# EXAMINATION OF BIRTH PREPAREDNESS AND COMPLICATION READINESS AMONG HOMEBIRTH PARENTS IN SUMBAWANGA RURAL DISTRICT: A QUALITATIVE STUDY

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**MA (Health Policy and Management) Dissertation**
**Muhimbili University of Health and Allied Sciences**
**July, 2013.**

# EXAMINATION OF BIRTH PREPAREDNESS AND COMPLICATION READINESS AMONG HOMEBIRTH PARENTS IN SUMBAWANGA RURAL DISTRICT: A QUALITATIVE STUDY

**By**

**Fabiola Vincent Moshi**

**A Dissertation submitted in partial fulfillment of the Requirements for the Degree of Master of Arts in Health Policy and Management of Muhimbili University of Health and Allied Sciences**

**Muhimbili University of Health and Allied Sciences**

**July, 2013.**

## CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled ***Examination of Birth Preparedness and Complication Readiness among Homebirth Parents in Sumbawanga Rural District. A Qualitative Study,*** in fulfillment of the requirements for the degree of Master of Arts in Health Policy and Management of Muhimbili University of Health and Allied Sciences.

_____

Dr. Tumaini Nyamhanga

(Supervisor)

Date: _____

## DECLARATION

## AND

## COPYRIGHT

I, **Fabiola Vincent Moshi**, declare that this dissertation is my original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature …… Date ……..

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## DEDICATION

This work is dedicated to my loving husband *Dr. Bilashoboka Engelbert* and our lovely sons *Justus* and *Julian*. Without their support, it would not have been possible to complete this dissertation.

## ABSTRACT

**Background**: It has been documented that 69.6% of deliveries in Rukwa region are assisted by unskilled attendants [2]. Since childbirth is inherently risky and unpredictable, one wonders why such a high proportion of women fail to access skilled attendance during delivery. The objective of the study was to explore homebirth parents' perceptions and practices on birth preparedness and complication readiness.

**Method**: The study employed a descriptive cross-sectional design using a qualitative approach. Purposive sampling technique was used to recruit study participants. Semi structured interviews and focus group discussions were used as methods of data collection. The data were analyzed using thematic analysis approach.

**Findings:** This study has established that male partners have low risk perception on pregnancy and childbirth. And that their low risk perception is influenced by low level of awareness of obstetric danger signs. Low risk perception limits their involvement in health facility birth preparedness and complication readiness. Likewise, the study found that women who chose to deliver at home have low risk perception on pregnancy and childbirth. The study found that these women's low risk perception and their decision to deliver at home were influenced by two factors. One, history of previous uneventful home deliveries assisted by unskilled attendants. Two, fatalistic attitudes – several study participants seemed to believe that obstetric complications are predetermined by supernatural powers. If they have to happen, they will, no matter what precautions are taken.

**Conclusion:** This study has documented that apart from commonly cited structural barriers to skilled birth attendants, low risk perception among both parents on complications related to childbirth and home delivery play a substantial role. Hence, the identified factors that influence low risk perception need to be addressed in order to enhance health facility birth preparedness and complication readiness.

## DEFINITIONS OF TERMS

**Obstetric Emergencies** these are life-threatening medical conditions that occur in pregnancy, during or after labor and delivery. There are a number of illnesses and disorders of pregnancy that can threaten the well-being of both mother and child. Obstetrical emergencies may also occur during active labor, and after delivery (postpartum) **[**38].

**Perception**: according to Oxford Dictionary, it is defined as the way in which something is regarded, understood or interpreted.

**Birth preparedness and complication readiness (BP/CR**) is the process of planning for normal birth and anticipating the actions needed in case of an emergency [39].

**Skilled care** refers to the process by which a pregnant woman and her baby are provided with adequate care during pregnancy, labor, birth and the postpartum and immediate new born period [40].

**Decision Making** is choosing between alternative courses of action using cognitive processes - memory, thinking, evaluation, etc [41].

**Homebirth Parents**, these are biological parents of a child who was born at home.

**Homebirth** is the act of giving birth to a child in one's own home or at the TBA's home. It is an instance of a woman giving birth to a child at home [7].

**Traditional Birth Attendants** WHO defines a traditional birth attendant (TBA) as a person who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other birth attendants. Also TBAs are usually old and experienced women who see their assignments primarily as contributing their skill for the good of the community.

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## ABBREVIATIONS

| | |
|---|---|
| ANC | Antenatal Care |
| BP | Birth Preparedness |
| CAHR | Central Asia Health Review |
| CR | Complication Readiness |
| DED | District Executive Director |
| DMO | District Medical Officer |
| ESIC | Employees' State Insurance Corporation |
| FBO | Faith Based Organizations |
| FGD | Focused Group Discussion |
| ICPD | International Conference on Population and Development |
| JHPIEGO | Johns Hopkins Program for International Education in Gynecology and Obstetrics |
| MDG | Millennium Development Goals |
| MoHSW | Ministry of Health and Social Welfare |
| MMR | Maternal Mortality Ratio |
| MNH | Maternal and Neonatal Health |
| MUHAS | Muhimbili University of Health and Allied Sciences |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organization |

# CHAPTER ONE: INTRODUCTION

## 1.1 Background to the Problem

Maternal mortality remains a public health challenge worldwide, and the global maternal mortality ratio of 342-900/100,000 live births annually is still unacceptably high [1]. A disproportionately high burden of these maternal deaths is shouldered by developing countries such as Tanzania, with a maternal mortality ratio of 454 per 100,000 live births [2].

In many developing countries, the majority of births occur at home without the help of a skilled assistant. Home deliveries in the absence of skilled professional attendants have been associated with infant and maternal deaths [3]. However, home deliveries without a skilled attendant are chosen or occur for a variety of reasons, including lack of birth preparedness, long distances or difficult access to a birth facility, costs of services and perceived lack of quality care in a health facility.

Birth-preparedness and complication readiness is a comprehensive strategy aimed at promoting the timely utilization of skilled maternal and neonatal health care. The key elements include: knowledge of danger signs; plan for where to give birth; plan for a birth attendant; plan for transportation and plan for saving money. In addition, a potential blood donor and a decision maker need to be identified. This is because every pregnant woman faces the risk of sudden, unpredictable complications that could end in death or injury to herself or to her infant [4]

In the study done in 25 low-income countries to find out trends and inequalities in where women deliver their babies revealed that in 15 countries, the majority of births were in women's homes, which was often their only option. More urban women and more in the richest (least poor) quintile gave birth in public or private facilities than rural and poorest quintile women [5].

Access to quality care during pregnancy and especially at delivery seems to be the crucial factor in explaining the disparity in maternal mortality and morbidity between the developing and the industrialized world. An estimated 90% of maternal deaths could be avoided, if adequate care was provided [6].

While in some developed countries, it is possible for women to decide to give birth safely at home [7] in developing countries, conditions are not safe enough to encourage women living in rural and remote areas to deliver at home. When home delivery occurs, some go well and others lead to complications and death. Complications occur when the family is not prepared to refer the woman to health facility. Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause the death or serious illness of the mother and/or the newborn baby.

Tanzania is one of countries with the highest rates of maternal morbidity in the world. Every hour of every day, one woman dies due to pregnancy, labor and delivery complications. According to Tanzania Demographic Health Survey, Maternal Mortality Ratio is 454/100,000 live births [2]. Most shocking is the fact that the majority of these deaths are preventable, simply through the use of skilled health workers qualified to manage a normal pregnancy; but who also have the capacity to identify complications during delivery and can facilitate a transfer to a medical facility.

Forty eight percent of Tanzanian women choose to give birth at home alone, with a relative or a Traditional Birth Attendant (TBA) for a variety of reasons – among them: distrust of the level of care that will be provided at a health facility, distance from the nearest facility, lack of finances and social norms which promote the practice of home delivery [2].

Factors influencing maternal health services utilization operate at various levels- individual, household, community and state levels. Depending on the indicator of maternal health services, the relevant determinants vary. Effective interventions to promote maternal health

service utilization should target the underlying individual, household and community factors that hinder them from using skilled attendants for delivery.

Therefore, there is a need of finding out parents' perceptions on birth preparedness and complication readiness among households with homebirths.

### 1.2 Problem Statement

Poor utilization of health facilities during delivery by pregnant mothers is still a major cause of maternal and childhood morbidity and mortality in Tanzania. More than 90% of all pregnant women attend antenatal care at least once and approximately 43% four times or more, yet only 51% receive skilled delivery care at available health units [2].

Specifically, despite the fact that the proportion of antenatal visits in Rukwa region is as high as 97.1%, the region has the highest proportion of home delivery in Tanzania. It has been documented that 69.6% of deliveries in the region are assisted by unskilled attendants [2]. The situation is so despite the fact that Sumbawanga rural district has a good number of health facilities – an average of one dispensary for two villages. Therefore since childbirth is inherently risky and unpredictable, one wonders why such a high proportion of women fail to access skilled attendance during delivery.

Previous studies have explained the supply side and social economic factors e.g. the cost of care, the acceptability and affordability [8,9]. However such studies lack information about homebirth parents' perceptions and practices on birth preparedness and complication readiness which have been shown to be important determinants of use of skilled birth attendance. It is this gap in knowledge that this study intended to fill.

### 1.3 Significance of the Study.

It has been established that skilled attendance during delivery is an effective intervention towards reducing maternal, new born, and child morbidity and mortality. However, only 51% of women access skilled attendance during delivery. Thus, examining homebirth parents' perceptions and practices on birth preparedness and complication readiness is an important step towards improvement of maternal, new born, and child health because it has been knotted

such perceptions affect use of skilled birth attendance. Knowledge gained from this study will contribute to better understanding of homebirth parents' perception and practices on birth preparedness and complication readiness. The study findings may contribute towards formulation of policies that will increase skilled attendance during delivery and, hence, achievement of millennium development goals (MDGs) 4 and 5.

### 1.4 Research Questions

This study intends to answer the following questions

1. What are the male partners' perceptions on risks associated with pregnancy and related danger signs?
2. What are the roles of male partners' in health facility birth preparedness and complication readiness?
3. What are women's perception on risks associated with pregnancy and related danger signs?

### 1.5 Research Objectives

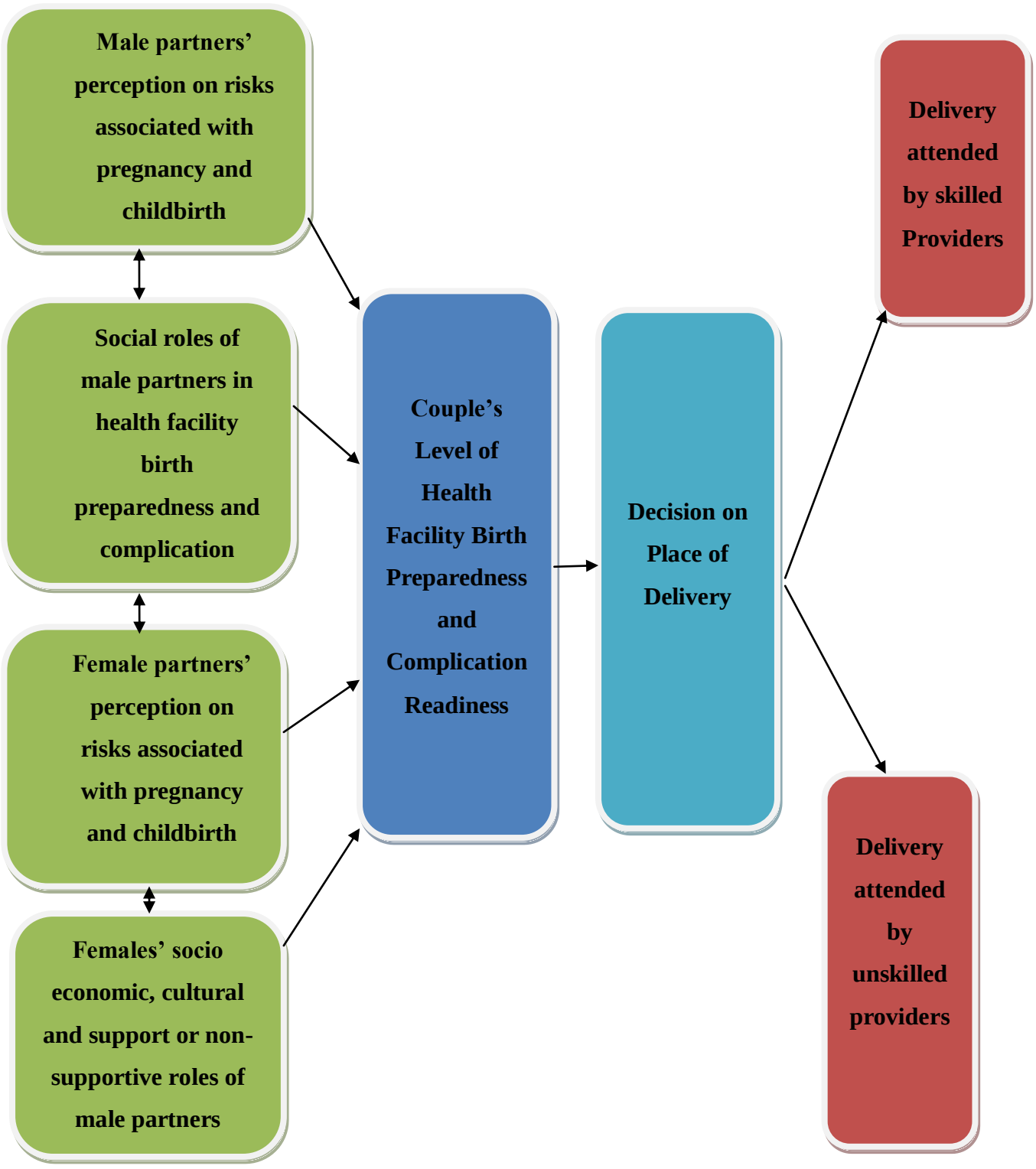
#### Broad Research Objective

To explore homebirth parents perceptions and practices on birth preparedness and complication readiness in rural Sumbawanga.

#### Specific Objectives

1. To assess male partners' perception on risks associated with pregnancy and related danger signs.
2. To assess the roles of male partners in health facility birth preparedness and complication readiness.
3. To assess women's perception on risks associated with pregnancy and related danger signs.

### 1.6 Conceptual Framework



### 1.7 Description of Conceptual Framework

Both parents' perception of risks associated with pregnancy and childbirth may influence their health facility birth preparedness and complication readiness, though somehow in different contexts. Male partner's risk perception and their social roles/ responsibilities in pregnancy and childbirth influence each other. What male partners are likely to do or not to do (social roles) in connection with safe-motherhood is partly determined by gender attitudes and beliefs. Likewise, female partner's obstetric risk perception may be influenced by socio-economic and cultural circumstances in which they live including supportive or non-supportive roles of their husbands/ male partners. All these interrelated factors ultimately determine the couple's level of health facility birth preparedness and complication readiness, which then defines choice of place of delivery. Thus, in summary, there are two pathways. Low obstetric risk perception leads to low level of birth preparedness and complication readiness, which is likely to result into home delivery. Here an unskilled person (traditional birth attendant-TBA and/or relative) attends the mother. On the other hand, high obstetric risk perception leads to high level of birth preparedness and complication readiness, which is likely to result into health facility delivery (skilled attendance).

# CHAPTER TWO: LITERATURE REVIEW

## 2.1 Birth Preparedness and Complication Readiness

Maternal literacy and availing of antenatal services are important predictors of birth preparedness; and birth preparedness is positively associated with skilled birth attendance. Maternal education is a strong predictor in preparation for birth and complication. Literate mothers are about two times more likely to be prepared for birth and complication than illiterate women [10, 11].

The principle and practice of birth preparedness and complication readiness (BP/CR) in a third world setting where there is prevailing illiteracy, inefficient infrastructure, poor transport system, and unpredictable access to skilled care provider show high potentiality of reducing the existing high maternal and neonatal morbidity and mortality rates. High level BP/CR promotes skilled care for all births and encourages decision making before the onset of labor [12].

The BP/CR matrix raises awareness of danger signs, thereby improving problem recognition and reducing delay in deciding to seek care [4]. It provides information on appropriate sources of care (promoters and facilities) making the care-seeking process more efficient. It also encourages households and communities to set aside money for transport and service fees, avoiding delays in reaching care caused by the search for funds.

Agreement of partners regarding the importance of delivery in the facility is associated with a higher likelihood of women delivering in a health facility. Specifically, when both partners rated skills of government doctors and nurses as higher than that of TBAs, the woman is twice more likely to deliver at a health facility than in the home [13].

## 2.2 Danger Signs for Obstetric Complications

Awareness of danger signs of obstetric complications during pregnancy, labor and postnatal period is the first essential step for appropriate and timely referral. Significant proportions of the pregnant women are unaware of obstetric danger signs [14] . This indicates the large proportions of pregnant women who do not have the knowledge are likely to delay in deciding to seek care [14,9].

Studies conducted among women in Tanzania [15] and Ethiopia [11] indicate low levels of awareness of obstetric danger signs during pregnancy, delivery and postpartum. Similarly studies have also indicated low rates of birth preparedness among women in Kenya [14] and Ethiopia [11,16] . The low awareness of danger signs coupled with lack of preparedness contributes to the delay in seeking skilled care henceforth leading to high levels of maternal mortality and morbidity [17].

Antenatal attendance provides an opportunity to inform and educate pregnant women about pregnancy, childbirth and care of the newborn, and therefore enable pregnant women acquire information on danger signs of pregnancy or childbirth [4].

Being urban resident have a significant association with mentioning at least two danger signs during pregnancy, child birth and postpartum period. This could be due to the fact that urban residents have better access to health information and maternal health services as compared with rural counterparts [18].

## 2.3 Role of Male Partners

There is a growing awareness and acceptance that men have an important influence on women's health and have distinct reproductive health needs of their own. Reaching out to men as partners may improve spousal communication and may help in early decision-making for seeking care if complications arise [19].

Their involvement during pregnancy and childbirth can lead to positive birth outcomes for the mother and child as well as a healthier marital relationship. A husband's positive involvement can take many forms, including transporting his wife to a qualified provider, providing household money to make that visit, giving helpful informational support during pregnancy, and offering emotional support during labor and childbirth [20].

When men accompany their wives to hospitals, they have more access to reproductive health information and could result in greater communication between men and women on subjects related to reproductive health and childcare. This improved interspousal communication could enhance pregnancy planning, birth preparedness and complication readiness [19].

The level of social (emotional, informational and instrumental) support provided by the husband to his wife and the husband's perception of social norms related medical intervention during childbirth are both associated with the type of provider utilized during childbirth. The husband's perception of social norms related to professional care is important to the type of advice and support he will give his wife during pregnancy and childbirth [21].

However, men consider maternity units as exclusively meant for women. The attitude of health staff and poor conditions in health centers imply that even husbands who accompany their wives to clinics are often ignored or made to hang around somewhere. This behaviour encourage men to give high priority to making plans for naming ceremonies rather than critical components of birth preparedness such as deciding on place of delivery, skilled assistance and identification of a blood donor. More worrisome is the lack of plans for decision-making and savings for obstetric emergencies [22].

Reasons for men's limited involvement in obstetric care include: ignorance, poverty, cultural and religious factors [22]. The variation in level of preparedness could be due to differences in literacy level, cultural practices, and poverty and in effectiveness of implementation of safe motherhood by the different national health systems. Previous studies interviewed women alone on matters patterning home deliveries [9,10,23]. Despite the fact that men in African

context hold decision-making power on households, they are least involved in interviews to hear from them to why their wives denied of skilled delivery.

The involvement of men in maternal health is a relatively new approach in dealing with the subject of sexual and reproductive health generally. This idea was endorsed by the International Conference on Population and Development (ICPD) held in Cairo in 1994 where representatives from more than 180 countries formally recognized the importance of men to women's reproductive health and also recognized the importance of men's own reproductive health [24].

### 2.4 Perception on Risks Associated with Pregnancy

Personal perceptions of risks is a representation of the individual's culture, including their beliefs, values and upbringing, as well as the influences of the individual's social network, which can include family members, spouses, friends, and community members [25].

Some previous literature has documented that knowledge and awareness of the possibility of medical risks do not avert parents from a home birth decision. Those who chose to give birth at home accepted that there was a risk of complications, but perceived these to be due to fate. Technical risks were considered a consequence of the decision to give birth in hospital, and were perceived to be avoidable [7].

Factors which influence pregnant women perceptions of risks include self-image, history, healthcare and the unknown. Those women who had previous uneventful delivery assisted by unskilled attendants and who do not have obstetric complication do perceive pregnancy and delivery as not associated with risks. A similar study [26] on factors influencing pregnant women's perceptions of risk revealed that women with complications have high-risk perception than those without complications

### 2.5 Influence of gender roles on birth preparedness and complication readiness

A gender relations analysis reveals power relations between men and women. Women carry the major share of the responsibility for the well-being of the household in most societies. This responsibility is rarely matched by autonomy to make decisions or by access to necessary resources [27].

Women's autonomy which include women's freedom of movement; discretion over earned income; decision making related to economic matters; freedom from violence or intimidation by husbands; and decision making related to health care appears to be a major determinant of maternal health care utilization among poor to middle-income women. Those with high decision-making authority are more likely to have a facility delivery than women with low decision-making. They likely have more ability to advocate for services and solicit assistance in obtaining those services [27].

Research has shown that women with less autonomy have to get permission from husbands, in-laws or other family members before seeking health care and in some cultures women need someone to accompany them to a health facility. A clear positive relationship has been demonstrated between gender factors and a woman's ability to seek and advocate for services for herself. Those who work for cash are more likely to participate in health care decision-making, making major household purchases, daily household purchases and visits to her family or friends than those who are not employed and those who do not work for cash [28].

The report of the 1995 United Nations Fourth World Conference on Women held in Beijing encouraged men to take steps towards achieving gender equality and better reproductive health. Ever since, several movements aimed at involving men in reproductive health have emerged under different names. The United Nation Population Fund (UNFPA), as one of the leading organizations in this respect, published its first Technical Report in 1995 on male involvement in reproductive health, including family planning and sexual health [24].

The achievement of gender-equality by women with respect to sexual and reproductive health cannot be possible without the co-operation and participation of men. Males either as young people or adults have so much to do with issues of sexual relationships, timing and frequency of sexual activity, use of contraceptives and the like. Men, whether as political leaders, judges, heads of armies and other agencies of force, wield enormous power over many issues relating to women, hence, would need to be involved in providing solutions to maternal health problems [29].

Men have decision-making powers in their different roles as husbands, fathers and political, traditional and religious leaders. The decision-making powers of men transcend all the spheres including health matters. It is therefore very essential that men, as decision-makers should play an active role in ensuring that maternal health outcomes are favorable for a healthy mother and baby [28].

### 2.6 Summary of literature review

Previous studies on issues pertaining to home delivery have identified socio economic factors as barriers to heath facility delivery. Most of previous studies interviewed women alone and few studies interviewed men alone. This study went a step further attempting to explore parents'(men and women) perceptions and practices on birth preparedness and complication readiness. In this study, information was collected from both parents who had their baby born at home. This study employed a qualitative approach.

# CHAPTER THREE: METHODOLOGY

This chapter covers the following subheadings:- study design, study site, sampling methods, data collection methods, data analysis methods and ethical issues.

## 3.1 Study Design

The study was descriptive cross sectional study. Qualitative research methods were employed which involved four focused group discussions and in-depth interviews from sixteen households. The respondents in the focused group discussion and in-depth interviews were the parents who had their youngest child delivered at home in age of one year and below. The interviews and focused group discussions covered the following themes: the reproductive history of the women, previous birth experiences, reasons for choosing homebirths, the process of decision making about the place of birth, the roles of male partners on birth preparedness and complication readiness, perceptions of risks and danger signs and barriers to health facility birth preparedness and complication readiness.

## 3.2 Study Site

The study was conducted in rural community of Sumbawanga District from March to April 2012. Sumbawanga Rural is one of the four districts that make up Rukwa region which is located in the Southern highlands of Tanzania. The district has a total population of 373,080 [30] and has 120 health facilities being 12 health centers and 108 dispensaries. Both health centers and dispensaries provide basic emergency obstetric care services. The district does not have a district hospital but the regional hospital (Sumbawanga) serves as second referral level for emergency obstetric; where emergency obstetric care services are provided for 24 hrs.

## 3.3 Sampling Methods

The non probability technique of sampling was applied and purposive sampling technique was used. The divisions in the district were listed and two out of seven divisions that are Kipeta and Mwimbi were selected. The two selected divisions had the highest number of home deliveries, three villages from each division. From the two divisions, six villages that are Ilemba, Selengoma, Mwimbi, Musoma, Nankanga and Solola were selected using the same criteria of high number of home deliveries. From the villages households were purposeful selected for in-depth interview and Focused Group Discussions. The researcher

went to the postnatal clinic and screen women who had home delivery. The first four mothers who had home delivery and who agreed to participate in the study were taken and the appointment were sought. Participants for focused group discussion were purposively selected from the village using Village Health Workers.

### 3.4 Data collection methods

Two data collection methods were used which are focused group discussions (FGDs) and in-depth interviews. Focused group discussions were used to explore information about the social context which might be necessary to further investigation through in-depth interviews. The interaction between participants and hearing from others in a focused group discussion provides a valuable opportunity to show and discuss the differences among participants [31]**.** In-depth interviews were individually focused to investigate personal perspectives. A tape recorder and handwritten field notes were used to capture information during in depth interviews and focused group discussions. The interview guides were developed in English and translated in Kiswahili to be used in the field.

Two trained interviewers/facilitators were recruited and trained to collect information in the study areas. A total of 4 FGD, two from male partners from Mwimbi and Ilemba villages and the other two from female partners of the same villages. Three focus group discussion consisted of ten participants and one focus group discussion of Mwimbi village had eight participants. In-depth interviews were conducted across the six villages and sixteen households were involved in the interviews. Informed consent, including the consent to use recording devices, was obtained from all respondents. No participant refused to give consent in this study.

### 3.5 Data analysis methods

Data generated from the in-depth interviews and focused group discussion were daily cleaned, verified and checked for quality and consistency against the tape-recorded data, Afterwards the data were sorted, transcribed and organized carefully.

For this study thematic analysis approach was used. This involved reading through the transcribed text of each interview and identifying responses relevant to the main questions raised by the study. Main steps which were used in thematic analysis were organizing and preparing the data for analysis, reading through the data, coding the data, identifying basic themes, organize themes and finally interpretation of data [32].
The recorded audio cassettes were labeled to identify code numbers of villages or interviewee identification number. Transcription was started concurrently with data collection. Each transcribed data had identification information.

The analytic process was based on reading and re reading all transcripts several times so as to have a clear understanding and to get a preliminary sense of the data and interaction with it. The coding was done using computer software named open code. The whole interview was chosen as a unit of analysis. The transcripts were converted from Microsoft Word into rich text format then imported into the software programme. The codes were allowed to emerge during data analysis and the meaning units were coded throughout the transcripts.

### 3.6 Ethical Issues

The research protocol was submitted and approved by Muhimbili University of Health and Allied Sciences (MUHAS) research and publication committee (Appendix 11). Before obtaining the respondents consent, the researcher explained to them the purpose of the interview, the content of the interview, and the confidentiality of the recorded information. In addition, they were informed that they could quit the interview at any stage. A written informed consent was obtained from the participant, and the interview was recorded after obtaining the written consent.

# CHAPTER FOUR: RESULTS

This chapter presents major findings of this study. It consists of two main sections, which are socio-demographic characteristics of participants and study themes.

## 4.1 Socio demographic Characteristics

### 4.1.1 Socio demographic of interviewed participants.

The average age of male and female partners involved in the study was 37 years (range 24-62) and 31 years (21-39) respectively. Majority of participants interviewed had more than three children. The table shows that 20 had less than 2 Kilometers and 12 had more than 2 Kilometers. That is 62.5% were lining at less than 2 Kilometers from health facility.

The table below presents the socio demographic characteristics of the participants who were involved in the interview.

**Table 1: Socio-demographic characteristics of participants interviewed (n = 32)**

| ***Characteristics*** | ***Number of Male partners*** | ***Number of Female Partners*** |
|---|---|---|
| ***Age (years)*** | | |
| 20-29 | 4 | 6 |
| 30-39 | 8 | 10 |
| 40+ | 4 | 0 |
| ***Education*** | | |
| None | 0 | 1 |
| Primary | 16 | 15 |
| Secondary | 0 | 0 |
| College | 0 | 0 |
| ***Distance to Nearest Health Facility*** | | |
| < 2Kilometers | 10 | 10 |
| >2Kilometers | 6 | 6 |
| ***Occupation*** | | |
| Peasants | 13 | 15 |
| Petty business | 2 | 1 |
| Others | 1 | 0 |
| ***Religion*** | | |
| Christian | 14 | 14 |
| Muslim | 2 | 2 |
| Others | 0 | 0 |

### 4.1.2 Socio demographic Characteristics of Participants in Focus Group Discussion.

The average age of male partners who participated in the focused group discussions was 37 years (range 25-61), the average age of female partners who were involved in focus group discussions is 31years (range 20-42). Majority of the study participants were peasant and had primary education.

The table below shows the social demographic characteristics of participants involved in focused group discussions.

**Table 2: Socio-demographic characteristics of participants involved in FGD (n = 36)**

| ***Characteristics*** | ***Number of Male Partners*** | ***Number of Female Partners*** |
|---|---|---|
| ***Age of the respondent (years)*** | | |
| 20-29 | 8 | 12 |
| 30-39 | 4 | 5 |
| 40+ | 6 | 1 |
| ***Education*** | | |
| None | 1 | 1 |
| Primary | 14 | 17 |
| Secondary | 0 | 0 |
| College | 2 | 0 |
| ***Occupation*** | | |
| Peasants | 14 | 17 |
| Petty business | 3 | 1 |
| Others | 1 | 0 |
| ***Religion*** | | |
| Christian | 18 | 18 |
| Muslim | 0 | 0 |
| Others | 0 | 0 |

### 4.2 Study Themes

Main themes for this study emerged out of thematic network analysis process (Appendix 12). The process generated fourteen codes covering fourteen basic themes. These basic themes were further clustered into eight organizing themes – which were finally condensed into three main (global) themes. These major themes are: Male partners' perception on risks associated with pregnancy and related danger signs; Women's perception on risks associated pregnancy and related danger signs and Role of male partners in birth preparedness and complication readiness. They are relevant to the focus of the study and serve as key sub-headings in the sections that follow.

#### 4.2.1 Male Partners' Perception on Risks Associated with Pregnancy and related Danger Signs

Male partners in the study reported different views regarding the extent pregnancy and child birth were associated with risks. Data analysis gave rise to three categories of risk perceptions.

Pregnancy perceived as not associated with any risks, ii) Pregnancy perceived as associated with some risks iii) Pregnancy perceived as highly risk.

***( i) Pregnancy Perceived as not Associated with Risks***

Several male respondents perceived pregnancy as a natural process, which is not associated with risks. This point of view was well presented by a male partner aged 33 years from Musoma Village, said:

> *"Pregnancy and child birth are not risky because most of times the woman get through successfully"(01Male Musoma,INT)*

Another male partner, 25 years old from Mwimbi village considered child birth as a normal natural process , he said:

> *"Pregnancy and childbirth is not risky because pregnancy and childbirth is a part of becoming an adult and having a baby is normal."(11Male Mwimbi,INT)*

When these participants were assessed for awareness on danger signs, they had low to moderate level of awareness. One of them who had low level of awareness pointed out correctly only five danger signs out of eighteen assessed.

***(ii) Pregnancy Perceived as Associated with some Risks***

Other respondents perceived pregnancy to be associated with some risks. The reason, which was given, was that the growth of fetus in the womb cannot be seen so the whole situation becomes unpredictable. A male partner aged 39 years from Musoma village said:

> *"The pregnancy and child birth is risky because it is difficult to see the growth of the baby inside my wife. If a problem arises it becomes big before I realize it is a problem"(06Male Musoma, INT)*

Besides, other respondents perceived pregnancy to be associated with some risks because a pregnant mother is seen to fall sick now and then. This was well mentioned by a male partner aged 45 years from Musoma village, who said:

> *"Pregnancy and child birth is risky because a pregnant mother falls sick easily. When my wife was pregnant; she had an abdominal pain, we went to the dispensary and they referred us to Sumbawanga (a regional hospital) where she was treated and discharged home" (05Male Musoma, INT)*

When these respondents were assessed on their level of awareness on danger signs, they showed a high-level awareness on danger signs. Out of the eighteen danger signs assessed, they managed to mention correctly more than twelve of them.

***(iii) Pregnancy Perceived as highly risky.***

Few male partners perceived pregnancy to be highly risky because life of both expectant mothers and newborn are at risk of sickness and death. A male partner aged 25 years from Mwimbi Village said:

> *"Pregnancy is highly risk because the pregnancy and child birth is between life and death." (10Male Mwimbi,INT).*

These few respondents showed high level of awareness on danger signs. They managed to point out more than twelve danger signs out of eighteen danger signs assessed. Although these few men seemed to be aware of danger signs involved in pregnancy and childbirth, they did not mobilize resources for health facility birth preparedness and complication readiness. This is because most of them do not perceive home deliveries as a risky behavior.

### 4.2.2 Female Partners Perception on risks associated with pregnancy and related Danger Signs

Female partners perception on risks associated with pregnancy is somehow similar to that of men. That is analysis of their response generated two categories of risks perception. These are:- i) pregnancy perceived as not associated with any risks. ii) Pregnancy perceived to be associated with risks.

***(i) Pregnancy Perceived as not Associated with Risks.***

In this group of women, pregnancy was perceived to be a normal natural process and most of them gave their own experiences of being pregnant and delivering successfully at their own homes. Some of these women had multiparity; some as many as seven kids and all kids delivered at home safely. The incidents of safe delivery assisted by unskilled attendants influenced the perception of pregnancy as not associated with risks. This was pointed out by a female partner aged 30 years from Musoma Village, who said:

> *"Pregnancy and delivery is not risky because most of time it went successful as you can see this is my seventh child and I have not encountered any problem; neither during pregnancies nor during deliveries" (08Female Musoma, INT).*

Apart from a history of uneventful home deliveries, another fact that made women perceive pregnancy as not risky was identified to be fatalistic attitude - Several study participants seemed to beleave that obstetric complications are predetermined by supernatural powers. If they have to happen they will, no matter what precausions are taken. This view was succinctly pointed out by a female partner aged 27years from Ilemba village, she said:

> *"It is difficult to prevent complications which may happen during pregnancy and childbirth because if it has to happen it must happen that is why there are women who go to hospital and develop complications and sometimes lose their babies, just as there are women who deliver at home and develop complications and lose their babies" (05Female Ilemba,FGD).*

When these participants were assessed for their level of awareness, they had a high level of awareness on obstetric danger signs. They managed to point out correctly more than thirteen danger signs out of eighteen assessed

***(ii) Pregnancy Perceived to be Associated with Risks***

These respondents perceived pregnancy and childbirth to be associated with some risks because most of the time pregnancy and childbirth proceeds successfully but sometimes complications do happen. A female partner aged 36 years from Musoma Village said:

> *"Pregnancy and childbirth is risky because anything can happen. Both mother and child are at risk of illness and death." (02Female Musoma, INT)*

When these respondents were assessed for their level of awareness, they had a high level of awareness on obstetric danger signs. They managed to point out correctly more than sixteen danger signs out of eighteen assessed.

### 4.2.3 Roles of Male Partners in Birth Preparedness and Complication Readiness

The organizing themes that were condensed to form this main theme serve as sub-headings for the relevant study findings, which follow.

***Male Partners' limited involvement in deciding the place of delivery***

It became clear from the interviews and focused group discussions that men have a limited involvement concerning making decision on the place of delivery. The research respondents highlighted two social cultural reasons that might be associated with men's limited involvement in deciding where their wives should go for delivery. The reasons are presented in the following sections:

- **Social Cultural Traditions**

The participants pointed out that men do not take trouble to decide the place of delivery for there is a tradition that requires that all married primigravidae should go to their parents home for delivery. This point of view was well presented by a man aged 24 years who said:

> *"Fathers do not have a say when it comes to deciding on the place of delivery. The decision is usually made by our mothers and mother in laws. For example in my case my wife during the first pregnancy went to her mother for delivery for it is a tradition for the first delivery to take place at her parents'home." (07Male Ilemba,FGD).*

- **Gender division of roles and reproductive health implications**

Gender division of roles surfaced as a factor that influences the decision on place of delivery. The study participants pointed out that male partner regard themselves as less concerned on deciding the place of delivery. The role of deciding the place of delivery is perceived to be of women and men perceive their role to be that of providing financial support. This view was well elaborated by a male partner aged 29 years from Mwimbi who said:

> "*A woman is the one who decides on place of delivery. The responsibility of husbands is to provide material supports like a hen for soup after a baby is born, a soap bar as a gift to traditional birth attendants" (06Male Mwimbi, FGD).*

In addition study respondents reported that the spouse do not have a habit of discussing how the delivery will be carried out in terms of logistics. One of the primary reasons for not having such discussions appeared to be the fact that male partners are very busy and believed that child birth is a natural process that is supposed to happen uneventfully. This point of view was pointed out by a male partner aged 24 years, who said:

> *"We are not used to discussing how delivery will be carried out. We are busy looking for money and we take it for granted that childbirth is a normal natural process that just happens" (06Male Ilemba, FGD).*

***Limited Scope of Resource Mobilization for Birth Preparedness and Complication Readiness***

Data analysis indicated that resource mobilization for birth preparedness and complication readiness was limited in scope in three ways:- i) Those who mobilize resources to be used in case of complications that require expertise beyond the capacity of TBA, ii) Those who mobilize resources for procurement of food and clothes, and iii) Those who do not mobilize resources at all.

**(i) Participants who Mobilize Resources to be Used in Case of Complications**

Some respondents are to some extent keen that they mobilize resources during pregnancy. However, they focus on taking the mother to the health facility after occurrence of complications. The mobilized resources are not used for assisting a delivering mother to access skilled services right away instead the money is spent for taking the mother to health facility after experiencing complications under the care of TBA. A male partner aged 36 years from Mwimbi village said:

> *"I kept some money as much as 40,000/=. I decided to keep such amount of money so that can help me in case of any complication." (10Male Musoma, INT).*

In addition, these respondents are well informed of the importance of keeping some money to assist on paying transport fare. Some do keep money for transport but the money is not used until a delivering mother is in a crisis. Thus delivery services at a health facility are regarded as a second line attendance. This was presented by a male partner aged 34years from Selengoma who said:

> *"I kept some money to assist me for transport if delivery develops any complication. I kept as much as 50,000/=. I was sure the money would be enough for transport" (13Male Selengoma, INT)*

While most study respondents asserted that it was the male partner's responsibility to save money, female partners noted that they put aside money themselves. A male partner aged 41

years from Musoma Village said that saving money is his key responsibility as a father. When his female partner was pregnant he saved as much as 20,000/= Tshs. When his female partner was interviewed, pointed out that she also saved some money when she was pregnant. She saved as much as 30,000/=, without her male partner knowing that she was saving some money to be used in case of emergence (02Male&Female Musoma, INT.).

The perception that the father is the one responsible for saving money for health facility delivery and complication readiness was evidenced by a female partner aged 34years from Ilemba village who said:

> *"I did not save money because my husband is the one responsible for paying any cost related to delivery" (14Female Ilemba,INT).*

However, respondents save some money for emergency but do not act promptly to assist their female partners to attend a foreseen danger signs. A pregnant woman who is diagnosed to have a danger sign during antenatal visit is referred to a second level health facility. However, male partners do not provide expected support to them so that they access referral services timely. They ignore the diagnosed danger signs because of fearing financial implications. This was well pointed out by a female partner aged 27years, who said:

> *"Men are responsible for keeping women from receiving skilled care early because when we report to them a danger sign diagnosed from antenatal clinic, they do not provide financial support timely. (02 Female Ilemba,FGD)*

**(ii) Participants who Mobilize Resources for Purchase of Food and Clothes**

Some study respondents appeared to view resource mobilization as not intended for covering delivery costs, but rather to cover the costs of food and clothes after the baby is born. This was mentioned by a male partner aged 36 years from Musoma Village who said:

> *"I kept some money to assist me after delivery for buying meat, Orange (a drink) and soda. Meat is for preparing soup as a thank giving to traditional birth attendant for the service." (01Male Musoma, INT).*

In addition saving money for food and clothes was mentioned by another respondent who said:

> *"Saving some money is my key responsibility. In this pregnancy I saved as much as 20,000/= for food and clothes to be used when our baby is born" (02Male Musoma,INT)*

**(iii) Participants who do not mobilize resources for health facility birth preparedness and complication readiness.**

These respondents perceive pregnancy and childbirth as a natural process which most of time takes place safely. Indeed some of them do not see the importance of saving some money because childbirth assisted by traditional birth attendants is cheap and sometimes the service can be offered and payment for the service be made afterwards. A male partner aged 27 years from Mwimbi Village said:

> *"We normally do not prepare for delivery because traditional birth attendants are available all the time. They are there, as when labor starts we call our mother in laws and are the one who look for traditional birth attendants. The traditional birth attendants are trained and they know how to assist delivery" (02Male Mwimbi, FGD).*

However, study findings showed that respondents who were living relatively far from health facility did not mobilize resources. This point of view was pointed out by a male partner aged 26 years from Selengoma village which is located about 5kilometers from the nearest health facility, who said:

> *"I neither purchase any delivery equipments nor save some money to be used during delivery (12Male Selengoma,INT.)"*

Morover, a respondent from Musoma Village, which is also located relatively far from health facility, said:

> *"We didn't prepare delivery equipment because it is the responsibility of traditional birth attendant to prepare equipments she need for assisting*

*delivery and I did not save money to assist during delivery or in case of complication."(05Male Musoma, INT)*

***Preparation of Alternative Service Provider.***

Male partner respondents reported to participate in identification of Traditional Birth Attendants who would be requested to assist during delivery. Traditional Birth Attendant is preferred because of cheap and accessible services. Some male partners participate in preparation of traditional birth attendants by informing them when their wives are pregnant so that the birth attendant stayed informed and ready to provide the service. A male partner aged 36years from Ilemba Village said:

*"I decided to inform a trained traditional birth attendant to assist in case I fail to get services in our health facility."(02Male Ilemba,FGD).*

These respondents insisted that the traditional birth attendants are given prior information because the onset of labor is unpredictable. The informed traditional birth attendant is the one consulted during labor. A male partner aged 54years in a focused group discussion said:

*"When my wife was pregnant I consulted a traditional birth attendant and informed her the status of my wife. This is important because when labor starts during night it become easy to get the birth attendant (05Male Ilemba,FGD)"*

# CHAPTER FIVE: DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

This chapters presents discussion of key findings, conclusion, and recommendations.

## 5.1 Discussion

This section is organized under the following sub headings: male partners perception on risks associated with pregnancy and childbirth; female partners perception on risks associated with pregnancy and childbirth; and role of male partners on birth preparedness and complication readiness.

### 5.1.1 Male Partners Perceptions on risks associated with pregnancy and childbirth.

This study found out that several male partners perceived pregnancy and childbirth as a normal natural process, which is not associated with risks. The incidents of successful pregnancy mask the possible risks, which may be encountered during pregnancy. Similar finding has been reported by the previous study done on determinants of male partner involvement in promoting deliveries by Skilled Attendants in Busia, Kenya [33]. It can be argued that the thinking of men that delivery is a natural phenomena arise from their lack of knowledge [22] regarding the complications that are associated with pregnancy, labor and delivery. Moreover, that perception has affected the male partner involvement in supporting their spouses in accessing delivery services from skilled attendants.

Linkage between the level of awareness of obstetric danger signs and the perception on risks associated with pregnancy and delivery were determined. It was observed that male partners who had low knowledge on obstetric danger signs have as well low level of perceptions on risks associated with pregnancy, labor and delivery. Low perception on risks associated with pregnancy labor and delivery do influence male partners involvement in safe motherhood. Previous study done in Lao [34] revealed that husbands who were aware of obstetric danger

signs and believed medical interventions were necessary; support their wives to access professional delivery.

Low awareness of obstetric danger signs among male partners could be due to majority of reproductive health programs focusing exclusively on women and the environment in maternity units is often not welcoming for male partners.

### 5.1.2 Female Partners Perceptions on risks associated with pregnancy and childbirth.

This study has established female partners who choose to deliver at home were encouraged to do so by the history of uneventful previous deliveries. Occurrence of uneventful deliveries masks the possibilities of occurrence of complications during pregnancy labor and deliveries. Female partners who had uneventful previous delivery assisted by unskilled attendants are likely to perceive pregnancy and delivery as not associated with risks and continue with the same behavior forgetting that obstetric complications are unpredictable.

Apart from the history of uneventful home deliveries, another fact that influenced female partners' failure to have health facility birth preparedness and complication readiness was identified to be fatalistic attitude [35] that obstetric complications are predetermined by supernatural powers. If they have to happen, they will, no matter what precautions are taken. Fatalistic attitude can encourage a person to slip into an unhealthy lifestyle. This suggests that women who choose to deliver at home attribute success or failure of childbirth to luck. This attitude has to be addressed if promotion of birth preparedness and complication readiness has to bare any fruits.

### 5.1.3 Roles of male partners on birth preparedness and complication readiness

This study found that male partners have a limited involvement on deciding the place of delivery. It was established that social cultural traditions and gender division of roles are two social cultural reasons, which might be associated with men's limited involvement in deciding where their wives should go for delivery.

This study found that married primigravidae has to deliver at their parents home. This makes male partners relax and exclude themselves from birth prepareadness and complication readiness. . This social cultural tradition leaves the mandate of deciding the place of delivery in hands of mother in laws. Mother in laws are the one who will take care of their daughters and are the one who will decide on delivery attendant.

Similar finding has been reported by the previous study done in Kenya [34], which found that traditions and cultural beliefs such as that of men perceiving pregnancy and delivery as a women's affairs who understand each other better than men do.

Another reason, which might be associated with men's limited involvement on deciding the place of delivery, is gender division of roles. Male partners regard themselves as having a responsibility of providing financial support whenever needed and their wives are the one supposed to decide on place of delivery because childbirth is their (women) responsibility.

Men's thinking is right biologically but wrong socially. In African patriarchal context, men are the gatekeepers and they are the ones who control family income. Therefore, their limited involvement in deciding the place of delivery might be a reflection of avoiding financial implications for accessing skilled services. Men should be enabled to appreciate the fact that homebirth is a risky undertaking and thus need to support their spouses access skilled attendance during delivery. The effectiveness of the supportive role of husbands is evidenced by a study done in Bangladesh [21] which found that husbands who believed medical interventions are necessary, and provided emotional, instrumental and informational support their wives accessed professional delivery.

Besides, this study found out that men's role of financial resource mobilization in preparation for childbirth is of limited scope. That is men whose wives deliver at home do save some money, not for going to health facility at an early stage of labor. Instead that money is reserved for use when a life threatening complication arises during home delivery.

This suggests that safe-motherhood is not considered a high priority matter. Keeping a delivering mother to unskilled attendants waiting for complications to occur is like playing a lottery with life of these mothers and their newborn. If she manages to deliver without developing complications the money is saved and if complications arise the money is used.
The study findings also show that some male partners mobilize financial resources but without primarily focusing on health facility birth preparedness and complication readiness. Instead, they primarily save money for buying foods and clothes for the newborn. Similar finding from has been reported by a study done in Homabay and Migori district in Kenya [36]. Also, another study done in Northen Nigeria [22] revealed that men give high priority to making plans for naming ceremonies rather than critical components of birth preparedness such as deciding on place of delivery, skilled assistance and identification of a blood donor.

Besides, the study has also established that several male partners do not mobilize resources at all. Findings from this study indicated that the main reasons, which contribute to this behavior is low awareness of danger signs, which influence their perceptions on risks associated with pregnancy and childbirth. Similar finding has been established by previous study [21] which revealed that awareness on danger signs and one feeling not susceptible to complications associated with pregnancy lead to low risk perception among male partners.

### 5.1.4 Study Limitation

This study was not without a limitation. It used a qualitative method that involved purposive selection of study sample. This approach has a limited generalization of study findings. However, like most qualitative studies, the goal of this study was not to generalize but rather to provide a rich, contextualized understanding of birth preparedness and complication readiness through the intensive study of home birth parents.

### 5.1.5 Credibility of the Findings:

In this study, the realistic value of findings was secured through the use of triangulation – both in-depth interviews and FGDs were used. Besides, member checking technique was utilized during data collection to increase trustworthness of the findings. The technique consisted of the researcher restating, summarizing, or paraphrasing the information received from focus group discussant (s) and a key informant, to ensure that what was heard or written down was infact correct. Hence, the researcher is confident that the qualitative findings of this study are logical and grounded in the data.

## 5.2 CONCLUSION

In conclusion, this study has documented that apart from commonly cited structural barriers to skilled birth attendants, low risk perception among both parents on complications related to childbirth and home delivery play a substantial role. Hence, the identified factors that influence low risk perception need to be addressed in order to enhance health facility birth preparedness and complication readiness.

## 5.3 RECOMMENDATIONS

Specifically the following recommendations are made for the attention of the district authorities as well as the MoHSW:-

1. There is a need for the Ministry of Health, in collaboration with district councils, to design and implement an educational programme for raising parents' awareness on risks associated with pregnancy and childbirth.
2. There is a need for the Ministry of Health, in collaboration with district councils, to design and implement a community based gender sensitization programme for enhancing participation of men in safe motherhood.

3. There is a need for the Ministry of Health, in collaboration with district councils to design and implement community sensitization on saving for health facility birth preparedness and complication readiness.
4. There is a need for Ministry of Health, in collaboration with district councils, to set aside funds for more studies on fatalistic attitude and the way it affects birth preparedness and complication readiness.

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## APPENDICES

**Appendix 1: Focused Group Discussion with male partners. English Version**

Village ……

Number of men in group…….

Age range of participant……

Closest health facility……

Closest referral facility…….

| To assess the role of male partners in health facility birth preparedness and complication readiness. | |
|---|---|
| Basic Line Questioning | Probe |
| Who usually decides where women give birth? | |
| In this community where do men prefer their wives to have birth? | Home Vs Health facility and why? |
| In this community what do men do regarding birth preparedness? | Plan for where to give birth<br>Plan for transportation |
| Do you think more men would be willing to allow their wives to use skilled attendants (define skilled attendants to them)? | Why/Why not? |
| What are the good things that happen with TBA? What are bad things that could happen? | |
| What are the good things that happen when women deliver with skilled attendants? What are some of the bad things that could happen? | |
| What happens in the household after a woman has an obstetric problem? | Good/Bad? How long does this last? |

| | |
|---|---|
| Why do you think some women with obstetric emergencies don't reach health facility in time? | Cost, distance, transport as well as other factors: Family decision making? Fear? |
| Do you think some men keep women from getting to skilled care in time when there is a problem? | What do they do and why |

**Appendix 2: Focused Group Discussion with female partners. English Version**

Village …….

Number of men in group…….

Age range of participant…….

Closest health facility……

Closest referral facility…….

| To Identify socio economic and cultural barriers against women's health facility birth preparedness and complication readiness. | |
|---|---|
| Basic Line Questioning | Probe |
| Who usually decides where women give birth? | |
| Where do you think most women prefer to give birth? Home or Health facility? | Why? |
| What are the good things that happened with TBA? What are bad things that could happen? | |
| What are the good things happen when women deliver with skilled attendants? What are some of the bad things that could happen? | |
| What happens in the household after a woman has an obstetric problem? | Good/Bad? How long does this last? |
| Why do you think some women with obstetric emergencies don't reach health facility in time? | Cost, distance, transport as well as other factors: Family decision making? Fear? |
| Do you think some men keep women from getting to skilled care in time when there is a problem? | What do they do and why |

**Appendix 3: In- Depth Interview with male partners. English Version**

Respondent ID …….

Age…….

Education……

Occupation……..

Normal delivery: Yes

No

**To assess male partners' perception of high risk pregnancy and danger signs**

1. When did your wife give birth to your youngest child?
2. How risky is pregnancy and childbirth?
   i) Not risky, why……
   ii) Risky, why…….
   iii) Moderate risky, why…….
   iv) Highly risky, why……
3. How far is health facility from your home?
4. How far is TBA's Home from yours?
5. Indicate whether the following are True, False, or I don't know.

| S/n | **sign during pregnancy** | True | False | I don't Know |
|---|---|---|---|---|
| 1 | Vaginal bleeding | | | |
| 2 | High grade fever | | | |
| 3 | Swelling of face, fingers and feet | | | |
| 4 | Convulsion or loss of consciousness | | | |
| 5 | Severe abdominal pain | | | |
| 6 | Awareness of fast heart beat | | | |
| 7 | Child does not move | | | |
| | **During delivery** | | | |

| | | | | |
|---|---|---|---|---|
| 1. | Prolonged labour more than twelve hours | | | |
| 2. | High grade fever | | | |
| 3. | Severe Vaginal bleeding | | | |
| 4. | Severe abdominal pain | | | |
| 5. | Convulsion or loss of consciousness | | | |
| | **After Delivery** | | | |
| 1. | High grade fever | | | |
| 2. | Severe Vaginal bleeding | | | |
| 3. | Severe abdominal pain | | | |
| 4. | Placenta retained more than one hour. | | | |
| 5. | Problems of Urination | | | |
| 6. | Convulsion or loss of consciousness | | | |
| 7. | Severe Abdominal Pain | | | |

6. When your wife was pregnant, how were you prepared for child birth?

   Probes: Place of delivery

   Transportation

   Serving of money (budget)

   Procurement of some delivery equipments.

7. Did your wife get any obstetric complications during pregnancy, child birth and after delivery? What did you do?

8. What are barriers to heath facility birth preparedness and complication readiness?

**Appendix 4: In- Depth Interview with female partners. English version**

Respondent ID …….

Age……

Education……

Occupation……..

Normal delivery: Yes

No

**To assess women's perception of high risk pregnancy and danger signs**

9. When did you give birth to your youngest child?
10. How risky is pregnancy and childbirth?
    i) Not risky, why…….
    ii) Risky, why……..
    iii) Moderate risky, why……
    iv) Highly risky, why……..
11. How far is health facility from your home?
12. How far is TBA's home from yours?
13. Indicate whether the following are True, False, or I don't know.

| S/n | **sign during pregnancy** | True | False | I don't Know |
|---|---|---|---|---|
| 1 | Vaginal bleeding | | | |
| 2 | High grade fever | | | |
| 3 | Swelling of face, fingers and feet | | | |
| 4 | Convulsion or loss of consciousness | | | |
| 5 | Severe abdominal pain | | | |
| 6 | Awareness of fast heart beat | | | |
| 7 | Child does not move | | | |
| | **During delivery** | | | |

| | | | | |
|---|---|---|---|---|
| 1. | Prolonged labour more than twelve hours | | | |
| 2. | High grade fever | | | |
| 3. | Severe Vaginal bleeding | | | |
| 4. | Severe abdominal pain | | | |
| 5. | Convulsion or loss of consciousness | | | |
| | **After Delivery** | | | |
| 1. | High grade fever | | | |
| 2. | Severe Vaginal bleeding | | | |
| 3. | Severe abdominal pain | | | |
| 4. | Placenta retained more than one hour. | | | |
| 5. | Problems of Urination | | | |
| 6. | Convulsion or loss of consciousness | | | |
| 7. | Severe Abdominal Pain | | | |

14. When you were pregnant, how were you prepared for child birth?

    Probes: Place of delivery

    Transportation

    Serving of money (budget)

    Procurement of some delivery equipments.

15. Did you get obstetric complications during pregnancy, delivery and after delivery? What did you do?

16. What are barriers to heath facility birth preparedness and complication readiness?

THANK YOU

**Appendix 5: Focused Group Discussion with male partners. Swahili Version**

Kijiji ……

Idadi ya wanaume kwenye kikundi …….

Umri wa wahiriki ni kati ya……Mpaka…..……

Kituo cha kutolea huduma za afya cha karibu kipo umbali wa km.……

Kituo cha rufaa ni km …….

| Kupima majukumu ya wanaume katika maandalizi ya wake zao kujifungulia hospitali na kukabiliana na dharua wakati wa mimba,kujifungua na baada ya kujifungua. | |
|---|---|
| Swali la msingi | Pima kwa kina |
| Ni nani kwenye familia huwa anamaamuzi juu ya sehemu ya kujifungulia? | |
| Katika kijiji hiki ni wapi mnapendelea wake zenu kujifungulia. | Nyumbani ama hospitali? Kwa nini? |
| Katika kijiji hiki mnafanya nini kwenye kuwaandaa wake zenu kujifungua? | Kupanga sehemu ya kujifungulia.<br>Kuandaa usafiri. |
| Mnafikiri wanaume walio wengi wangependa wakezao kujifungulia hospitali kwenye wataalam? | Kwa nini? |
| Ni vitu gani vizuri vinavyofanywa na wakunga wa jadi wakati wa kumsaidia mama ajifungue? Ni vitu gani vibaya vinavyoweza kutokea kwa akina mama wakiwa kwa wakunga wa jadi? | |
| Ni vitu gani vizuri vinavyotokea mama akijifungulia kwa wataalam hospitali? Ni vitu gani vibaya vinavyoweza kutokea akina mama wakiwa kwa wataalam hospitalini. | |

| | |
|---|---|
| Je nini kinafanyika kwenye familia mama anapopata kidokezo cha hatari(taja vidokezo vya hatari) wakati wa mamba, kujifungua au baada ya kujifungua? | Kidokezo cha hatari kilidumu kwa muda gani? |
| Je mnafikiri ni kwanini akina mama wenye vidokezo vya hatari wakati wa mimba, kujifungua au baada ya kujifungua wanachelewa kufika hospitalini? | Gharama?, Umbaliiri? Ukosefu wa usafiri? Kucali?helewa kutolewa maamuzi ya kwenda hospitali? Woga? |
| Je mnafikiri wanaume ndio wanaowachelewesha wake zao wenye vidokezo vya hatari kupata huduma hospitalini kwa wakati? | Huwa wanafanya nini na kwa nini? |

**Appendix 6: Focused Group Discussion with female partners. Swahili Version**

Kijiji ……

Idadi ya wanaume kwenye kikundi …….

Umri wa wahiriki ni kati ya……Mpaka…….……

Kituo cha kutolea huduma za afya cha karibu kipo umbali wa km.……

Kituo cha rufaa ni km …….

| | |
|---|---|
| Kuchunguza vitu vinavyowakwamisha akina mama kujiandaa kujifungulia hospitali na kukabiliana na dharura pindi ijitokezavyo. | |
| Swali la msingi | Kupima kwa kina. |
| Ni nani kwenye familia huwa anamaamuzi juu ya sehemu ya kujifungulia? | |
| Je mnafikiri wanawake wengi wangependa kujifungulia wapi? | Kwa nini? |
| Ni vitu gani vizuri vinavyofanywa na wakunga wa jadi wakati wa kumsaidia mama ajifungue? Ni vitu gani vibaya vinavyoweza kutokea kwa akina mama wakiwa kwa wakunga wa jadi? | |
| Ni vitu gani vizuri vinavyotokea mama akijifungulia kwa wataalam hospitali? Ni vitu gani vibaya vinavyoweza kutokea akina mama wakiwa kwa wataalam hospitalini? | |
| Je nini kinafanyika kwenye familia mama anapopata kidokezo cha hatari(taja vidokezo vya hatari) wakati wa mamba, kujifungua au baada ya kujifungua? | Kidokezo cha hatari kilidumu kwa muda gani? |
| Je mnafikiri ni kwanini akina mama wenye vidokezo vya hatari wakati wa mamba, | Gharama?, Umbaliiri? Ukosefu wa usafiri? Kucali?helewa kutolewa maamuzi ya kwenda |

| | |
|---|---|
| kujifungua au baada ya kujifungua wanachelewa kufika hospitalini? | hospitali? Woga? |
| Je mnafikiri wanaume ndio wanaowachelewesha wake zao wenye vidokezo vya hatari kupata huduma hospitalini kwa wakati? | Huwa wanafanya nini na kwa nini? |

**Appendix 7: In- Depth Interview with male partners. Swahili Version**

No ya utambulisho ya mshiriki …….

Umri…….

Elimu……

Kazi……..…….

**To assess male partners' perception of risks associated with pregnancy and danger signs**

1. Lini mke wako alijifunga mtoto wako mdogo?
2. Mimba na kujifungua ni hatari kiasi gani?
   i) Siyo hatari
   ii) Ni hatari
   iii) Ni hatari kiasi
   iv) Ni hatari sana.
3. Ni umbali kiasi gani kutoka hapa kwako mpaka hospitali?
4. Ni umbali kiasi gani kutoka hapa kwako mpaka kwa mkunga wa jadi?
5. Kwa kila kidokezo kifuatacho sema kweli kama ni kidokezo hatari, si kweli kama siyo kidokezo hatari na sijui kama hujui.

| No. | **Vidokezo wakati wa mamba.** | Kweli | Si kweli | Sijui |
|---|---|---|---|---|
| 1 | Kuona matone ya damu | | | |
| 2 | Homa kali | | | |
| 3 | Kuvimba uso mikono na miguu. | | | |
| 4 | Kifafa cha mamba au kupoteza fahamu. | | | |
| 5 | Kuumwa tumbo sana. | | | |
| 6 | Kuyasikia mapigo ya moyo | | | |
| 7 | Mtoto hachezi | | | |
| | **Wakati wa kujifungua** | | | |
| 1. | Uchungu wa muda mrefu zaidi ya masaa kumi na mbili | | | |

| | | | | |
|---|---|---|---|---|
| 2. | Homa kali | | | |
| 3. | Kutokwa damu nyingi | | | |
| 4. | Maumivu makali ya tumbo. | | | |
| 5. | Kifafa au kupoteza fahamu. | | | |
| | **Baada ya kujifungua** | | | |
| 1. | Homa kali | | | |
| 2. | Kutokwa damu nyingi | | | |
| 3. | Maumivu makali ya tumbo | | | |
| 4. | Kondo la nyuma kutotoka baada ya saa moja. | | | |
| 5. | Maumivu wakati wa kukojoa au mkojo kutoka kidogo kidogo | | | |
| 6. | Kifafa au kupoteza fahamu. | | | |

6. Wakati mkeo alipokuwa mjamzito ulijiandaaje kuzaliwa kwa mtoto wako?

   Kipimo cha kina:

   Sehemu ya kujifungulia

   Usafiri

   Kutunza pesa.

   Kununua vifaa vya kusaidia kujifungua kama mipira, kiwembe,pamba

7. Je nini kinafanyika kwenye familia mama anapopata kidokezo cha hatari(taja vidokezo vya hatari) wakati wa mamba, kujifungua au baada ya kujifungua?

8. Je ni vikwazo gani vinavyopelekea kushindwa kuwaandaa wake zenu kujifungulia hospitalini? Vinavyosababisha kushindwa kujiandaa kukabiliana na dharura wakati wa mImba, kujifungua, na baada ya kujifungua?

**Appendix 8: In- Depth Interview with female partners. Swahili Version**

No ya utambulisho ya mshiriki …….

Umri…….

Elimu……

Kazi……..…….

**To assess female partner's perception of risks associated with pregnancy and danger signs**

1. Lini ulijifunga mtoto wako mdogo?
2. Mimba na kujifungua ni hatari kiasi gani?
   i) Siyo hatari
   v) Ni hatari
   vi) Ni hatari kiasi
   vii) Ni hatari sana.
3. Ni umbali kiasi gani kutoka hapa kwako mpaka hospitali?
4. Ni umbali kiasi gani kutoka hapa kwako mpaka kwa mkunga wa jadi?
5. Kwa kila kidokezo kifuatacho sema kweli kama ni kidokezo hatari, si kweli kama siyo kidokezo hatari na sijui kama hujui.

| No. | **Vidokezo wakati wa mamba.** | Kweli | Si kweli | Sijui |
|---|---|---|---|---|
| 1 | Kuona matone ya damu | | | |
| 2 | Homa kali | | | |
| 3 | Kuvimba uso mikono na miguu. | | | |
| 4 | Kifafa cha mamba au kupoteza fahamu. | | | |
| 5 | Kuumwa tumbo sana. | | | |
| 6 | Kuyasikia mapigo ya moyo | | | |
| 7 | Mtoto hachezi | | | |
| | **Wakati wa kujifungua** | | | |
| 1. | Uchungu wa muda mrefu zaidi ya masaa | | | |

| | | | | |
|---|---|---|---|---|
| | kumi na mbili | | | |
| 2. | Homa kali | | | |
| 3. | Kutokwa damu nyingi | | | |
| 4. | Maumivu makali ya tumbo. | | | |
| 5. | Kifafa au kupoteza fahamu. | | | |
| | **Baada ya kujifungua** | | | |
| 1. | Homa kali | | | |
| 2. | Kutokwa damu nyingi | | | |
| 3. | Maumivu makali ya tumbo | | | |
| 4. | Kondo la nyuma kutotoka baada ya saa moja. | | | |
| 5. | Maumivu wakati wa kukojoa au mkojo kutoka kidogo kidogo | | | |
| 6. | Kifafa au kupoteza fahamu. | | | |

6. Wakati ulipokuwa mjamzito ulijiandaaje kuzaliwa kwa mtoto wako?

   Kipimo cha kina:

   Sehemu ya kujifungulia

   Usafiri

   Kutunza pesa.

   Kununua vifaa vya kusaidia kujifungua kama mipira, kiwembe,pamba

7. Je nini kinafanyika kwenye familia mama anapopata kidokezo cha hatari(taja vidokezo vya hatari) wakati wa mamba, kujifungua au baada ya kujifungua?

8. Je ni vikwazo gani vinavyopelekea kushindwa kujiandaa kujifungulia hospitalini? Vinavyosababisha kushindwa kujiandaa kukabiliana na dharura wakati wa mimba, kujifungua, na baada ya kujifungua?

ASANTE SANA

**Appendix 9: Informed Consent Form, English version.**

MUHIMBILI UNIVERSITY COLLEGE OF HEALTH AND ALLIED SCIENCES DIRECTORATE OF RESEARCH AND PUBLICATION, MUHAS CONSET FORM.

Greetings,

My name is ……..studying at school of public health and social science at Muhimbili University College of Health Sciences in Dar es Salaam. I am doing research on Examination of Birth Preparedness and Complication Readiness among Homebirth Parents in Sumbawanga Rural District.

**Purpose of the Study**

The purpose of this study is to examine birth preparedness and complication readiness among homebirth parents.

**Kind of participation involved**

If you agree to join this study you will be required to answer series of questions that have been prepared for the study through interviewing in order to obtain the intended information regarding birth preparedness and complication readiness among homebirth parents.

**Confidentiality**

All collected information will be kept confidential and will only be used for study purpose. Identification number will be used.

**Risks**

We do not expect any harm to happen to you because of participation in this study.

**Right to withdraw and alternatives**

To participate in this study is completely voluntary. You can freely choose not to participate in this study and even if you have already accepted to participate in this study you can quit at any time if you feel so. No penalty or loss of any benefit upon refusal to participate or withdrawal from the study.

**Benefits**

If you agree to take part in this study we hope that the information we gather from this study will be beneficial to you as a household in the district and other parts of the country.

**Who to consult**

If you ever have questions about his study you should consult the study coordinator or the principal investigator; **Fabiola Moshi**, Muhimbili University of Health and Allied Sciences (MUHAS), P.O.Box 65001 Dar es Salaam, Tel.0767837019.

If you have questions which need further clarification as participant you have a right to call **Prof. M. Aboud**, Director of Research and Publication Committee, MUHAS P.O.Box 65001 Dar es Salaam.

**Signature**

Do you agree?

Participant agrees……Participant does not agree…….

I……have read the consent in this form, my questions have been answered, I agree to participate in this study.

Signature of participant……

Signature of research assistant……

Date of signed consent

**Appendix 10: Informed consent form. Swahili version**

**FOMU YA RIDHAA**

Hujambo?

Ninaitwa……..Mwanafunzi wa shahada ya uzamili wa afya ya jamii katika chuo kikuu cha Afya ya Tiba cha Muhimbili.

**Madhumuni ya Utafiti**

Utafiti huu unalenga…….

Nini kunachohitajika ili kushiriki?

Ili kushiriki katika utafiti huu inabidi kukubali na kujiunga kwa kujibu maswali utakayoulizwa.

**Usiri**

Taarifa zitakazokusanywa kupitita dodoso hili zitakuwa siri na hakuna mtu yeyote atakayemabiwa ulichosema. Taarifa zitaingizwa kwenye ngamizi kwa kutumia namba za utambulisho.

**Hatari**

Hakuna hatari yoyote itakayotokea kwako kutokana na ushiriki wako kwenye utafiti huu.

**Haki ya kujitoa au vinginevyo**

Ushiriki katika utafiti huu ni hiari. Kutotkushiriki au kujitoa kutoka kwenye utafiti hakutakuwa na adhabu yoyote na hutapoteza stahili zako endapo utaona ni vyema kufanya hivyo.

**Faida**

Kama utakubali kushiriki katika utafiti huu itakuwa ni fanaka kwa vile utafiti huu una lengo la kuchunguza maadnalizi ya kujifungua na utayari wa dharura zitokanazo na uzazi.

**Endapo utapata madhara au la**

Hatutegemei kupata madhara yoyote kutokana ushiriki wako katika utafiti huu.

**Nani wa kuwasiliana naye**

Kama kuna swali kuhusiana na utafiti huu itabidi kuwasiliana na mhusika mkuu Fabiola Moshi wa Chuo kikuu cha Afya na Sayansi ya Tiba Muhimbili,S.L.P 65001,Simu 0767837019.

Kama una maswali zaidi unaweza kuwasiliana na Prof M. Aboud Mkurugenzi wa Kamati ya Utafiti na Uchapishaji,Chuo Kikuu cha Muhimbili.

Je?Umekubali?

Mshiriki amekubali……Mshiriki hajakubali……

Mimi……nimesoma maelezo au fomu hii, maswali yangu yamejibiwa na nimeridhika. Nakubali kushiriki katika utafiti huu.

Sahihi ya mshiriki…….

Sahihi ya shahidi……..

Sahihi ya mtafiti msaidizi……

**Appendix 11: Ethical Approval**

**MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES**
**DIRECTORATE OF POSTGRADUATE STUDIES**

P.O. Box 65001
DAR-ES-SALAAM
TANZANIA
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*E-MAIL dpgs@muhas.ac.tz*
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Direct line: 2151378

Ref. No. MU/PGS/SAEC/Vol. VI/254

28th March, 2012

Ms. Fabiola V. Moshi,
MA-Health Policy and Management,
**MUHAS.**

**RE: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED "EXAMINATION OF BIRTH PREPAREDNESS AND COMPLICATION READLINESS AMONG HOMEBIRTH PARENTS IN SUMBAWANGA RURAL DISTRICT: A QUALITATIVE STUDY"**

Reference is made to the above heading.

I am pleased to inform you that, the Chairman has on behalf of the Senate approved ethical clearance for the above-mentioned study.

Thus ethical clearance is granted and you may proceed with the planned study.

Prof. Z. Premji
**DIRECTOR, POSTGRADUATE STUDIES**

/emm

c.c. Vice Chancellor, MUHAS
c.c. Deputy Vice Chancellor – ARC, MUHAS
c.c. Dean, School of Public Health and Social Sciences

**Appendix 12: Thematic Network (from codes to global themes)**

| Codes | Basic themes identified | Organizing themes | Global themes |
|---|---|---|---|
| - **male partners' involvement**<br>- **decision making**<br>- **cultural practice**<br>- **low risks perception**<br>- **Rely on fixed assets.** | 1. Male partners' responsibility is to provide financial support.<br>2. Decision on place of delivery is done by mothers<br>3. First child to be born under assistance of her own mother<br>4. Some male partners prepare some money to help in case of emergence.<br>5. Some male partners do not keep some money to assist them during childbirth and they have low perception of risks associated with childbirth.<br>6. Some male partners rely of fixed assets they have in a household to be used in emergency. | Gender division of roles<br>Social cultural traditions<br>Resource mobilization | **Role of Male Partners in Birth Preparedness and Complications Readiness.** |
| - **Inform TBA** | 7. Some male parntners participate in preparation of traditional birth attendants by informing them that their wives are pregnant. | Preparation of alternative treatment | |

| | | | |
|---|---|---|---|
| - **Natural process**<br>- **Most of times went successful**<br>- **It is uncertain**<br>- **Falling sick easily** | 8. Some male partners perceive pregnancy as natural process, which is not associated with risks.<br>9. Male partners perceive pregnancy as moderately risk because most of times, it went successful but sometimes it may develop complications.<br>10. Some male partners see pregnancy and childbirth as risk because it is accompanied by sickness and a pregnant woman fails to work as she used to work. | Pregnancy perceived as natural process.<br>Perceived to be risky due to sickness | **Male partners' perception of risks associated with pregnancy and danger signs** |
| - **Most of time it went successful**<br>- **Both are at risk of illness**<br>- **A natural process**<br>- **Fall sick easily.** | 11. Pregnancy is perceived to be moderately risky because most of time it progress uneventifully.<br>12. Pregnancy is perceived be a natural process and hence not associate with risk.<br>13. Pregnancy is perceived to be risky because both mother and child have increased chances of falling sick.<br>14.Pregnancy is perceived to be highly risky because of sickness | Pregnancy perceived as a natural process<br>Pregnancy perceived to be risky due to sickness | **Women's perception of risks associated with pregnancy and danger signs**. |