriers can be addressed through birth preparedness?

Time—10 mins.

Brainstorm and Discussion

Facilitator asks participants to brainstorm reasons women are not using available delivery care and writes participants' responses on large newsprint or poster paper. Once the list is complete, facilitator reads the list to participants. Facilitator asks participants to identify all the factors or barriers that could be addressed through better/more effective birth preparedness and writes participants' responses on large poster paper. Facilitator can provide the following examples if participants do not mention them:

- Uncertainty about expected due date;
- Lack of knowledge about costs of transport to health facility (during day and during night hours);
- Lack of information about the costs of delivery care at health facilities;
- Lack of information/knowledge about when plans should be made;
- Concerns that planning for delivery or preparing for an emergency may invite misfortune;

- Taboos against buying items for a baby that has not yet been born; or
- Lack of knowledge about the specific items that will be needed during delivery or where to obtain them.

Facilitator asks the group to look at the list of reasons for non-use of skilled delivery care and compares it to the list of the topics they currently address during antenatal counselling. Facilitator compares the two lists, highlighting the gaps between participants' current counselling topics and the information needed by women and facilities to overcome barriers to prepare for delivery.

Topic C: Counselling on birth preparedness

Time—25 mins.

Developing a Birth Preparedness Counselling Chart

Facilitator explains that birth is a difficult event to prepare for because the onset of labour is unpredictable. For communities that are poor and lack means of transport, it is especially difficult—though all the more essential—to adequately prepare for delivery. Facilitator explains to the group that effective counselling on birth preparedness equips women and their families with problem-solving skills and empowers them to better anticipate the problems they may encounter and identify ways to overcome them. Facilitator emphasises that to be useful and practical, counselling has to be tailored to each woman's individual circumstances and be sensitive to the prevailing cultural norms and beliefs.

Facilitator explains to the group that they will jointly develop a **Birth Preparedness Counselling Chart** that participants can use to ensure they are helping women anticipate the difficulties of reaching skilled care during delivery and generate plans to overcome these challenges.

Facilitator posts the prepared newsprint or poster paper that contains the left-hand column of the **Birth Preparedness Counselling Chart** (see **Resource B**) where all participants can see it and explains that there are ten essential points women and their families need to know to adequately prepare for birth.

Facilitator distributes **Resource A: Birth Preparedness Information Needs** so participants can refer to it during the activity. Drawing on the explanations provided in **Resource A**, the facilitator explains the meaning of each of the ten points listed in the left-hand column of the **Birth Preparedness Chart** that is posted in front of the group. Facilitator asks participants to brainstorm specific issues that need to be explored with the woman to help her identify steps to prepare for delivery. Facilitator supplements the discussion with the questions provided in the right-hand column of **Resource B** as needed.

After the group completes the counselling chart, facilitator asks participants if there is any other information needs or issues that should be explored with the woman. Facilitator notes the additions on newsprint or poster paper.

Topic D: Wrap-up

[Time—5 mins.]

Facilitator distributes copies of **Resource B: Birth Preparedness Counselling Chart** and **Resource C: Community Perspectives on Pregnancy, Childbirth and Birth Preparedness** to participants. Facilitator points out that the problem-solving skills and approaches participants will learn throughout LSS training can be shared with antenatal clients to help them prepare for delivery, emphasises that cultural norms and beliefs can strongly influence the patterns of birth preparation and reminds participants that understanding their clients' beliefs is essential to helping them through counselling and advice. The facilitator refers participants to **Resource C** and explains that the handout includes information and examples concerning birth preparedness and barriers to birth preparation and facility-based care among women that were gathered through qualitative research on birth preparedness among women in Igunga District, Tanzania and Migori and Homabay Districts in Kenya. Facilitator provides participants several minutes to read the case studies.

Facilitator explains that the case studies illustrate that it is important to use problem-solving approaches in

counselling women about birth preparedness, to help women explore the challenges and difficulties they may face and determine strategies for overcoming these challenges. Facilitator asks participants to discuss the following questions (possible answers and discussion points are included after the questions):

Questions

1. What are the key steps in preparing for birth?
2. What are the major points that should be covered during antenatal counselling?
3. What are some barriers to birth preparedness?
4. What are some starting points for counselling women on birth preparedness and motivating them to prepare for delivery?
5. What realistic solutions can counsellors can provide women during antenatal counselling to overcome barriers to birth preparation?

Discussion Points

1. Preparing for birth entails saving money to pay for service charges/fees, medical supplies and transport to a facility as well as saving additional money in case of an emergency. Other elements of birth preparedness include deciding on a delivery location, discussing delivery preferences with family members, identifying means of transport to a facility, identifying potential blood donors and knowing the danger signs associated with obstetric complications.
2. Antenatal counselling should include advice on: attending antenatal care each month throughout pregnancy; preparing for delivery and possible emergencies; steps involved in preparing for birth; risks associated with pregnancy, delivery and the postpartum period; danger signs of obstetric complications; and the importance of early postpartum care and when to attend postpartum check ups. Antenatal counselling should also address HIV/AIDS to ensure that women are informed of the increased risks of HIV/AIDS during pregnancy, how to protect themselves against HIV/AIDS and where to go for voluntary counselling and testing (VCT) services.
3. Barriers to birth preparedness include gaps in knowledge concerning preparing for birth and the risks associated with pregnancy and delivery; financial and geographical barriers that make saving money and reaching a facility challenging and cultural beliefs, attitudes and taboos surrounding preparation for birth, pregnancy, delivery and the postpartum period. Many communities believe that planning for birth will bring bad luck or is unwise since the baby may not live. ANC counsellors can help women explore these beliefs and prepare for other future events (e.g. how they can save in advance to pay for school fees or for the next planting season, etc.).
4. Communities are generally concerned about maternal death and recognise the risks associated with pregnancy and delivery; thus, they may be motivated to learn about how they can make childbirth safer. Women may be motivated to seek antenatal care to determine their due date, knowing the foetal presentation and detecting complications, which can serve as a starting point for counselling them on birth preparedness. Some women and families are motivated to prepare for birth by saving money and buying essential medical supplies, but they lack feasible solutions to economic and geographical challenges.
5. Counsellors can help women see how saving a very small amount of money each week adds up to a significant amount after nine months of pregnancy. Similarly, ANC providers can help women explore traditional taboos or beliefs that discourage birth preparedness and see how they do prepare for unforeseen or unpredictable events in other aspects of their lives. To help women overcome transport or geographic barriers, providers can help women explore available transport options or the possibility of temporarily moving closer to the facility close to the anticipated date of delivery.

Resource A: Birth Preparedness Information Needs

What woman/family needs to know:
1. Expected due date: Woman needs to know expected due date and that it is only an approximate or estimated date—labour may start before or after the expected due date.
2. Planning and preparation are life-saving: Woman needs to know that many obstetric complications are unpredictable and can arise suddenly and without warning. Planning or preparing for delivery does not invite such events to happen. Although it is difficult to plan for an event that will happen at an unknown date, planning and preparation can save a woman's life.
3. Obstetric risks and appropriate facility for delivery: If the woman is at higher risk she needs to understand why it is crucial to deliver at a health facility and she needs to know when she should go (e.g. before her expected due date? When labour starts?) To which facility should she go? Is there a maternity waiting home where she can stay near the facility before delivery? Even if the woman does not have serious risk factors, she still needs to be able to recognise signs of serious complications. She also needs to know that a health facility is the safest place to deliver. She needs to know which facility she should go to for delivery and whether services are available at night.
4. Basic supplies needed: The woman needs to know basic items that she should have ready for delivery, how much they may cost, and where they can be obtained. If making preparations for a baby that is not yet born is not culturally acceptable, counselling should mainly focus on items that the woman herself will need (rather than items for the baby) recommending the woman and her family amass savings to buy necessary items for the baby once it is born.
5. Facility charges for normal delivery and costs of early postpartum care: The woman needs to know what charges she can expect for a normal delivery. She also needs to know the costs associated with a caesarean section, especially if it is likely to occur given her obstetric history.
6. Available transport options and associated costs: The woman needs to know available options for reaching a facility where she can deliver her baby at night or during the day. She needs to know the approximate travel time to the facility as well as the costs involved.
7. Total anticipated expenses: The woman needs to know the sum total that supplies, service delivery charges and transport to the facility are likely to cost so she can set aside sufficient funds.
8. Possible sources of funds: The woman needs to realistically assess whether she/her family will be able to put aside the required funds or brainstorm other possible sources of support—relatives, neighbours, friends, etc. She should also know of/explore other community-level resources, such as emergency loan funds, women's groups, merry-go-rounds, etc. if they are in existence.
9. Whom to involve in birth preparations: The woman needs to know that preparing for delivery is a family responsibility and that family dialogue and discussion are essential for obtaining support and the necessary contributions. She needs to assess the roles of various family members in care-related decision-making and involve these key decision-makers in discussing the issue, as well as identify individuals who can be called upon to support her during pregnancy, delivery and the early postpartum period.
10. When to start birth preparations: Whether she is in her 2 nd or her 8 th month of pregnancy, the woman needs to be motivated and empowered to start preparing for skilled care during delivery and the early postpartum period as soon as possible. Given all the preparations that need to be made, she needs to map out a realistic timeframe for making the preparations needed.

Resource B: Birth Preparedness Counselling Chart

What woman/family needs to know:	→	What health provider needs to explore with the woman:
1. Expected due date	→	<ul style="list-style-type: none"> Does she know her expected due date and what it means?
2. Planning and preparation are life-saving	→	<ul style="list-style-type: none"> Are there cultural norms that discourage delivery preparations/planning? What types of preparations are discouraged? What information would alleviate the woman's concerns about preparing for delivery? What types of preparations are culturally acceptable? How can these preparations be encouraged and how can they serve as an entry point for making other important birth preparations?
3. Obstetric risks and appropriate facility for delivery	→	<ul style="list-style-type: none"> Does the woman have any serious risk factors (e.g. primiparous, previous C/S or fistula, etc.) that make it imperative that she deliver in a health facility? Given her profile, does she know which health facility she should go to for delivery? If labour starts at night, should she go somewhere else?
4. Basic supplies that will be needed	→	<ul style="list-style-type: none"> Does the woman know what items she should have ready for delivery? (e.g. gloves, cotton wool, sutures, drugs, etc.)? Does she know how much these items will cost? Does she know where she can obtain them? In case of an emergency, who will be able to donate blood?
5. Facility charges for delivery	→	<ul style="list-style-type: none"> Does the woman know how much routine delivery services are likely to cost? If she is likely to have a caesarean section, does she know what the cost will likely be? What are the costs of early postpartum care?
6. Available transport options and associated costs	→	<ul style="list-style-type: none"> Does the woman know how to reach the facility once labour begins? During daytime hours? During night time hours? How far away is the facility? How long will it take? How much will the trip cost? During the day? At night?
7. Total expenses that can be anticipated	→	<ul style="list-style-type: none"> Based on the forecasted expenses (4, + 5 + 6), what is the total amount the woman should save for delivery and early postpartum?
8. Possible sources of funds	→	<ul style="list-style-type: none"> Does the woman think it is feasible to save the funds on her own? Does she need help from other family members? Whom does she think she can approach? Are there any other possible sources of funds in the community? An emergency loan fund? A woman's group with a merry-go-round? Who in the family is/are the key decision-makers regarding use of health services and delivery care?
9. Whom to involve in birth preparations	→	<ul style="list-style-type: none"> Does the woman consider it feasible to talk with family decision-makers about birth and preparing for delivery? If not, why not? How can these concerns be addressed? Are there particular family members with whom the woman feels comfortable discussing birth preparations? Can these family members assist in discussing the issue with the household decision-maker(s)? What is the best way to discuss the issue with influential family members who prefer that women deliver at home rather than at a health facility? What are the reasons they give for delivering at home, and what information could help change their attitudes?
10. When to start birth preparations	→	<ul style="list-style-type: none"> How much time does the woman have to prepare for delivery? Which preparations (talking with family members, identifying transport options, saving money, etc.) seem most feasible? Which seem most difficult?

Resource C: Community Perspectives on Pregnancy, Childbirth and Birth Preparedness: Homabay and Migori Districts, Kenya¹

Attitudes towards pregnancy and childbirth: Community members view women's general health status as poor and associated this with higher risks of complications during pregnancy and delivery. While respondents generally believed that pregnancy is not a disease, they also said that expectant mothers need constant monitoring and evaluation to identify and address health problems that could interfere with the pregnancy or result in suffering or death. Respondents cited that seeking care from a combination of formal health and traditional providers, such as TBAs and herbalists, is the most effective way to prevent complications because patients have access to complementary medical and herbal treatments.

We have native and modern drugs. We have to be ready with treatment on both sides. (Husband, Homabay)

Aside from care-seeking, most study participants cited various precautionary measures that pregnant women should adopt to ensure better overall health. Directives on eating well, reducing workloads and avoiding sexual relations were widespread in the communities. While study participants asserted that women should not overwork themselves during pregnancy, they observed that in practice, most women continue to work in the fields, carry water, collect firewood, etc. throughout their pregnancies and many only stop performing these tasks when labour begins. Study participants also cited cases of women who continued working even after the onset of labour:

A pregnant woman should avoid tedious work like carrying heavy load and digging.... she should not have sexual intercourse with the husband. She should eat well. Eat oranges and other fruits. (Woman, Migori)

She works up to the last minute and after a short while you hear the baby crying as if she was in the bedroom. (Woman, Homabay)

Use of antenatal care: Relative to the national antenatal coverage rate in Kenya, estimated at 92%, the use of antenatal care in Homabay and Migori districts, estimated at 69% and 60%² respectively, is low. Women in these districts tend to first seek antenatal care during late pregnancy and almost half attend only one antenatal care visit. Because many women seek antenatal care from both facility-based and traditional providers, only a minority receive care exclusively from skilled attendants (such as doctors, midwives, nurses, and clinicians) at district hospitals, health centres, dispensaries or private clinics. Key motivations for seeking skilled antenatal care were obtaining a Mother's Card, knowing the probable due date, checking the presentation of the foetus and detecting other complications.

ANC is good, because you are told when you will deliver then this makes you prepare. It gives you time for proper preparations of delivery. (Woman with obstetric complications, Migori)

Household dialogue about pregnancy and childbirth: Community members generally indicated that in most households, pregnancy and childbirth are matters that can be freely discussed. Still, some perceived pregnancy and childbirth as private and personal matters that should only be shared or discussed with close family members. Sometimes these discussions involve the woman's in-laws (e.g. mother-in-law, father-in-law, brothers-in-law, etc.) or senior co-wives. While most respondents reported that they talked about pregnancy and childbirth with family members, a few stated that these matters are not

¹ Findings from interviews with women, men, female elders, community leaders, traditional birth attendants and skilled attendants, conducted in December 2001 – March 2002, Homabay and Migori Districts.

² Rates according to district records.

discussed. Of these study participants, a small number reported that taboos or traditional beliefs restricted such discussions, noting that announcing pregnancy and talking about it could invite misfortune, putting the health and life of the woman and her baby at risk.

Since giving birth is seen by [Luo people] as a matter of life and death, and discussing it is also seen as a taboo, we normally leave it to God. That is why it is difficult to discuss about it with another person. (Partner, Migori)

Yes, there can be [taboos] and this differs from family to family. They fear that I may talk about this, and that and somebody may do something bad about it. (Woman, Migori)

Preparations during pregnancy: Most community members viewed preparations for childbirth and delivery to consist of putting aside money for the costs of delivery, unanticipated emergency expenses or purchasing items for the baby (e.g. clothing, towels, blankets, soap, napkins, etc.) once it is born. Saving funds was generally identified as the responsibility of the husband; however, some women indicated that they themselves put aside money.

While most mentioned saving money as an important preparation for birth, many viewed other preparations, such as buying a layette and purchasing other items for the baby, as inadvisable. They perceived such preparations as inviting misfortune, and commented that one could not know whether the pregnancy would result in a live baby.

Despite the fact that purchasing items for the baby before it is born is generally seen as inadvisable in the communities surveyed, staff at local health facilities indicated that their counselling on birth preparedness is primarily focused on preparing items for the baby, rather than saving money or developing a plan for reaching a health facility when labour begins. Skilled attendants described advising women to sew clothes and blankets for the baby and to purchase various items, like soap, basins, napkins, soft towels, etc. Relatively few skilled attendants reported advising women to purchase items needed during delivery, such as gloves or cotton wool, and almost none mentioned counselling women on saving money. Thus, while health providers try to assist women in preparing for delivery, their counselling efforts currently focus on preparations that are not culturally acceptable in the surrounding communities.

It is only after you have delivered that you can buy baby a layette. But when I have not delivered, there is nothing that I buy. (Woman, Migori)

It is just cultural beliefs; most people don't want to outgrow these old beliefs. Because when you have prepared things and when you go to hospital and the baby dies, you will not know what to do with the things you have bought. Some people will take all they have prepared and bury the child with them. So they don't like doing it in advance. They'd rather buy when they have already seen the baby. (Skilled attendant, Migori)

The clan does not accept the preparation because of superstition. (Woman, Homabay)

Family decision-making regarding place of delivery: Study respondents offered mixed and conflicting views about whom, within the family, is the chief decision-maker about care during pregnancy and childbirth. Some study participants, including women of reproductive age, TBAs and men, asserted that men are the primary decision-makers; whereas others identified mothers-in-law or other family members as the key decision-makers. Most community members suggested that care-related decisions are rarely made unilaterally, and the woman herself may influence these decisions.

On the other hand, it appeared that few people make advance decisions about where delivery will take place. One of the primary reasons for not making such decisions is the fact that the onset of labour is unpredictable. Some respondents argued that it was

impossible or futile to make advanced decisions about something that could not be accurately forecast.

I was just comfortable [discussing these issues], but I didn't know when I would deliver. (Woman, Migori)

Decisions about birth are made when labour begins, when you are just about to give birth, or even after you have given [birth]. (Woman, Homabay)

No, we didn't participate in any decision-making. This is because as I told you that it is the will of God where a woman could deliver. I am saying this because labour is unpredictable, it could start any time even in the middle of the night. So when it suddenly starts at any time you will just go to a nearby place to get help. For example a nearby TBA. (Woman, Migori)

Use of facility-based delivery care: While most 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.

We only go to the TBAs because they are nearer to us and they keep us very close that you may not think of going to the hospital. But actually, we should be going for skilled care. Sometimes it is the distance between home and the hospital that discourages. (Woman, Homabay)

Sometimes labour starts at night, and the TBAs are near, so the clients are taken to them.... TBAs are closer to the pregnant mothers in the village than the health facility. (TBA, Homabay)

When the baby is unexpected, the only alternative is a TBA. (Partner, Homabay)

Like this area of ours, we have women problems and the roads are bad. Instead of taking a pregnant woman in labour to hospital at night, it is impossible. (TBA, Homabay)

Awareness of obstetric complications and warning signs: The majority of community members surveyed were aware of various obstetric complications and offered explanations of their causes in local terms and according to beliefs and practices of the Luo people. In both districts, haemorrhage or excessive bleeding during pregnancy, delivery and postpartum was mentioned more frequently than other complications and identified as the leading cause of maternal death. Obstructed labour, ruptured uterus, retained placenta and abortion (or miscarriage) were also mentioned, as were medical problems aggravated by pregnancy, such as anaemia or malaria. Further, participants cited a range of socio-economic and gender issues in women's daily lives that contribute to poor overall health, linking these factors to maternal complications.

Despite widespread general awareness about obstetric complications, participants' knowledge about them was limited. In explaining the causes and consequences of obstetric complications, community respondents revealed a variety of misperceptions. In addition, it was evident that they have difficulty recognising complications when they occur.

Preparation for obstetric emergencies: While most study participants viewed the occurrence of obstetric complications as a serious matter and noted the importance of saving funds in case of emergencies, research in Homabay and Migori showed that few people actually make advance preparations in case such complications arise. Among the

23 women/families who had experienced an obstetric complication, only three had actually put aside funds in advance. This indicates that despite widespread awareness of the need to have funds available, many families are unable to amass any savings. Similarly, none had identified means of transport in advance of the complication.

Poverty and lack of resources were cited as the primary reasons that families do not make these preparations. Many study participants indicated that while they had wanted to prepare for an emergency, they were too poor to put any money aside because their funds went toward purchasing food and other necessities. Another reason commonly cited for not planning or preparing for emergencies was that it was impossible to know if a problem would occur and that one could not plan for an unknown event.

No one can know the type of problem she is going to get or not. Anyone can get any problem at any time. It comes unexpectedly and is never planned for. (Community leader, Homabay)

How do you prepare for the unknown? (Woman, Homabay)

There was no preparation except they took me to the TBA because we didn't know whether I could deliver normally or with complications. (Woman with complications, Migori)

Many study participants, both young and old, viewed preparations for obstetric emergencies as a “bad omen,” an action that could actually create problems for the expectant woman. As is common in many other settings, taboos and superstitious beliefs discourage women and their families from preparing for emergencies.

Because few preparations are made for delivery or for obstetric emergencies, communities experience long delays in reaching a facility where skilled care is available. Few families have sufficient savings, and considerable time is spent borrowing funds or selling assets to obtain money for transport and service delivery costs. Families also incur long delays in finding means of transport or walking long distances to the nearest health facility. Furthermore, many families sought care at mid- and lower-level facilities where treatment or services were not available. Even when women do reach an appropriate facility, many women/families do not have the required supplies or the funds with which to purchase them. Ultimately, these obstacles result in lengthy delays—up to several days—in reaching an appropriate facility and receiving the appropriate care, putting women’s lives at risk.

From here (home) to Homabay to Kisumu, going back for check-up, he sold all his cattle...It was 56,000 shillings. (Woman with obstetric complications, Homabay)

It was the distance to the hospital, it is far and we wanted to take her to Migori. The money also delayed a bit. It took one week before she went. (Family member of woman with obstetric complications, Homabay)

In the morning they decided to go to the health centre where she would start with since she was in pain, and that was the nearest [health facility]. Only that by bad luck, they were not allowed in...They don't deliver first-borns. (Family member of woman with obstetric complications, Migori)

Use of early postpartum care: The early postpartum period (first two weeks) is perceived as a time of risk for the newborn, though not for the mother. Postpartum care for the mother is generally viewed as unnecessary unless the woman is experiencing complications. Given these attitudes, as well as the unavailability of maternal postpartum care at health facilities and the distance/cost involved in seeking skilled care, few women attend postpartum care.

Care after delivery? Ahhh. That they will not get. It's not even there. How would you get the care? You have already delivered and are now at home, and mother is fine and well. Your job now is to take the baby to the clinic. Who would examine you? You are not sick and you are examined? You delivered well. Who would examine you? (Woman, Migori)

Key implications for birth preparedness:

- Communities perceive pregnancy and childbirth as risky—a perception that may help motivate them to prepare for delivery.
- Aspects of formal antenatal care services that are valued by community members, like learning due date, knowing foetal presentation and detection of complications can serve as a starting point for birth preparedness counselling.
- There are no rigid taboos that restrict family discussion or dialogue about pregnancy or delivery, and while husbands and mothers-in-law exert a strong influence over these decisions, the woman herself is usually involved or consulted.
- Cultural norms and beliefs support certain types of preparations, such as saving funds; however, making purchases for the baby is perceived as inadvisable and risky given that the outcome of the pregnancy cannot be known and such preparations may invite misfortune.
- Although community beliefs and norms generally support putting aside money for delivery, in practice families find it difficult to save funds due to poverty as well as beliefs regarding the impossibility of planning for an event that is unpredictable.
- When complications arise, considerable and life-threatening delays occur as families try to mobilise funds and reach a facility where care is available.
- Among women who experienced a complication, many first sought care at inappropriate facilities where no treatment was available, indicating that better advice and counselling is needed to ensure that families can go directly to an appropriate facility.
- Use of postpartum care in the first two weeks after delivery is low and generally perceived as unnecessary if the woman is not experiencing a problem.