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**QUALITATIVE ASSESSMENT OF ATTITUDES  
AFFECTING CHILDBIRTH CHOICES OF  
JAMAICAN WOMEN**

**WORKING PAPER: 5**

**November 1990**

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**Maxine Wedderburn  
MotherCare/Hope Enterprises, Ltd.**

**Mona Moore  
MotherCare/The Manoff Group**

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**MotherCare Project  
1616 N. Fort Myer Dr., 11<sup>th</sup> Floor  
Arlington, Virginia 22209 USA**

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## TABLE OF CONTENTS

I.	EXECUTIVE SUMMARY .....	1
II.	BACKGROUND .....	3
III.	RESEARCH OBJECTIVES .....	7
IV.	RESEARCH METHODOLOGY .....	9
	A. Sample Selection .....	9
	B. Survey Instruments .....	10
	C. Discussion Format .....	11
	D. Facilitating Technique .....	11
	E. Key Characteristics of Sample .....	12
V.	CONCLUSIONS .....	13
	A. Attitude Toward Childbirth .....	13
	B. Childbirth Location Choice .....	13
	1. Hospital .....	13
	2. Home Delivery .....	14
	3. Maternity Centre or Clinic-Attached Facility .....	14
	C. Response to Proposed Facility .....	15
	D. Pregnancy and the Antenatal Period .....	16
	E. Risk Recognition .....	16
	F. Knowledge Base .....	16
	G. Pattern of Antenatal Care .....	16
	H. Barriers to Care Seeking .....	16
VI.	DETAILED FINDINGS .....	17
	A. Pregnancy .....	17
	1. Emotional Response to Pregnancy .....	17
	2. Knowledge of Reproductive Anatomy and Physiology .....	18
	B. Risks .....	19
	1. Recognition of Risks and Perceived Susceptibility .....	19
	2. Primary Sources of Knowledge .....	19
	C. Antenatal Care .....	21
	1. Perceived Value of Antenatal Care .....	21
	2. Pattern of Attendance at Antenatal Clinic .....	24
	3. Barriers to Early Initiation of Antenatal Care .....	24
	4. Myths and Their Impact on Accessing Care .....	25
	D. Childbirth .....	26
	1. Emotional Response to Childbirth .....	26
	2. Risk Recognition in Childbirth .....	26
	3. Expectations of Care During Delivery .....	27
	E. Choice of Delivery Facility .....	28
	1. Factors Impacting Choice of Facility .....	28
	2. Assessment of Hospital Delivered Experiences .....	29
	3. Assessment of Actual Home Experience .....	30
	4. Assessment of Actual Birthing Centre Experience .....	31

F.	Proposed Facility .....	31
1.	User Assessment of Home-Away-From-Home Delivery Concept .....	31
2.	User Concerns .....	32
3.	General User Expectations .....	33
4.	Summary of User Response by Location .....	33
VII.	RECOMMENDATIONS .....	37
VIII.	DISCUSSION .....	39
	BIBLIOGRAPHY .....	43
	APPENDICES	
	I. Research Instruments	
	II. Pictures of Marva	

## I. EXECUTIVE SUMMARY

In Jamaica, demand for hospital childbirth has increased dramatically within the past decade, especially in urban and periurban areas. This has led to overcrowding of hospital facilities and compromised the quality of childbirth attendance at the major government maternity hospital in the capital city. To address this and related maternal health care utilization problems documented in a recent nationwide study of perinatal mortality, the Jamaican Ministry of Health is exploring several possible means of strengthening the health system's capability to provide out-of-hospital childbirth.

One proposed childbirth alternative would provide the option of midwife-attended birth in a specially created maternity room attached to a neighborhood clinic, for those pregnant women who had been screened and anticipated normal deliveries. At the request of the Ministry of Health, MotherCare collaborated with a local marketing firm with expertise in market research to design and implement a qualitative study to determine the acceptability of the proposed alternative childbirth location. Women who had recently given birth in a variety of settings participated in focussed group discussions and depth interviews island-wide. Research instruments were designed to elicit the factors influencing choice of childbirth location, how amenable current childbirth choices are to change, and the specific conditions which would motivate pregnant women to choose community based childbirth. Use of marketing methods such as projective interview techniques and pile sorts provided insight into potentially sensitive areas such as the denial and shame found to be associated with unwanted pregnancies.

There were marked differences in acceptability of the proposed alternative childbirth location between urban and rural women. Most urban women expressed a preference for hospital childbirth, primarily due to the perceived safety offered by the proximity of medical expertise for obstetric emergencies. Conditions for acceptance of alternative birth location by urban women include availability of emergency medical care or transport, and more personalized care than that currently provided by hospitals. Lack of social support and poor attitudes among maternal care providers in hospitals were more disturbing to urban women than the difficult physical conditions often experienced during hospital childbirth such as shortages of supplies or bed space.

In rural areas, where childbirth often takes place at home attended by a midwife, women preferred home birth but were more receptive to the proposed alternative birth location. Conditions for acceptance by rural women included assurance of privacy, and provision of the same basic comforts and social support that home birth allows.

Prior childbirth experience exerted a strong influence on acceptance of the alternative birth location. Acceptance was higher among women who had given birth in one of several existing facilities similar to the proposed clinic-attached maternity room. Women who experienced complications during previous pregnancies or births attached greater importance to availability of medical back-up than women who had uncomplicated births.

An additional research objective was to determine women's knowledge of and attitudes toward antenatal and obstetric risk, and identify barriers to antenatal care use. Although pregnancy is considered a normal life event among respondents, childbirth was perceived as potentially dangerous by the majority of women interviewed. However, most women were familiar with only the common symptomatic complaints of pregnancy, and less than ten percent of women could identify any specific risks or dangers of pregnancy or birth. Hypertension, hemorrhage

and problems related to the umbilical cord were the antenatal, intrapartum and neonatal complications most frequently identified.

Prior experience affected both knowledge of risk factors and awareness of the need for antenatal care. Knowledge of risk was limited to those complications previously experienced by women themselves, or by close friends and relatives. The majority of women did not associate multiparity with increased risk. The outcome of a woman's first pregnancy is an important factor influencing perceived personal susceptibility to risks or complications in subsequent pregnancies. Most women who had problem free first births saw little need to seek antenatal care or trained attendance for future births.

Antenatal care users knew more about the content of and need for such care than non-users. Barriers contributing to late initiation of antenatal care include inability of government clinics to provide early confirmation of pregnancy, poor attitudes of maternal health care providers, inadequate knowledge of the need for antenatal care, and emotional factors such as shame, embarrassment or denial of unwanted pregnancies.

Potential applications of the research results are discussed. These include:

- Establishing the alternative childbirth location in communities where the concept was well received, with attention to meeting the conditions women identified as prerequisites for acceptance;
- Promotion of alternative birth locations in other areas, addressing expressed resistances to acceptance of the concept;
- Providing the education women need to better understand antenatal and obstetric risk; and
- Encouraging personalized care and better patient/provider relationships.

## II. BACKGROUND

### Maternal Morbidity and Mortality

In 1986, the Jamaican Ministry of Health conducted an extensive national investigation of perinatal mortality. In addition to documenting pregnancy outcome and identifying the major maternal and neonatal health problems island-wide, the Perinatal Mortality and Morbidity Study (19) provided detailed quantitative information on patterns and problems of maternal health service utilization.

The maternal mortality rate in Jamaica documented by the study is 11.5/10,000. Maternal deaths occurred with greatest frequency in rural areas, either in hospitals or at home, and the majority were avoidable. Avoidable maternal deaths were most commonly attributed to non use of or deficiencies in antenatal care, out-of-hospital childbirth by high risk women, and service system delays in detecting and treating intrapartum complications. Reduced access to health services and transport was documented among high risk women, and may have been a factor contributing to their deaths.

As in many developing countries, complications related to hemorrhage, sepsis and hypertensive disorders of pregnancy were the main causes of maternal death. However, the rate of eclampsia in Jamaica (7/1000 pregnancies) is significantly higher than that in many other nations (18). A strong relationship between maternal mortality, age and parity has been demonstrated, with deaths among women over 34 years of age who had delivered five or more children three times higher than among nulliparous women. Excluding hypertensive disorders of pregnancy, sexually transmitted diseases were among the leading causes of maternal morbidity. Detection and treatment of some STDs is currently problematic, and almost 300 cases of neonatal syphilis were reported in Jamaica in 1989.

### Utilization of Maternal Health Care

#### Hospital Childbirth

Unlike many developing nations, demand for formal maternal health services is strong in Jamaica. Hospital childbirth is the overwhelming preference of Jamaican women, with approximately 75 percent of all births occurring in one of the island's 26 hospitals. Obstetric care for normal delivery is the most common reason for hospital admission, followed by accidents and complications of pregnancy. One fourth of all births in Jamaica take place at Victoria Jubilee Hospital (VJH), the island's largest maternity facility, in Kingston.

The standard fee for hospital delivery is JA \$50 (US \$10). This is usually collected when a woman presents during the antenatal period for "booking," and creation of her pregnancy and delivery record. In addition to the fee, two units of blood are routinely requested.

Several infrastructural problems, coupled with high demand for hospital birth, have created a difficult childbirth environment for both maternal care users and providers in many hospitals throughout the island. Two thirds of all hospitals in Jamaica do not have a full time obstetrician on staff, and there are currently over a thousand vacant posts for nurses and midwives. Supplies and support facilities, such as emergency transport or blood for transfusion, though often available, may be poorly distributed, especially in rural areas.

Overcrowding has become a widespread and widely recognized problem. At the time of the Perinatal Mortality Survey, over one third of hospitals had at least one maternity bed occupied by two women. In some hospitals where demand for services is high and staff limited, especially at VJH, the situation is more severe and can result in unattended births. Approximately 20 percent of public hospital births nationwide in Jamaica are not attended by a trained health worker.<sup>1</sup>

### Out-of-Hospital Childbirth

There are several smaller, free standing maternity centres in Jamaica. Kiwanis Maternity Centre, a 12-bed facility linked to nearby Jubilee Hospital, provides midwife-assisted, community-based childbirth to periurban residents in the Kingston area. Midwives also attend births at maternity centres in two rural communities, Chester Castle and Balaclava.

Approximately 20 percent of all births in Jamaica occur out of hospital, primarily at home. Unlike some advanced developing nations, midwife attended home birth is considered an acceptable childbirth location by Jamaican maternal health planners, and government policy encourages use of domiciliary childbirth services. Domiciliary service was widely utilized throughout Jamaica until as recently as the early 1980s, when political disturbances and violence decreased its availability, especially in urban areas. Three quarters of all births in Jamaica, regardless of location, are midwife attended. Midwives in rural areas perform an average of 2.1 home deliveries annually, compared to less than four per year for midwives practicing in urban areas (19).

Due to constraints of distance, transportation and communication, a substantial number of home births are also unattended. In many instances, the midwife is summoned, but is unable to reach the household before the birth occurs. Almost four hundred unattended home births were reported by the 78 midwives interviewed in the Perinatal Mortality Study. Lack of trained birth attendance for home births is of particular concern, as over 80 percent of older multiparous women, those at highest risk of maternal mortality in the Jamaican setting, choose to deliver at home.

A small fraction of pregnant women (five percent) seek birth attendance from informally trained women known as "nanas." Although the continued presence of these traditional birth attendants is controversial, according to one survey, they assisted 10 percent of home births among multiparous women aged 40 and over in 1989 (12).

### Health Centre-Based Childbirth

Midwives and public health nurses at over 400 health centres throughout Jamaica are the designated source of primary antenatal and postnatal care in both rural and urban areas. From this health centre base, midwives in rural areas also provide domiciliary childbirth services to women in nearby communities. Most health centres are not designed with facilities for on-site childbirth, and pregnant women who attend for antenatal care are referred for hospital birth or approved for home birth, according to medical need and the woman's preference for birth location.

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<sup>1</sup>**Note:** "Attended" is defined as presence of a health professional for control of the head during delivery.

In several areas, health centre midwives have requested permission to conduct births at the health centre itself. An example of this is in Enfield, a small rural community miles over difficult terrain from the nearest hospital. Available space has been reorganized to provide a maternity room for women who prefer a midwife-assisted birth but do not wish to deliver at home. Women are requested to bring a family member to provide food and postnatal attention, linen for the delivery, and to pay the customary home delivery fee. These "home-away-from-home" births provide elements of the social support and comfort of home births and assurance that a midwife will be present to attend the birth.

## **Antenatal Care**

According to Ministry of Health policy, routine antenatal care is provided at no cost to all pregnant women at government health centres in the community, or as an outpatient service at government hospitals. Norms for antenatal care recommend at least five antenatal visits, and antenatal physical and laboratory examination, including: screening for historical obstetric risk or current pregnancy problems, STDs, sickle cell disease, urinalysis, serial measurement of blood pressure, maternal weight and fundal height, and health education (10).

Almost all pregnant women in Jamaica seek formal antenatal care at least once, irrespective of age, parity, education, or geographic location (12). The average number of antenatal contacts is five, substantially higher than that of many developing nations. However, approximately two thirds of all pregnant women interviewed during the Perinatal Mortality Survey initiated antenatal care during the second trimester (66 percent), and almost one quarter delayed initiation of antenatal care until the third trimester. First trimester use of private sources of antenatal care, where laboratory confirmation of early pregnancy is available, is widespread (7).

Several studies have contributed to available knowledge on patterns of antenatal care use in Jamaica, and pregnant women's reasons for use or non-use of formal health care during pregnancy. Primiparous women in urban and periurban areas seek antenatal care earlier than multiparous women in these areas. However, that early initial contact is frequently their only contact with the antenatal care system (14). Women of higher parity in urban areas were generally more frequent antenatal care users (56 percent with three or more visits), but many did not seek care until well into the second trimester of pregnancy or later. Women who sought antenatal care at community health centres initiated care earlier than those women who attended antenatal clinic at Victoria Jubilee Hospital in downtown Kingston. Long lines and waiting times at VJH may contribute to delays in seeking antenatal care from that source (15).

Socioeconomic and geographic factors that have been shown to influence utilization of antenatal care in other settings, such as distance, access (1) cost (17, 20), and household environment (13) have also been documented in Jamaica. These cost and distance factors may be more significant barriers to antenatal care use in rural areas (7).

A common reason given by urban and periurban women for attendance at antenatal clinic is the desire to begin the arrangements necessary to assure a hospital birth, known as "booking" in Jamaica. User fees and blood donations associated with this registration requirement do not appear to limit use of care (14). Poor attitude of maternal health care providers, and attitudinal factors such as shame or embarrassment among pregnant women themselves, can negatively affect utilization of antenatal care (7).

Interestingly, the Perinatal Mortality Survey did not identify failure to utilize antenatal care as directly contributing to maternal mortality (19). However, the study did conclude that maternal mortality could be reduced through more effective early detection and management of hypertensive disorders of pregnancy, indirectly indicating potential benefits of increased, timely use of antenatal care by Jamaican women.

The research which this report describes provides information that can assist the Ministry of Health in addressing several of the maternal health care service delivery and service utilization concerns documented by the Perinatal Mortality Study.

The MOH is considering the possibility of replicating on a larger scale alternative childbirth locations similar to the health centre- attached maternity room spontaneously initiated by local midwives in Enfield, described earlier. This is intended primarily to reduce overcrowding and difficult service conditions at major urban government maternity facilities. However, increasing the availability of community-based alternatives to hospital birth can also affect maternal health and pregnancy outcomes in rural areas. Much of the maternal mortality in Jamaica which occurs among multiparous women in these areas where home delivery is common, might be avoided through better access to the "home-away-from-home" birth environment provided by the proposed alternative.

Talking with women themselves can provide guidance to the MOH on whether pregnant women are likely to make use of such birth options, and under what specific circumstances out of hospital birth will be acceptable. This approach can also provide information on how to best promote the birth alternative to pregnant women and others involved in childbirth location decision making.

Only pregnant women who are not considered at obstetric risk would be encouraged to seek out-of-hospital birth. The research therefore also investigates women's perceptions of the risks and problems associated with pregnancy and birth, as ability to identify risk may influence appropriate choice of birth location as well as utilization of antenatal care.

### **III. RESEARCH OBJECTIVES**

The high demand for hospital-based childbirth services in Jamaica challenges the capacity of the health system not only to cope but to provide consistently high quality care. In its search for solutions the Jamaican Ministry of Health proposes the introduction of alternative community clinic-based birthing facilities to relieve some of the pressure currently being experienced by government hospitals. Hope Enterprises Ltd. was commissioned to undertake a study designed to explore the viability of the concept against the following objectives:

1. To investigate beliefs, perceptions and attitudes influencing decision making for choice of childbirth location.
2. To determine how amenable current childbirth location practices are to change.
3. To establish whether childbirth location alternatives being considered by the Ministry of Health are acceptable to women and under which specific circumstances or conditions.
4. To determine women's knowledge of, and attitudes toward antenatal and obstetric risk and how this affects the use of those services.

In considering the foregoing objectives, specific issues were thought to directly impact on the areas being investigated and therefore worthy of focus in the study. These were:

#### **Objective 1:**

- a. Perceptions of pregnancy.
- b. Perceived value of antenatal (preventive) care.
- c. Expectations of childbirth assistance.
- d. Sources of childbirth-related information - kinship network, peers, health system, media.
- e. Reasons for preference of birth location:
  - Attitudes of kinship network toward home/hospital.
  - Attitudes toward, and preference for types of childbirth attendants.
  - Perceptions of home versus hospital-based childbirth environment.
  - Knowledge of risk/complications of labor and delivery (susceptibility/severity).

#### **Objectives 2 and 3:**

- a. Specific attributes associated with home/hospital delivery.
- b. Resistance points - internal/external barriers.
- c. Level of satisfaction with previous birth experience.

## IV. RESEARCH METHODOLOGY

Qualitative research was undertaken among a total of 220 women, interviewed in 22 focus groups and 16 depth interviews.

Depth interviews were thought prudent owing to the sensitive nature of the study, as respondents are sometimes reluctant to discuss personal issues in a group setting.

Individual depth interviewing was therefore used as a means of uncovering any other information that may not have surfaced at the group level.

### A. Sample Selection

A multi-phased stratified sampling approach was used to identify the 220 participants for the study. The sampling frame was designed to facilitate the isolation and study of:

- Urban versus periurban versus rural attitudes to determine whether the degree of urbanization or sophistication of a region resulted in different attitudes to the concept being proposed;
- Attitudes of recent users of hospital facilities versus those delivering at home and in other facilities such as maternity centres or clinic-attached centres;

The island was first zoned into urban, periurban and rural health regions within which health centres/clinic locations were selected by the Ministry of Health based on the types of childbirth services offered by the particular clinic in the area. Specific respondents were then identified by the midwife at the selected health centres based on:

- Date of last delivery (deliveries had to be within the prior six-month period);
- Type of birthing facility used in most recent delivery;
- Parity<sup>2</sup>

The sample was therefore comprised of (see Tables 1 and 2):

- Multiparous women (1-5 delivery experiences) - 18 groups
- Grand multiparous women (5+ delivery experiences) - 3 groups
- Nulliparous women (currently pregnant, no prior delivery experience) - 1 group

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<sup>2</sup>**Note:** Since the proposed facility will cater to low risk multiparous women only, this group of respondents were targeted as the primary focus.

Table 1. Numbers of Focus Groups by Location, Parity and Delivery Centre						
GROUPS	PARITY			DELIVERY CENTRE		
	Multips	Grand	Nullips	Home	Hosp.	Other
			Multips			
Urban	2	1	-	-	3	-
Perurban	3	-	-	1	2	-
Rural	13	2	1	8	5	2
TOTAL	18	3	1	9	10	2

(NOTE: Nullips were currently pregnant hence no delivery centre.)

Table 2. Numbers of Individual Interviews by Location, Parity and Delivery Centre						
	Multips	Grand	Nullips	Home	Hosp.	Other
			Multips			
Urban	2	-	-	-	2	-
Perurban	4	-	-	1	3	-
Rural	10	-	-	3	6	1
TOTAL	16	-	-	4	11	1

Grand multiparous women and nulliparous women were included to ascertain the extent of their awareness of their own risk status and whether they would expect to be delivered at the proposed facility. Understanding this was considered vital to understanding the extent of the education that would be necessary in order to promote correct choice of facility among these high risk groups.

See Appendix I for detailed list of groups studied by area.

## B. Survey Instruments

Group discussions were led by a trained Moderator aided by the following instruments:

- a. Demographic data sheet for each respondent
- b. Discussion Guide for focus groups
- c. Moderator cues for technical content
- d. Pen and ink drawings for facilitating discussion/projective technique
- e. Structured questionnaires for in-depth individual interviewing

All instruments were first pretested before refining the final instruments used in the study.

See Appendix I for copies of instruments used.

### **C. Discussion Format**

Each group was led by an experienced moderator who set the mood for the discussion, diffused the anxieties of the participants and concentrated on building group confidence as the basis for frank and open discussion. This being a very private and personal topic it was important to establish a tone of interaction and respect early in the sessions.

Members were encouraged to recognize and respect each other as being integral to the group's success. Physical acknowledgement of each others presence was done by holding hands in a circle as seated. While respondents held hands, the moderator affirmed the oneness of the group as women and mothers and explained that each member brought to the group her own unique experience in childbirth which has earned her the right to speak with authority.

This vested authority was further reinforced by use of a (projective) facilitating technique in which the participants acted as mentors to a teenaged pregnant girl. This method provided them the safety of a medium through which to express their own thoughts, attitudes and experiences of pregnancy and childbirth, confidently and authoritatively, without fear of being challenged, since Marva, the fictional character used, was in no position to argue, having never had the experience herself.

Group discussions were convened in an informal local setting in which respondents could feel relaxed and unintimidated. Additionally, every effort was made to hold the sessions away from the clinic premises to minimize the risk of participants not wanting to be critical of the health system for fear of victimization.

### **D. Facilitating Technique**

Pen and ink drawings (18 x 22 inches) were used to represent a newly pregnant girl, Marva (see Appendix II). Marva was presented as a close friend and social equal of each member. Marva was described as being inexperienced and had come to seek the support and advice of her friend. The sessions took the form of role playing with respondents focussing on Marva as each member acted as counsellor, big sister and confidante to her.

Marva was presented in various stages, viz:

- Marva on discovering the pregnancy, expressionless;
- Various expressions reflecting a range of emotional responses to the event. Respondents were then invited to discuss the reaction they anticipated she would have, and why, as well as the response they would prefer her to have.
- Marva during the antenatal period . . . the respondents must advise her how to proceed during this period. What should be her next move, should she seek help, if yes, where, how often and why. What should she expect at the clinic . . . are there risks involved of which she should be advised.

- Marva faced with having to decide where to have her baby. How should she proceed for her first baby, and would the issues influencing this choice change for the second baby.

Advice given in these forums was a composite of personal experiences, as well as personal assessment of what is desirable and necessary and what is not. Of note is the fact that since all respondents had had successful birth outcomes, they all confidently defended their behavior and attitude to the pregnancy regardless of how unconventional it was.

Participants enthusiastically assumed their role as counsellors relating their own perceptions, knowledge and experience in so doing. The technique also enabled the moderator to play a less obtrusive role. The sessions proved to be very stimulating as each participant felt worthy of contributing.

Sessions lasted approximately two hours each and were tape recorded. Assistant moderators documented important points throughout and noted key moments of obvious non-verbal communication which could enhance the understanding of attitudes to what was being said.

### E. Key Characteristics of Sample

An analysis of the sample showed the majority as being:

- Between the ages of 18-35 years (86.7 percent)
- Semi-literate (only ten percent had attained high school level or received any form of technical training)
- Unemployed (75 percent)
- Living with partner (46.3 percent) or involved in a visiting relationship, 38 percent, while living at home with the nuclear family, versus 12 percent married;
- Live in crowded conditions often without the basic amenity of water in the home 66.7 percent;
- Had antenatal care at least once during pregnancy (99 percent).

Fertility status of respondents:

currently pregnant/no prior birth experience	- 5.0 percent
1 child	- 23.2 percent
2 children	- 28.2 percent
3-5 children	- 37.3 percent
5+ children	- 6.3 percent

These women typify the large lower income sector of the Jamaican society.

## **V. CONCLUSIONS**

### **A. Attitude Toward Childbirth**

Childbirth is perceived as the most critical time of the pregnancy, a time of "life and death." Not more than ten percent of respondents could however explain any of the complications which could arise. For the remainder, the intense pain and prolonged labor which they experienced had firmly rivetted in their minds this fact of impending and unknown danger.

It is a time when professional assistance is thought to be vital. This assistance could be either that of medical experts, as in the case of most, or spiritual experts (obeahman) as in the case of a few, or both.

A woman is thought to be "most vulnerable" at this time in her life and would rather deliver in a hospital if at all possible.

Therefore:

Women should be counselled at antenatal clinic on the real risks involved in childbirth, as their currently strong perception of potential risk helps to drive their quest for a hospital delivery in the hope that a doctor will be within easy reach.

They must be made to understand the nature of the risks they face and their own susceptibility to these risks in order to allay their fears of the unknown and promote more efficient use of the health facilities available.

### **B. Childbirth Location Choice**

#### **1. Hospital**

In view of this perception of childbirth, the hospital is recognized as the ideal place for delivery since it offers professional expertise in the event of an emergency.

The next best alternative to a hospital delivery is delivery at home attended by a midwife. But in the urban and periurban locations of Kingston and Spanish Town, where the demand for hospital deliveries is greatest, mothers are of the opinion that midwives no longer make house calls hence--they do not consider this an option available to them.

Many women also consider the privacy afforded in the hospital more suitable to the birth experience than the crowded conditions and consequent lack of privacy which they face at home.

Still others who could probably find a quiet vacant room at home for delivery, are reluctant to cope with the blood and "mess" at home and think a hospital is really designed to handle all of this.

Although their perception of the hospital is that it is the "right" place for childbirth because of the doctor and its physical capabilities, their experience leaves them very disappointed with the quality of care received at the hospital. The hospital is found to fall dismally short of delivering the reassuring and comforting support they seek. There is no fulfillment in the

experience; they are robbed of the joy and satisfaction which they had anticipated. Instead many leave feeling dehumanized and stressed. Overcrowded and uncomfortable conditions at hospitals are not a major dissatisfaction for this group of mothers who endure such conditions in their homes daily.

Therefore:

The dissatisfactions being encountered with the hospital system provide an ideal opportunity for offering alternatives which address these dissatisfactions and promote better use of institutional resources.

This should of course be accompanied by education designed to convince low risk mothers of the adequacy, and not inferiority, of the proposed facility.

## 2. Home Delivery

Unlike our findings in the urban and periurban areas, many rural women do use and have a much more positive attitude towards home deliveries.

These women are willing to deliver at home because they anticipate being able to access professional help there. This could be either a midwife, as in the majority of cases, or a "Nana" (traditional birth attendant). These rural women seemed much more likely to have a home delivery when they lived long distances from the hospital and were consequently faced with high transportation costs. Women who had delivered at home had all had positive experiences and were most satisfied with the caring and supportive environment afforded them at home. The quality of care was thought to be superior to that received in the hospital. The smaller, more intimate setting provided the supportive atmosphere they needed.

In the final analysis it was evident that although the primary focus of all women is the technical capabilities of a hospital, the focus changes for low risk women. These mothers base their level of satisfaction on the quality of care received since they do not perceive the need for any sophisticated expertise.

Therefore:

The care and support provided by the home environment, which can be readily replicated in a small facility, provides more satisfaction to low risk mothers than the technological capabilities of the hospital and would be a good platform on which to position the new concept.

## 3. Maternity Centre or Clinic-Attached Facility

There were a few such facilities that had been used both in the rural areas, such as Enfield and Chester Castle, and in the urban area of Kingston. In all cases, mothers who had either used or heard of these facilities spoke highly of the quality of care received there. They are seen as providing high quality care with the assurance of being able to readily access medical assistance in an emergency. The small size of these facilities is thought to be the main reason for the improved service offered, since the nurse/midwife is operating with much fewer demands on her time.

Therefore:

New initiatives in maternity health care can readily find a niche and be accepted by mothers if the experience communicated to them or experienced by them is positive and satisfying.

### **C. Response to Proposed Facility**

The concept of the proposed birthing facility was represented as a room attached to a clinic with space for three to four beds. This facility would be equipped to handle normal deliveries only. A midwife would always be in attendance and the patient would be expected to bring along a family member to provide any additional help that might be needed. The mother would be discharged within hours after delivery.

Response to the concept varied but was generally positive.

- Urban and periurban respondents tended to be apprehensive at first about not having a doctor on site, but eventually viewed the concept positively. This was largely due to the positive experiences they had either had or heard about in a similar type of facility in the Tivoli Gardens area of Kingston (Kiwani's Centre).
- Rural respondents were basically enthusiastic about the idea as they could see it considerably easing the transportation costs they now face, or the inconvenience of having the baby at home because of the distance they live from the hospital.

Only in Chester Castle, where participants have the use of a well established free standing maternity centre, did they view the proposed concept negatively as its smaller size made it seem inferior to that to which they were accustomed.

- The major attraction of the concept to all was its perceived ability to deliver the reassuring and supportive environment for which they yearned, both because of its small size and the fact that a family member could be present to see to their comfort. This hope of improved quality of service was warmly welcomed.
- Major concerns were:
  - the ability of the facility to handle emergencies; and
  - the ability to guarantee privacy since clinics tend to be roadside structures in the heart of towns.

Therefore:

The proposed concept could gain the ready acceptance of the target group since the essentials of caring and attention are inherent in it. The extremely positive response to the one in existence in Enfield and the one in Kingston bear testimony to its appeal and viability.

It should, however, be introduced together with education and counselling of mothers in respect to obstetric risk, their severity and their own susceptibility to ensure a level of understanding and appreciation for the adequacy of the facility on the one hand, and its limitations on the other for special cases.

#### **D. Pregnancy and the Antenatal Period**

Pregnancy is considered a normal life happening but it emerges as one characterized by heavy emotional stress, particularly in the first three to four months. It is in no way a special socio-cultural event in which the entire family shares, but rather a lonely one.

#### **E. Risk Recognition**

Problems associated with the antenatal period are largely symptomatic and few are aware of serious dangers associated with this period. The most widely known risk was that of hypertension which many claimed to have suffered from and which they diagnosed as being stress related.

#### **F. Knowledge Base**

Knowledge is largely based on observation of what happens at antenatal clinic, to which mothers lend their own interpretations. The nurse was cited as the primary source of pregnancy related information with that received from parents being largely secondary. The most informed respondents were from clinics where antenatal classes were held and the Nurse was accessible for counselling.

#### **G. Pattern of Antenatal Care**

Antenatal care is sought after the mother has completed her third month of pregnancy because "the clinics do not take you unless you are certain you are pregnant." The first three months are therefore used to confirm the pregnancy, whether formally or informally.

Antenatal care is thought to be necessary for the first pregnancy as knowledge gained there is then applied to subsequent pregnancies, so lessening the reliance on clinic care.

#### **H. Barriers to Care Seeking**

Embarrassment and fear of reprimands from health workers and criticism from the wider community are major barriers to accessing antenatal care even at the accepted three to four months.

## VI. DETAILED FINDINGS

The detailed findings here presented represent those of the entire sample unless otherwise indicated.

### A. Pregnancy

#### 1. Emotional Response to Pregnancy

The emotional response of the mothers to their pregnancy was clearly impacted by the socio-economic conditions under which they lived. The majority had become pregnant in an environment of financial dependence, unstable visiting relationships, crowded living conditions (four to five persons to one room) often with the nuclear family. The pregnancy then heralded increased hardships, depression and great sadness for the majority of respondents.

On the other hand, it was noticeable that wherever a respondent was either married or working she was likely to be positive and happy about her pregnancy. It was generally felt that:

If you are married and working it's okay.

Pregnancies to the majority were unplanned, and often the result of casual encounters. With a lack of commitment from the male partner, the burden of financial support must fall on the mother's nuclear family which is already over-stretched. This is often at the heart of the negative response to the pregnancy:

I think it is the financing because some of the man don't share the burden.

Resulting hostilities, ostracism and denials ensue. Respondents often spoke of feeling 'embarrassed' and 'ashamed,' as they saw themselves responsible for causing this additional burden on the family.

This feeling of shame results in a deliberate denial of the pregnancy, a refusal to disclose to boyfriend or family. A close friend is likely to hear of the pregnancy before anyone else.

The mother-to-be is careful not to reveal the pregnancy until it is absolutely necessary.

For about four months I did not tell anybody . . . I cried.

Early disclosure will only hasten the ostracism and hostilities from parents and guardians, the denial of paternity from the father, the reprimands from health workers and the criticism from the wider community.

A teenage mother is often both verbally and physically abused by her parents who now see their dreams of a better life for her shattered, particularly if she were still in school:

Sometimes you might be going to school and get pregnant and you parents will cuss you . . . because dem spending dem money on you and you tek up baby instead of you lesson.

Sometimes your parents may have plans for you and when you least expect you are pregnant so it is a setback.

She may even have to find new accommodation, abandoned and alone.

When dem find out dem turn me out of the house.

This was the experience of many. Many were the stories recounted of mental trauma particularly in the first three months of pregnancy when the secret must be kept.

The mother-to-be is overcome with sorrow; the joy of an expectant mother is a sentiment alien to this group of dependent women.

Pregnancy for them is essentially a negative experience. Notwithstanding this, there appears to be some deep inner satisfaction of self-actualization for first pregnancies regardless of the trying circumstances, and we detected a yearning for a positive, joyous experience. Consequently they would like Marva, our fictional character to be happy and:

She should try not to fret, even if the circumstances not right and she may not know who the father is and her parents are quarrelling.

## **2. Knowledge of Reproductive Anatomy and Physiology**

Most respondents knew very little about the functioning of the reproductive system. They do what comes naturally in copulation and often assume that if a pregnancy does not result they are infertile.

The majority claim to have been surprised by their pregnancy although they were sexually active and not protected by contraceptives.

Still others claim to have been on contraceptives and had "just stopped." Some assume they will not become pregnant because they are "too small" or they "only did it once." They are not aware of the time during the menstrual cycle in which conception is most likely.

The majority tended to view contraceptives as harmful to their bodies and avoided using them:

Form rock inna me.  
Give me cancer.  
Mek the baby born deformed.  
Causes inflammation of the womb.

All respondents were aware that a missed period could indicate a pregnancy, but many were also aware that this need not be so and tended to wait for other signs such as nausea, drowsiness, tiredness. Many primiparas told of being made aware of their pregnancy by either their mother or their boyfriends, "but me never did believe" an indication of the extent of their ignorance and of their denial.

Their reproductive years are filled with games of Russian roulette and unwittingly they perpetuate their sadness in unplanned pregnancies.

## **B. Risks**

### **1. Recognition of Risks and Perceived Susceptibility**

In answer to the discussion point concerning some of the risks or dangers connected with pregnancy, it was obvious that their knowledge of possible risk was restricted to those which they or their friends had experienced.

At least 90 percent of mothers knew of and spontaneously mentioned:

- blood pressure (high or low)
- nausea/morning sickness
- dizziness
- tiredness
- drowsiness
- foetus incorrectly positioned in uterus
- intolerance for certain foods
- craving for the unusual such as ashes, dirt, raw flour

No more than one or two respondents in each group spontaneously mentioned:

- diabetes
- kidney problems
- headaches from blood pressure
- swelling of the hands and feet (kidney related)
- anemia
- sexually transmitted disease
- sickle cell
- constipation
- backache
- miscarriages

Many claim the emotional stress of pregnancy had affected their blood pressure and most said they had suffered from high blood pressure in the early stages of the pregnancy.

### **2. Primary Sources of Knowledge**

The perceived degree of severity, however, of any known condition associated with pregnancy is a result of observation of what happens at the antenatal clinic.

For this reason, many made the deduction that first pregnancies and hypertensives were at risk because:

Nurse always checking you pressure.

Nurse always say first baby must deliver in hospital because anything can happen.

While in the case of first pregnancies they assert that "anything can happen," implying serious complications, not many knew the potential severity of hypertensive disorders although many claimed that the emotional stress of pregnancy had affected their blood pressure.

Possibly many are saved from serious complications from hypertension, not because they were informed of the consequences, but because as the pregnancy matured they resigned themselves to dealing with it and, as they advised Marva:

It happen already, nothing you can do bout it so you just have to go on [living].

The only respondents who were very aware of the seriousness of hypertensive disorders were those who attended health centres where antenatal care included counselling and mothercare classes.

We were fortunate to encounter a few communities where this was the case, where the clinic was a very integral part of the community, where Nurse was a very well respected and loved individual and where the respondents were consequently very well informed, and were comfortable and positive talking about their pregnancies.

Their use of this information (learnt from observation) as it relates to first pregnancies is also instructive. Having recognized that first pregnancies are the ones targeted by the health authorities, they then deduce that subsequent pregnancies will always take the pattern of the first. A first pregnancy and delivery, free of complications, therefore means all others will be likewise. A feeling of complacency and *deja vu* then overtakes them.

This attitude, which acts to erode their perception of the need for antenatal care, is reinforced with each complication-free pregnancy. They are therefore surprised when as grand multiparas they happen upon difficult pregnancies and births:

Me sick for the nine months with this last one.

I have five children and I never feel sick with any of them but this last one and I have to spend the whole time in hospital.

Others report serious hemorrhaging, but still they offer their own explanations. One respondent theorized that this happened because the baby was of a different sex than the previous ones. Some had rationalized that the body weakens with each pregnancy but only in two cases did we find that they were in fact aware that they were at increased risk, having been so informed at the clinic.

Again it was noticeable that in both locations where we found these more informed respondents, the Nurse was an authority figure who was respected, revered, and who they were not afraid to approach with their problems.

It is therefore understandable when official statistics reveal a strong relationship between maternal mortality and parity, with deaths among women with parity five or over three times higher than among nulliparous women.

Their source for formal knowledge is that given voluntarily by the Nurse, and wherever this is not made available to them they remain unaware and ignorant, formulating their own explanations.

Most had experienced nausea, dizziness, tiredness, drowsiness. Problems of diabetes, kidney related ailments, anemia, headaches were experienced by the minority while constipation and backache were not readily recognized as being caused by the pregnancy although many did experience them.

## **C. Antenatal Care**

### **1. Perceived Value of Antenatal Care**

It was the opinion of all respondents that during pregnancy, a woman must pay special attention to her health. This could be either under the formal auspices of an antenatal clinic or along the informal lines of "health conscious behavior" initiated by the individual, expressed through the use of health promotive dietary, lifestyle and personal habits.

#### Formal Care

Antenatal care at a clinic was considered important by many for two reasons:

1. To ensure a successful pregnancy outcome - a healthy baby.  
I know a lady who never go to clinic and the baby born invalid.
2. To register/book for a hospital delivery.

The mother-to-be goes to the antenatal clinic to:

Get advice and see if she is in good health.

To have her blood and urine tested, her weight taken, to make sure the baby is healthy and sometimes for tonic.

The clinic is also the place to get advice on things such as diet and dress:

She will tell you to eat plenty vegetables, things to make the baby and yourself healthy because you will need a lot of blood.

She will tell you to wear loose clothing so that your blood circulate better.

Attendance at antenatal clinic is also considered important in providing access to a hospital delivery. The "blue card" which the patient is issued upon registration at the clinic, becomes a veritable passport, ensuring access to the hospital.

The perception is that you are ignored and "treated bad" without the "blue card" because it:

Save the Nurse time at the hospital. When you go to have baby and have you card she get you name and address and such the like from it and don't have to ask you again.

Others saw it as indicating that you had been under the care of the clinic prior to delivery and so would indicate your health status.

With their low level of literacy and the tendency to be therefore very visual, much honorary status is ascribed to the "blue card." It announces your pregnancy even as it provides easier access to the hospital. One 14 year-old, pregnant with her first child, told of being sent to the clinic by her mother who suspected she was pregnant. On arrival home, she decided to continue denying the pregnancy but her mother said:

You can't hide it from me, let me see the card you get . . . me know what the "blue card" mean.

### Informal Care

The first pregnancy was generally thought to dictate the pattern of the others, hence many who had uncomplicated first pregnancies tended to become complacent about antenatal care. This was more noticeable among grand multiparas and/or those who were particularly embarrassed and ashamed of their pregnancy. Antenatal care for them took the form of "health conscious behavior" which they themselves initiated. This included:

- eating the right foods
- wearing loose clothing
- reducing salt intake
- avoiding lifting heavy loads
- avoid sliding.

They argued that:

Some things the Nurse going tell you to do, you know already so you just do the right things.

While the first two practices cited above were seen as contributing to a successful pregnancy outcome, the third was to minimize high blood pressure, their biggest fear in pregnancy. and the fourth and fifth to minimize the possibility of a miscarriage.

For many respondents who live without running water in the home, carrying heavy loads of washing to the standpipe is a regular part of their reality. This must now be avoided as is the possibility of sliding by the slippery pipe when you go to fetch water.

In addition to pursuing this health conscious behavior, many will however visit the clinic even once to register/book and obtain their all important "blue card."

My mother te'l me what to do and when is almost seven months she tell me to go to the clinic because if I don't have the blue card them won't mek me go into the hospital.

Some seemed unsure of the real value of antenatal care. They explained the procedure followed at the clinic in a very superficial light:

She weigh you and sometime she test you blood and urine . . . she give you tonic (iron tablets) if you blood weak.

They did not seem to ascribe any real importance or value to these functions and these were the ones most likely to use the clinic merely to ensure access to the hospital.

The more financially able who were married or in stable live-in relationships were less fearful of public criticism. seemed to have a higher feeling of self worth and were much more likely to have accessed regular monthly antenatal care.

To go through a pregnancy without formal antenatal care is to them a risky endeavor because "anything can happen."

### Alternative Care

This conclusion was further reinforced when it became obvious that all mothers were prepared to take some form of action if they perceived they were in any danger. An indication of this was the fact that many who rarely attend antenatal clinic and who initiate care late were often the most firm in their belief that "you have to go look 'bout yourself."

They do in fact initiate care but not medical care as, in their own interpretations, some of the problems encountered in pregnancy such as eclampsia, are problems of the spirit world, problems for the "mother lady," not for the clinic. They will travel long distances at great cost to access this care because:

It happen to my sister three times and she loose her baby every time, but is somebody set it pon her.

Yes it nearly happen to me but me go look bout meself . . . is me boyfriend mother never like me.

Me see it happen to one lady in hospital and them say is her boyfriend other baby mother set it pon her.

Many, particularly where they knew they were not the only sexual partner of their "baby's father" took the precaution of "looking 'bout themselves" to keep off evil which usually came in the form of long labors when:

The baby wouldn't born till me mother go look bout me.

or the possibility of the baby dying within hours after birth.

That is mostly what you hear bout now.

It is a time at which a woman is thought to be at her most vulnerable, a time at which she is most susceptible to harm by spirits. Presumably a pregnancy is supposed to be normal and anything abnormal must be from the supernatural. They fill the gaps in their knowledge once again with their own explanations which can be detrimental to their health and that of their baby.

Hence it is our conclusion that many who appear ignorant of the risks, and their susceptibility to them and appear to make scant use of available formal health facilities, do in fact recognize that some amount of risk is involved and do take preventative action but in the wrong realm. Educating them of the medical origins of some of these problems and the degree of their own susceptibility could greatly improve their use of antenatal services and consequently improve risk detection and management.

## 2. Pattern of Attendance at Antenatal Clinic

Approximately 90 percent of the sample claim to have had their pregnancy confirmed during the first three months of pregnancy, whether by a private doctor or informally confirmed via symptoms associated with a pregnancy. They will then follow the following pattern of care:

- Commence antenatal care at the beginning of the second trimester.
- Make approximately four to five visits between that time and delivery.

Approximately ten percent of respondents claimed to follow a course of:

- No formal confirmation of pregnancy.
- Initiate their own "health conscious behavior" and pursue this unless a specific problem develops in which case other help is sought.
- Attendance at clinic once for registering/booking for hospital delivery.

## 3. Barriers to Early Initiation of Antenatal Care

The most oft cited reasons for the pattern of care followed are:

- a. Clinics do not offer pregnancy tests and will not accept you as a patient until you are certain you are pregnant, hence the three month wait.
- b. Embarrassment and consequent reluctance to disclose the pregnancy
- c. Fear of the reprimands and criticisms of health workers at clinics.

The majority of respondents indicate that three months was the time to start antenatal care. This, it became clear, meant after the pregnancy is three months old, that is, in the second trimester. Respondents are of the opinion that the clinics will not accept you during the first trimester. This time is needed to confirm the pregnancy whether formally or informally.

Respondents explained that the clinics do not confirm pregnancies and, if you care to, you will have to go to a private doctor to have this done. Having received confirmation you can then commence antenatal care at the clinic in the second trimester.

Many however delay initiating care out of embarrassment and fear of the reprimands and criticism from health workers which act as significant internal barriers to accessing early antenatal care. Replies such as the following were frequent:

I know that it [antenatal care] is necessary but because I did coward [initiated care at seven months].

You feel coward to go in to Nurse. If you never feel coward you would go from you three months.

They are 'coward' or afraid of the reprimands from the health workers because:

Me come back too quick [last baby was two years old at the time].

I did not go to the clinic. . . . I get frustated, tired to go, I feel ashamed. . . . I had one in October and get back pregnant in December.

I was scared to go because I didn't want anybody to know.

Teenagers often had to be accompanied by a friend before they were able to find the courage to start attending the clinic due to embarrassment and shame.

These negative messages seem to act as real deterrents to accessing care and often it was clear that if it were not for the need to obtain the all important "blue card" to gain hospital admission, many more would not seek care during pregnancy.

The other generally accepted factors such as distance, transportation costs etc., were rarely cited as hindrances to care and even when these were probed, the ensuing discussions led one to conclude that these are really secondary.

It seemed clear that their embarrassment and shame, coupled with a lack of appreciation for the role which antenatal care plays in ensuring their health and that of the baby acted as the real determinants of their pattern of formal antenatal care.

#### 4. Myths and Their Impact on Accessing Care

There were many don't's which seemed to guide behavior of the pregnant woman particularly in the rural areas.

Among the more prevalent were:

If you turn back pumpkin vine the baby can become deformed.

You should not work because the baby will die.

If you look at dead your baby will die.

You mustn't twist barb wire . . . it will mek the baby navel string wrap around.

You mustn't carry pot on you head or the afterbirth won't come.

Don't sit on large stones or the baby won't move.

Don't drink from bottles, the baby will stifle.

All myths were connected with adverse effects to the foetus and most had to do with the umbilical cord which "can wrap round the baby neck and kill him." The myths connected with the dangers of the umbilical cord were numerous but were often scoffed at, particularly by the more educated in the groups.

## D. Childbirth

### 1. Emotional Response to Childbirth

The experience of childbirth is seen as the most critical stage of the reproductive process. It was often described as "a matter of life or death," unlike their perception of the antenatal period as largely uneventful and risk-free.

Although one may argue that the investigation focussed on women who had had no complications during their last pregnancy and childbirth, it is interesting to note that most still recognized the actual childbirth experience as "a matter of life and death."

This perception seems to arise from the fear of the pain of labor which heralds the unknown, the unpleasant and the terrible. There is a great fear of the unknown and the more intense and prolonged the pain of labor, the more afraid they become.

### 2. Risk Recognition in Childbirth

Some of the complications of which mothers were aware but which very few were able to verbalize apart from the oft repeated "you can die" were:

Fits (preeclampsia/eclampsia)

It kills some of the mothers . . . it is dangerous.

Fits was said to be the resultant effects of high blood pressure which was "very serious":

Yes, very serious, it can kill you and can cause fits at delivery.

Difficult Delivery

Having the baby is life and death . . . is not cutting a slice of cake.

Severe Labor Pains

I keep thinking a not ready and putting it off . . . because of the fear of the pain.

At the ninth month you feel very anxious . . . you feel a lot of pain . . . the pain is very hot.

You feel sad and wondering what will happen because the pain is a life or death pain.

Hemorrhaging (bleeding)

That mostly happen when mothers lose their baby and go home and do a lot of work.

Many fear not only medical complications developing during delivery, but also spiritual interference as this they contend is the time at which they are most vulnerable to evil spirits.

Referring to the 'spiritual interference' many insist that no one must know either when you are due for delivery or when you actually go as the spirit will accompany you to the hospital.

Keeping the evil spirit in ignorance is one way to control it.

It is never good to tell you friend when you going have baby because they can hurt you.

A lot of people harm that way . . . these things happening before you and me born.

You can die while having the baby and it is not anything Doctor can help you with.

### 3. Expectations of Care During Delivery

Against this background of fear, their greatest need at this time is for emotional reassurance, comforting, and an emotionally supportive environment. Unfortunately however, the experience of many is that of a hostile and uncaring environment in which they are expected to cope with the minimum of assistance or encouragement. For the few who had pleasant experiences, they attribute this to luck:

I just lucky to meet a nice nurse.

Older nurses are usually thought to be more caring.

Since they view the likelihood of receiving good quality care as a matter of chance, their major offensive is prayer:

You just have to pray that you come through alright.

You just have to pray that you meet a nice nurse.

They try to influence a positive experience by "taking good things to the hospital," "putting your bag where it is supposed to go," "spreading up the bed," etc. Whatever they perceive as helping to soften the attitude of the nurse they will do but generally see themselves as otherwise powerless to influence the outcome of the experience, there are no guarantees:

It just depends on who [Nurse] you meet up.

## **E. Choice of Delivery Facility**

### **1. Factors Impacting Choice of Facility**

Because of the widely held view that childbirth is "a matter of life and death," the hospital was seen as the safest place to give birth. It is considered safe not so much because of the quality of care provided, but rather, the technology and expertise which should be available in the event of an emergency.

Hospital baby is much safer than at home because some time the mother can fall into difficulty and trying to find something to rush her to hospital could cost the baby's life.

Jubilee is the best, [safest] anywhere at all you go and have difficulty they have to take you back to Jubilee.

Additionally, urban overcrowding, lack of privacy, the probing and sensitive questions of the children, lack of basic amenities in the home and the reluctance to convert the limited space into a messy treatment area fuel the push to hospital confinement.

Many perceive the hospital as designed to cope with the blood and other discharges which are synonymous with childbirth and this is a task which most homes are not readily equipped to handle.

The hospital therefore fulfills many of their requirements in being:

- Designed to offer specialist care in case of an emergency
- Designed to handle the blood and other discharges associated with childbirth.
- Provides greater privacy than obtains at home with the usually crowded conditions in which these mothers live.

The hospital essentially is seen as the "safest" place in which to give birth, the "right" place in the face of self preservation.

Additionally, in the urban areas, particularly Kingston, most mothers are of the opinion that midwives are not available for home deliveries:

I don't think they are about again.

I wouldn't know where to get one to come to my home.

Essentially the Kingston mothers generally see themselves as having no alternatives while some rural mothers who were able to identify midwives to assist them at delivery were reluctant to deliver at home even if the midwife had approved it for delivery:

That is what Nurse say, but we know inna weself that it is not alright. We don't really have any vacancy for that.

Mothers were also uncomfortable coping with the sensitive questions asked by young children during a home delivery and many had nowhere else to send the children during this period.

## 2. Assessment of Hospital Delivered Experiences

While the hospitals were found to cater to their needs on one level, for these low risk mothers with whom we worked, their unsatisfied emotional needs were universal.

These mothers did not need to access the emergency services of the hospital and so their assessment of their experience focussed on the quality of care provided.

The experience left most bitterly dissatisfied. The quality of care fell far short of their expectations.

Staff attitude to patients is the greatest problem. This they describe as not even coldly professional but openly hostile, demeaning, disrespectful, lacking in empathy, condemnatory, condescending, harsh.

You need someone to comfort you, instead they are adding fury to fire . . . is like you have a gun shot and they take you to hospital and you get another shot.

The way the Nurses carry on, whether you dead or live is nothing . . . they don't make you feel important like is a life.

The mothers experienced psychological alienation, the feeling of being unwelcome, of having erred, the distancing of the health worker from the user and the resulting stress.

At the hospital some of the Nurse are very feisty and cruel . . . especially if you young and unmarried they want to handle you and be feisty.

They handle you rough and tell you words that a Doctor or Nurse should not tell a patient.

I have heard of someone dying at the hospital because of lack of blood.

Nurse handle me rough . . . she treat me like a goat.

The people who work at Jubilee don't care . . . me see mother just have baby and have to buy cold box juice and after that she have to get oxygen mask . . . she nearly dead.

The physical problems of overcrowding and insufficient amenities encountered in the hospitals are not new to these patients, as they cope with them daily in their own homes. These are tolerable. They are however distraught at the posture of indifference and antagonism which most have encountered in these institutions at a time when their greatest need is reassurance and support.

Many seem to eventually become torn between their expectations and the harsh reality resulting in conflict and ambivalence. While they truly hold to the idea of the hospital as the ideal place for childbirth, they consciously influence a change of location in their own deliveries by delaying going to the hospital at the onset of labor. To quote one primipara:

I did not get much of the bad treatment because I made sure and went when it was almost time so I did not have to suffer much of it [the hostile attitude of workers].

Many are however not as lucky and end up delivering at home. Many claimed that they really had intended a hospital delivery but "never reach on time." But did they really want to go, or are they merely saying this because a hospital delivery is "right"?

The hospital is the right place to deliver.

Often respondents who voiced a preference for home delivery had to defend this position to other members of the focus group. One got the impression that all "modern" women have hospital deliveries, it is the "right delivery." They obviously need reassurance otherwise.

### 3. Assessment of Actual Home Experience

Home deliveries were chosen for different reasons depending on the location viz:

- Very rural women: distance from hospital, transportation costs and availability of a midwife or traditional birth attendant.
- More urban dwellers in the rural areas: dissatisfaction with hospital experience and availability of a midwife.
- Teenagers: wanted their mothers with them or mothers wanted to attend the birth.

Home deliveries were found to undoubtedly provide the reassuring and comforting environment which emerged eventually as the greatest need of low risk women:

At the hospital them put you aside but at home you have the midwife and you mother.

Yes, just the comfort side why most people would want to stay home.

It's not that is a better experience is the treatment . . . they don't treat you good at the hospital.

You are more comfortable at home because sometimes it is plenty deliveries at the hospital and at home Nurse spend more time helping you.

While the home environment caters to the emotional need, it cannot however provide the peace of mind and mental security of being able to access medical assistance in the event of an emergency. This seemed to be a real fear of every mother which is kept alive by the intense pain of labor.

If you do not have a Nurse it don't make sense having it at home because it is a risk on your life.

During the actual birth the child can get entangled in the cord and stifle if you don't know what you doing.

Home deliveries are seen as pleasant but risky experiences. This fear seems to be undoubtedly exaggerated because of inadequate knowledge and communication concerning risk detection and their own risk status.

User attitudes are a composite of their personal experiences of the health care system, their subsequent perception of the quality of care and their own seeking for solutions to lessen the hurt, the feeling of alienation and inferiority, of low self worth.

#### **4. Assessment of Actual Birthing Centre Experience**

Investigations carried out among users of birthing centres such as available at Enfield in St. Mary, Tivoli Gardens in Kingston or of the Maternity Centre at Chester Castle, all highlight a very high level of user satisfaction.

Among women having experienced a comfortable, caring atmosphere in these birthing centres, in no instance did we find any user who intended to use the hospital for future deliveries unless complications developed. These facilities all offer the basic environment of caring which these low risk mothers focus on. In all the facilities, there was a warm shared relationship with the midwife resulting in a very positive experience even if no less physically painful. In fact, we encountered two other areas where the midwives now plan to provide a home-away-from home delivery service at the clinic if the need arises.

#### **F. Proposed Facility**

##### **1. User Assessment of Home-Away-From-Home Delivery Concept**

Users were introduced to the concept as one which:

- would be attached to the clinic;
- would be for normal births;
- would be assisted by a midwife;
- a family member would be expected to accompany the mother to provide assistance;
- would be used only for deliveries;
- would not be likely to have more than three to four beds;
- the mother would be able to return home within hours after delivery.

An illustration of the interior of the room with Marva entering was used to facilitate conceptualization.

Perceived positive aspects of the proposed facility emerged as:

##### Emotionally Supportive

- Would foster a warm, supportive environment, being a smaller, more intimate unit with one to one contact throughout the experience.

##### Reassuring

- Presence of a family member would reinforce the atmosphere of reassurance and comforting which emerged as one of the primary needs at this time.

### Familiar Attendants

- Having accessed antenatal care at the clinic where delivery will take place, nurse/midwife would now be more of a friend than a stranger.
- Presence of family members also ensure the friendly and familiar atmosphere synonymous with empathy.

### Positive Shared Experience

- Being attended by a midwife with whom you are familiar, along with a family member for the duration of the labor and delivery, would ensure a positive, shared experience for the mother.

### Professionally Attended Birth

- Guaranteed professional attention throughout the labor and delivery due to the small and intimate scale of the facility.

A professionally attended birth is always desirable but not always realized at home due to late arrival of the midwife and in hospital, due to inadequate staff which is unable to cope with the many deliveries.

### Comfortable Surroundings

- Respondents report having had to share beds in hospitals due to overcrowding and limited resources.
- Still others report having had to "catch the baby with my nightie" as there was no delivery table available and "I was standing, waiting around."

## 2. User Concerns

### Emergency Capabilities

- Absence of a doctor on the premises in case of an emergency. However, assurances that he/she would be accessible at the hospital allayed most of these fears, particularly in the rural areas.

### Privacy

- Due to very central, roadside location of most clinics, many respondents expressed concern as to the degree of privacy that would be guaranteed as:

We no want nobody hear we when we bawl out.

or as:

We no want nobody come peep in through the window.

### Facilities for a Warm Drink

- A warm drink was seen as vital after delivery and many expressed the hope that this would be available. Unavailability of a hot drink was also one of the dissatisfactions which women expressed with hospital care. Inclusion of a hot plate or electric kettle for this purpose would rate highly in their assessment of the facility.

### 3. General User Expectations

- Attending midwife will be the one assigned to the clinic and with whom they would be familiar from antenatal clinic.
- An environment of caring, comforting and empathy will be fostered.
- The room must seem more like a home than an institution. Respondents visualizing the room saw curtains and flowers.
- User will provide personal care items for herself and baby as she now does for a hospital delivery.
- Facility will provide basic items such as sheet and pillow.
- Fee will be the same as in hospital.
- Bed or couch will be provided for either patient or family member to rest after delivery, if necessary.

### 4. Summary of User Response by Location

#### **Rural**

Area: Enfield

Primary facilities in use: Home-away-from home birthing facility

Response: Enthusiastic

Observation: High level of user satisfaction with pilot facility now in operation.

Area: Rio Grande Valley

Primary facilities in use: Home/Hospital

Response: Enthusiastic

Observation: Delivery facility has been identified as needed long ago. Distance and high transportation costs to hospital or midwife make concept extremely attractive.

Area: Balaclava

Primary facilities in use: Home/Hospital

Response: Enthusiastic

Observation: Midwife in Maggotty (outlying district) now facilitates residents of Balaclava in this way at her clinic.

Transportation costs to hospital make idea attractive.

Area: Granville

Primary facilities in use: Home/Hospital

Response: Guarded enthusiasm

Observation: More urban residents who deliver at Cornwall Regional Hospital and are satisfied, hesitant and would not readily change.

Rural residents however enthusiastic and midwife in these outlying districts now facilitates residents in this way at her clinic.

Area: Junction

Primary facilities in use: Home/Hospital

Response: Enthusiastic

Observation: Positive response impacted by dissatisfaction with hospital deliveries and corresponding satisfaction with midwife attended home deliveries.

Area: Chester Castle

Primary facilities in use: Maternity Centre

Response: Hesitant

Observation: Respondents see concept as inferior to that which they are now accustomed to at their free standing Maternity Centre.

Concept may attract only the very rural residents who now have difficulty reaching the centre in Chester Castle.

**Peri-Uban**

Area: Spanish Town, St. Ann's Bay

Primary facility in use: Hospital

Response: Enthusiastic

Observation: Dissatisfaction with treatment at hospital.

**Urban**

Area: Spanish Town, Kingston

Primary facility in use: Hospital

Response: Guarded Enthusiasm

Observation: Facility would have to "prove itself," however:

- High level of dissatisfaction with hospital deliveries make the concept worthy of trial.
- Positive experiences with similar facility in Tivoli Gardens in Kingston also positively impact their willingness to try the facility.

Tabulated Responses Regarding Use of New Birthing Facility (n=220)

Very Likely	...	89.2%
Maybe	...	3.6%
Not Likely	...	7.2%
		100.0%

Reasons Why Respondents Would Use Facility

Transportation costs eased	...	37.5%
Would receive better treatment	...	26.6%
Reassuring environment (Nurse/Family)	...	16.4%
Less crowded than hospital	...	14.8%
More convenient than home	...	4.7%

Reasons Why Respondents Would Not Use Facility

Better care at hospital(Doctor present)	...	66.7%
More comfortable at home	...	20.0%
Has to be well established	...	6.7%
Needs to have privacy	...	6.7%

## VII. RECOMMENDATIONS

Given the climate of dissatisfaction with the quality of maternity care in hospitals, the timing seems right for introduction of alternate birthing centres. These centres would offer improved quality of care to a target group whose satisfaction with the experience is ultimately determined by the quality of care received<sup>3</sup> and not by medical competence.

- The facilities should be promoted at clinic level as being able to offer that environment of support and intimacy which emerged as vital to a positive birth experience.
- Mothers should be educated at the antenatal clinics and taught the risks involved in their pregnancy, deemphasizing the perception that a doctor is essential for every delivery.

Mothers now identify the clinic nurses as their primary source of information. It is therefore prudent that the opportunity is taken at that level to provide the mother with whatever information is necessary to guide her pattern of accessing formal maternal health care.

This information should be voluntarily provided, in a systematic and organized way. It should be initiated by the Nurse, as the mothers are for the most part unaware of their ignorance.

- Nurses should take time to counsel mothers, as well as be more caring and less judgmental as patient experiences will play a major role in the extent to which mothers will continue to use these facilities.
- The facility should reinforce the caring environment in its physical appearance, e.g., fitted with curtains and facility for a hot drink after delivery, while still maintaining some clinical assurances, e.g., trolley with basic medical instruments and childbirth equipment must be visible.

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<sup>3</sup>Note: Quality of care is defined here as interaction with medical staff.

## VIII. DISCUSSION

Recently, there has been increased recognition of the need to redesign maternal health services and facilities, to allow provision of maternal care which is more acceptable and accessible to women (2, 16). Examples of attempts to redesign maternal health services for low income women include access improvements in India (6), use of "maternity huts" in Zaire (3) and Brazil (4), and establishment of satellite antenatal clinics in Dublin (5).

However, it is unusual for maternal health planners to seek the opinions of women themselves **before** initiating changes in maternal health services, as is the case in Jamaica. Incorporating the views of women into the development of new strategies for maternal health services delivery is an innovative approach which may result in more effective utilization of those services.

It is unclear whether the research results, which provide overall information on acceptability of the proposed birth alternative, can reliably predict actual patterns of women's future utilization of the proposed facility. However, discussions with new mothers provided a wealth of in-depth information on the many attitudinal and behavioral factors that influence women's choice of childbirth location in the Jamaican setting. In addition, the qualitative research instruments and techniques used for this research can be adapted and used in other developing nations with similar information needs.

Several of the key findings provide guidance to the Ministry of Health regarding site-specific potential acceptability and use of the proposed alternative birth location. Overall, there were marked differences in acceptability of the proposed birth alternative, as well as the specific conditions of acceptability, between urban and rural women.

Most urban women expressed a preference for hospital childbirth, primarily due to the perceived safety offered by the proximity of medical expertise for obstetric emergencies. Conditions of acceptance by urban women thus included availability of emergency medical care or transport. Although urban women expressed dissatisfaction with service conditions at the major government maternity hospitals, they appeared to be willing to tolerate impersonal care, personal inconveniences and poor health care provider attitudes in exchange for greater perceived safety.

In rural areas, where childbirth often takes place at home attended by a midwife, women preferred home birth but were generally more receptive to the proposed alternative birth location. Conditions for acceptance by rural women are very different than those of urban women, focussing more on personal concerns than safety. These include assurance of privacy, as many government health centres are located at the roadside, and provision of some of the same basic comforts and social support that home birth allows.

These findings highlight the different strategies that might be required to successfully promote the alternative birth location to two distinctly different target audiences. For example, the original concept proposed by the Ministry of Health was often referred to as "home-away-from-home" birth. The research findings support the use of this term in communication strategies aimed at rural women. However, to promote use of the alternative birth location among urban women, who placed perceived safety above all other conditions of acceptability, the alternative might best be promoted as "hospital-away-from-hospital" birth.

Much of the information provided by this research confirms the results of other investigations into determinants of maternal health care utilization, both in Jamaica and in other developing nations. For example, prior experience with use of and exposure to the maternal health care system exerted a strong influence on acceptance of the alternative birth location among Jamaican women. This effect has also been demonstrated among women in other developing countries, as well as in industrialized nations (11).

Prior experience with the reproductive process was also documented to affect maternal health knowledge. Most women interviewed were familiar only with the common symptomatic complaints of pregnancy, and less than 10 percent could identify any specific risks, dangers or problems of pregnancy or birth. Those women who identified specific conditions, such as preeclampsia or hemorrhage, related their knowledge to their own experience with the problem, or the experience of a friend or neighbor. This is consistent with research among pregnant adolescents in Guatemala (9). Jamaican women's knowledge of and attitudes toward antenatal and obstetric risk also influenced their willingness to accept the proposed birth alternative. Women who had experienced complications during previous pregnancies or births attached greater importance to the availability of medical backup than women who had uncomplicated births.

The research also provides additional insight into reasons underlying current patterns of antenatal care use in Jamaica, which corroborate the findings of previous studies, such as lack of knowledge of the need for antenatal care, shame or embarrassment about pregnancy (7), or dissatisfaction with poor attitudes of maternal health care providers (14). An important conclusion of this research is that lack of capability to diagnose early pregnancy at government health centres contributes significantly to pregnant women's delay in initiation of antenatal care. Although this has not been previously documented in Jamaica, it has been shown to influence early use of care in Papua New Guinea (8) and the Philippines (20). Making supplies and equipment to diagnose early pregnancy available at the health centre level in Jamaica might be a relatively affordable experimental intervention to increase use of antenatal care during the first trimester of pregnancy.

The primary objective of this research was to determine the acceptability, conditions of acceptance, and channels for promotion of a community-based alternative childbirth location. It is encouraging that in addition to satisfying these research objectives, the findings also documented beliefs and perceptions among new mothers which are consistent with those of pregnant women and mothers in other countries. Despite substantial regional and national variations which country specific research is designed to uncover, this thread of consistency in women's thinking about matters related to pregnancy and childbirth helps to remind us of the shared childbirth experience and sisterhood of women around the world.

The research results have been presented to the Jamaican Ministry of Health, who are considering options which the research suggests. Potential applications of the research results could include:

- Establishing the alternative childbirth location in communities where the concept was well received, with attention to meeting the conditions women identified as prerequisites for acceptance;
- Promoting alternative birth locations in other areas, addressing expressed resistances to acceptance of the concept;

- **Providing the education women need to better understand antenatal and obstetric risk; and**
- **Encouraging personalized care and better patient/provider relationships in government maternal care facilities.**

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**APPENDIX I: RESEARCH INSTRUMENTS**

**TIMETABLE  
MOTHERCARE PROJECT - JAMAICA**

DATE	AREA	TYPE OF GROUP	
February 6	Rio Grande Valley	1 F/G Multip	Home Delivery
		1 F/G Multip	Hospital "
February 9	Balaclava (St. Eliz)	1 F/G Nullip	
		1 F/G Multip	Home Delivery
		1 I/I Multip	" "
		1 I/I Multip	Hospital "
February 13	Junction (St. Eliz) (2 teams)	1 F/G Multip	Home Delivery
		1 F/G Multip	Hospital "
		1 F/G G/Multip	" "
		1 I/I Multip	" "
February 15	Rio Grande Valley (Moore Town)	1 F/G G/Multip	Home Delivery
		1 F/G Multip	" "
		1 I/I Multip	Hospital "
February 16	Chester Castle (Hanover) - (2 teams)	1 F/G Multip	Home Delivery
		1 F/G Multip	Mat. Centre
		1 F/G Multip	Hospital Del.
		1 I/I Multip	Home "
		1 I/I Multip	Hospital "
February 19	St. Ann's Bay	1 F/G Multip	Hospital Del.
		1 I/I Multip	" "
		1 I/I Multip	" "
February 20	Kingston	1 F/G Nullip	
		1 I/I Multip	Hospital Del.
		1 I/I Multip	" "
February 21	Granville (St. James) (2 teams)	1 F/G Multip	Home Delivery
		1 F/G Multip	Hospital "
		1 I/I Multip	Home "
		1 I/I Multip	Hospital "
February 23	Spanish Town	1 F/G Multip	Home Delivery
		1 F/G Multip	Hospital "
		1 I/I Multip	" "
		1 I/I Multip	Home "
February 26	Enfield (St. Mary)	1 F/G Multip	Home Delivery
		1 F/G Multip	Mat. Centre
		1 I/I Multip	Home Delivery
		1 I/I Multip	Mat. Centre
February 27	Kingston	1 F/G Multip	Hospital Del.
		1 F/G G/Multip	" "

F/G = Focus Group

I/I = Indepth Interviews

**MODERATOR'S GUIDE FOR FOCUS GROUP DISCUSSIONS  
DESIGNED TO GAIN AN UNDERSTANDING OF THE CHILDBIRTH  
CHOICES OF JAMAICAN WOMEN AND ASCERTAIN RESPONSE  
TO PROPOSED ALTERNATIVE**

**HOSPITAL/MATERNITY CENTRE DELIVERED GROUP**

**I. INTRODUCTION AND WARM UP (10 mins)**

**A. Moderator gives brief overview of study**

- Purpose of Study - to learn as much as possible about your concerns with some of the maternity services available. This will make the Ministry of Health better able to improve the services where possible and so help to better ensure that you and your new baby remain healthy.
- Sponsors of Study - Jamaican Ministry of Health in conjunction with MotherCare and USAID.
- Procedures for Discussion
  - 1 1/2 - 2 hour discussion. Tape recorded.
  - Semi-structured but informal discussion. Interested in everyone's opinions on the subject. Want everyone to participate as all thoughts are important. No right or wrong answers.

**B. Introduction of Participants**

Ask each respondent to hold the hand of participant beside her forming a circle in recognition of our oneness as women and childbearers and our mutual respect for each other in the group.

Each participant to introduce themselves and give brief comments pertaining to number of children, sex of children, date of last delivery etc.

## II. PREGNANCY AND PRENATAL CARE (ATTITUDINAL AND BEHAVIORAL) (25 mins)

- Projective Technique - relive pregnancy and childbirth as a three-part drama, i.e., discovering the pregnancy; interim nine month period; childbirth. This will be relived through a central character, Marva, who will be portrayed through pen and ink illustrations.

### A. Emotional Response to Pregnancy

**EXERCISE** - Introduce Marva and the possible emotional response she might experience having discovered she is pregnant.

- Respondents to select mood they think appropriate and discuss reason for selecting that mood.
- Was that your own response to your last pregnancy?
- What must Marva be thinking now?

### B. Prenatal Care - Knowledge, Attitude, Practice

- What should Marva do next?
- Does pregnancy involve risk to health/does pregnancy offer any danger to health?
- What kinds of risks/dangers?
- How will she know if she is at risk/in danger?
- Will she need special care? Why?
- Where should she go for this care, when, how often?
- Who will provide this care?
- Should she seek care whether or not she has a problem?
- Is there other care that she should also seek?
- What type/where?
- Will Marva need to take special precautions during pregnancy?
- What are these?
- Who will tell her about these?
- Would pregnancy outcome be the same whether or not Marva received care?

48

### C. Prenatal Risk - Knowledge, Severity and Susceptibility

- Prompt for complications not mentioned simultaneously above
- Have you ever heard of these?
- Are they frequent?
- What causes them?
- Do you know of anyone who has ever suffered from any of these?
- Have you yourself ever suffered from any?
- How likely are you to experience any of them with your next pregnancy - very likely, hardly likely, maybe?
- Reasons for answers?

## III. CHILDBIRTH (30 mins)

### A. Knowledge of Risk in Labour/Delivery

EXERCISE - Show drawing of Marva ready to deliver

- Are there other risks/dangers/problems that Marva should be aware of as she prepares for childbirth?
- What are these? (unprompted)
- How serious are these?
- Are they likely to happen to her?
- Are there any precautions she can take to prevent them?
- Have you known of anyone who actually had these problems?
- Have you ever had any yourself?
- Prompt for knowledge of Fits, haemorrhage/bleeding, fever if not previously mentioned.
- Have you known anyone who actually had these problems?
- How common are they?
- If you were to give birth again are any likely to occur?
- Why yes/no?

- EXERCISE**
- Show drawings of Marva ready to deliver
  - Show drawings of various attendants
  - Show drawings of various facilities

- Where would you like Marva to go and who would you like to attend her?
- Why did you choose that location? (group consensus)
- How early in the pregnancy should she have decided where to have the baby? Who would have helped her decide?
- What preparations will she need to make prior to time for delivery in order to have the baby here?
- Is it possible that she may have the baby elsewhere even though she had planned otherwise?
- If yes, what are some of the factors that can cause this?
- How can she be sure that she is actually ready to deliver?

**B. Delivery Experiences and Quality of Care Received**

- How early in the pregnancy did you decide to deliver in the hospital?
- What made you decide to deliver in the hospital? advantages/disadvantages.
- Assistance expected from Nurse/Midwife
- Type of assistance received, attitude, behaviour etc.
- Were you satisfied with level of assistance? Could assistance have been better?
- What are some of the things that stand out in your mind about the care you received (how you were treated)?
- Would you like next delivery to be just like last one?
- If no, in what ways would you like it to be different?
- Do you know anyone who delivered at home or maternity centre or were any of your previous birth experiences at any of these locations? (ASK OF MULTIPS ONLY)
- From what you heard or experienced, were those better or worse than the experience you just described to me?
- How better/worse?

#### **IV. ALTERNATE BIRTHING FACILITY (35 mins)**

##### **A. Introduce Concept of Alternate Birthing Facility via Marva About to Enter the Facility**

- Profile of new facility - attached to clinic, to be used only for normal birth, midwife attending birth, can accommodate more than one mother.

##### **B. Response to Facility**

- What type of care would you expect her to get here?
- What can she expect from the birth attendant?
- Do you think it will be like delivering in a hospital?
- If yes, in what way?
- Should she be concerned about anything in particular when delivering here?
- If yes, what?
- Would you yourself like to deliver here?
- Why yes/no?
- What are the likely advantages to delivering here?
- What would make women want to use it?
- What would make them not want to use it?

#### **WRAP-UP**

**MODERATOR'S GUIDE FOR FOCUS GROUP DISCUSSIONS  
DESIGNED TO GAIN AN UNDERSTANDING OF THE CHILDBIRTH  
CHOICES OF JAMAICAN WOMEN AND ASCERTAIN RESPONSE  
TO PROPOSED ALTERNATIVE**

**HOME DELIVERED GROUP**

**I. INTRODUCTION AND WARM UP (10 mins)**

**A. Moderator Gives Brief Overview of Study**

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- Sponsors of Study - Jamaican Ministry of Health in conjunction with MotherCare and USAID.
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  - 1 1/2 - 2 hour discussion. Tape recorded.
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- Respondents to select mood they think appropriate and discuss reason for selecting that mood.
- Was that your own response to your last pregnancy?
- What must Marva be thinking now?

### B. Prenatal care - Knowledge, Attitude, Practice.

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- Is there other care that she should also seek?
- What type/where?
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- What are these?
- Who will tell her about these?
- Would pregnancy outcome be the same whether or not Marva received care?

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- Prompt for complications not mentioned spontaneously above
- Have you ever heard of these?
- Are they frequent?
- What causes them?
- Do you know of anyone who has ever suffered from any of these?
- Have you yourself ever suffered from any?
- How likely are you to experience any of them with your next pregnancy - very likely, hardly likely, maybe?
- Reasons for answers?

## III. CHILDBIRTH (30 mins)

### A. Knowledge of Risk on Labour/Delivery

EXERCISE - Show drawing of Marva ready to deliver

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- What are these (unprompted)
- How serious are these?
- Are they likely to happen to her?
- Are there any precautions she can take to prevent them?
- Have you known of anyone who actually had these problems?
- Have you ever had any yourself?
- Prompt for knowledge of Fits, haemorrhage/bleeding, fever if not previously mentioned.
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- How common are they?
- If you were to give birth again are any likely to occur?
- Why yes/no?

- EXERCISE**
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  - Show drawings of various attendants
  - Show drawings of various facilities
- 
- Where would you like Marva to go and who would you like to attend her?
  - Why did you choose that location (group consensus)
  - How early in the pregnancy should she have decided where to have the baby? who would have helped her decide?
  - What preparations will she need to make prior to time for delivery in order to have the baby here?
  - Is it possible that she may have the baby elsewhere even though she had planned otherwise?
  - If yes, what are some of the factors that can cause this?
  - How can she be sure that she is actually ready to deliver?

**B. Delivery Experiences and Quality of Care Received**

- Did you actually plan to deliver at home or did it just happen?
- How early in the pregnancy did you decide to deliver at home?
- What made you decide on a home delivery?
- Who assisted you, midwife, nana, family member?
- Did the attendant arrive in time for the birth?
- If no, how long after did they arrive?
- At what stage did you send for them?
- Did you have to provide transportation for them?
- What type of assistance did they provide for you?
- Were you satisfied with the level of assistance? Could assistance have been better?
- What are some of the things that stand out in your mind about the care you received (how you were treated)?
- Are there any aspects of home delivery which you do not like?
- What are these?
- Would you like your next delivery experience to be just like the last one?

- If no, in what ways would you like it to be different?
- Do you know anyone who has delivered at a hospital or maternity centre or were any of your previous birth experiences at these locations?
- From what you have heard or experienced, were those better or worse than the experience you just described to me?
- How better/worse?

#### **IV. ALTERNATE BIRTHING FACILITY (35 mins)**

##### **A. Introduce Concept of Alternate Birthing Facility via Marva About to Enter the Facility**

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- Do you think it will be like delivering in a hospital?
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- Should she be concerned about anything in particular when delivering here?
- If yes, what?
- Would you yourself like to deliver here?
- Why yes/no?
- What are the likely advantages to delivering here?
- What would make women want to use it?
- What would make them not want to use it?

#### **WRAP-UP**

## CUES

### 1.a. Perception of Pregnancy

Anxiety, fear for self

Future

Economic dependency

Social (shame)

Complications

Minor (nausea, constipation, edema, backache)

Seriousness (HTN, difficult delivery, pain)

Fears for baby

Rejection

Economic

Will not be good mother

Loss of personal freedom.

Partner will go outside for sex during pregnancy

Anxiety about breastfeeding

Birth as normal vs. pathological event

Family oriented vs. personal experience

Desire for pregnancy

Bonding with baby, father

"Womanhood"/Fertility

Bonding with baby (desire for family )

Maternal feelings

Better care from family for her

More economic support from baby's father

Social support network

**1b. Value of Prenatal (Preventive) Care**

<b>Perceived Problems in Pregnancy</b>	<b>Perceived Severity of Problem</b>
Nausea/vomiting	Any behaviour changes (self-initiated or on medical recommendation).
Anaemia/dizziness	
HTN/preeclampsia	Initated this pregnancy?
Miscarriage	Previous pregnancy?
Fetal malformations	Sought prenatal care this pregnancy? When? Where? Why? Why not?
STDs	
UTI	
Tired	
Backache/constipation	

**1c. Expectations of Childbirth Assistance**

- Type/level of prenatal care required/desired
- Type/level of delivery assistance required/desired
- Who would you expect to do it
- Interventions/treatments/procedures
- Personalized individual care

58

## 1d. Sources of Childbirth Related Information

### **Kinship network**

#### Female relation

mother

other female relative: mother-in-law, sister, aunt

#### Male relation

father

husband

#### Other female not related

health worker      friend

MD                      neighbour

Nurse/Midwife      teacher

CHA                    co-worker

other                    "other woman"

Nana

Other community

Radio

TV

Newspaper, print

### **Types of advice**

For mother:

healthy - avoid problems

previous difficulties - prevent recurrence

Need for prenatal care for baby:

for booking - EDC

Need for delivery assistance

Seek:

medicines, treatment, dietary advice, advice on common conditions (backache,

nausea, leg cramps),

emotional/social support

Limit sexual activity

Limit work/rest more

Other

54

**1e1. Reasons for Preference**

**Types of Attendants**

doctor

midwife/nurse

nana

other

self

**Attitude to attendants**

**Characteristics**

helpful/reassuring

rude/insulting

impersonal

threatening

supportive/understanding

inexperienced/experienced

qualified

respect

encouraging/sympathetic

culturally insensitive

indifferent

involved/indifferent

explain/educate/advise

follows traditions/culture

**1e2. Perceptions of Home vs. Hospital Based**

**HOME (midwife assisted)**

**Procedures**

ROM  
enema  
shave  
no pain relief?

**Fear of or comfort**

sympathetic individual attention  
quiet, familiar environment  
hygiene constraints, water  
crowded, lack of privacy  
Lack of emergency equipment/emergency  
transport/emergency personnel  
unable to handle complications  
  
assistance with after care of baby and  
family  
traditions maintained free/inexpensive

**HOSPITAL**

**Procedures**

c/section  
induced labor  
CPD  
forceps/vacuum  
rupture membranes  
episiotomy/sutures  
anaesthesia/pain relief  
enema  
fetal monitor  
shave  
IV

**Fear of or comfort**

crowding in ward  
sharing bed  
self-deliver  
clean (relatively) environment  
presence of emergency  
equipment/transport  
qualified personnel able to handle  
complications  
  
traditions ignored expensive  
booking/distance

**1e3. Knowledge of OB Complications (Susceptibility/Severity)**

haemorrhage (bleeding)

preeclampsia/eclampsia (FITS)

difficult delivery

sepsis - fever

pain in labor

long labor

66

**2/3b. Barriers**

availability of supplies/need  
provider attitude  
cost (clinic fees)  
  
waiting time (time costs  
scheduling of clinic sessions  
short consultation time  
transport costs  
distance  
care for other children/family resistance  
fear, shame  
rumours, privacy  
political?

perceived quality of services  
confidence in provider  
"appropriate" (choice) of services (technical  
and attitude)  
  
acceptable referrals  
full service  
setting, environment  
outcome of previous

**INDEPTH INTERVIEWS  
MOTHCARE PROJECT - JAMAICA**

I would like you to share with me some of your knowledge and experience related to pregnancy and childbirth.

Let us imagine we have a friend named Marva who has just discovered she is pregnant:

Emotional response to pregnancy

1. What do you think Marva's first thought will be when she discovers she is pregnant?

---

2. What do you think her mood will be like. e.g., sad, happy, scared etc.

---

3. Why do you think she will be \_\_\_\_\_?

---

Antenatal Care

4. Will Marva's pregnancy cause any changes in her health?

Yes \_\_\_ No \_\_\_

5. IF YES, ASK

What will these changes to her health be?

---

6. Anything else?

---

7. Will she need any type of care or assistance during the pregnancy?

Yes \_\_\_ No \_\_\_ GO TO Q13

8. IF YES, ASK What kind?

---

9. Where will she go for this care? \_\_\_\_\_

10. How early in the pregnancy should she go?

---

17

11. How often should she go? \_\_\_\_\_
12. Who will provide this care? \_\_\_\_\_
13. Did you yourself get any special type of care during your pregnancy?  
\_\_\_\_\_
14. What type? \_\_\_\_\_
15. Where did you go? \_\_\_\_\_
16. How did you know you should go?  
\_\_\_\_\_
17. Do you think your pregnancy would have been different if you had not gotten this care?  
Yes\_\_\_ No\_\_\_
18. Why yes/no? \_\_\_\_\_  
\_\_\_\_\_
19. What is it really that this special care during pregnancy is for?  
\_\_\_\_\_

**Knowledge of Pregnancy Risks**

20. Have you ever heard of any problem that can occur during pregnancy?  
Yes\_\_\_ No\_\_\_
21. **IF YES, ASK:** What are these?  
\_\_\_\_\_
22. Anything else? \_\_\_\_\_
23. **PROMPT FOR ANY OF THE FOLLOWING NOT MENTIONED ABOVE**

Have you ever heard of pregnant women suffering from:

	Yes	No		Yes	No
Nausea/Vomiting	___	___	A malformed foetus	___	___
Dizziness	___	___			
Hypertension	___	___			
Miscarriage	___	___			
Backache/constipation	___	___			
Tiredness	___	___			

24. Did you suffer from any of these?

Yes\_\_\_ No\_\_\_

25. IF YES, ASK: Which ones did you suffer from:

\_\_\_\_\_

26. Do you think the problems are common and happen frequently to pregnant women?

Yes\_\_\_ No\_\_\_

27. IF YES, ASK: Which happen most commonly?

\_\_\_\_\_

28. Do you know what causes any of these things to happen to pregnant women?

\_\_\_\_\_

29. Do you think you could experience these problems if you were to become pregnant again?

Yes\_\_\_ No\_\_\_

30. Why Yes/No \_\_\_\_\_

31. How would Marva know if a problem she is having is serious?

\_\_\_\_\_

32. What should she do about the problem?

\_\_\_\_\_

33. Where would she be able to get help? \_\_\_\_\_

Childbirth

34. Marva is now ready to have her baby, where would you recommend that she should have the baby?

\_\_\_\_\_

35. Are there other places that she could have had the baby?

Yes\_\_\_ No\_\_\_

36. IF YES, ASK: Where \_\_\_\_\_

37. Why did you select \_\_\_\_\_ for her? \_\_\_\_\_

38. Who will attend to her here? \_\_\_\_\_

39. What would her experience be like if she delivered at \_\_\_\_\_ instead?

40. Is it possible that there could be problems during delivery?

Yes \_\_\_ No \_\_\_

41. What type of problems could Marva have during delivery?

42. ASK ONLY THOSE NOT MENTIONED ABOVE

Have you ever heard of:

	Yes	No
Haemorrhage (bleeding)	___	___
Fits	___	___
Difficult delivery	___	___
Pain	___	___
Long Labour	___	___
Fever	___	___

43. Have you ever had any of these problems? Yes \_\_\_ No \_\_\_

IF YES Which? \_\_\_\_\_

44. Have you known anyone who has had any of these problems?

Yes \_\_\_ No \_\_\_

45. If you were to give birth again, do you think any of these things could happen to you?

Yes \_\_\_ No \_\_\_

46. Why Yes/No? \_\_\_\_\_

47. Thinking of your last birth experience at hospital/home, how would you describe what happened to you there?

48. Was it a good experience? \_\_\_\_\_

49. Why yes/no? \_\_\_\_\_

66

50. What did you like the most? \_\_\_\_\_  
\_\_\_\_\_
51. What did you like the least? \_\_\_\_\_  
\_\_\_\_\_
52. Was it different from what you had expected? \_\_\_\_\_
53. IF DIFFERENT, ASK: How was it different? \_\_\_\_\_  
\_\_\_\_\_
54. Would you like your next birth experience to be the same?
55. What would make your next birth better for you? \_\_\_\_\_  
\_\_\_\_\_
56. What are some of the things that you think most women want to have a good childbirth experience?  
\_\_\_\_\_
57. Do you think it is possible to have these things? \_\_\_\_\_

Reaction to Alternate Birth Location

It is now two years later and Marva is ready to give birth to her next child. She has heard of this new room which has been added to the clinic in her town. It is used only for delivery. A midwife is there to assist. It is not likely to have more than 3-4 beds and she can leave soon after delivery if there are no problems.

Marva decides to use this room.

58. What kind of birth experience do you think she will have there?  
\_\_\_\_\_
59. Do you think it will be very different from her previous hospital/home delivery? \_\_\_\_
60. Why yes/no \_\_\_\_\_
61. Do you think you would deliver at a place like this? \_\_\_\_\_
62. Why yes/no? \_\_\_\_\_
63. What do you think would make mothers choose this location?  
\_\_\_\_\_

- 64. What would make mothers not want to use this location?  
\_\_\_\_\_
- 65. How soon after having the baby would you like to go back home provided there are no complications? \_\_\_\_\_
- 66. If it were nearer to you than the hospital are you more likely to use it? \_\_\_\_\_
- 67. Would it be easy for you to arrange transportation on to the hospital or back home should you need it? \_\_\_\_\_
- 68. Would you expect to pay the same as a home delivery or a hospital delivery? \_\_\_\_\_
- 69. Do you think you would have to provide any extra things here that you would not need to provide if you delivered at hospital/home? \_\_\_\_\_
- 70. IF YES, ASK: What would these be?  
\_\_\_\_\_
- 71. Do you think your friends would like to go there? \_\_\_\_\_
- 72. Why yes/no? \_\_\_\_\_

**INDEPTH INTERVIEWS  
MOTHERCARE PROJECT - JAMAICA**

I would like you to share with me some of your knowledge and experience related to pregnancy and childbirth.

Let us imagine we have a friend named Marva who has just discovered she is pregnant:

Emotional Response to Pregnancy

1. What do you think Marva's first thought will be when she discovers she is pregnant?

\_\_\_\_\_

2. What do you think her mood will be like, eg. sad, happy, scared etc.

\_\_\_\_\_

3. Why do you think she will be \_\_\_\_\_?

\_\_\_\_\_

Antenatal Care

4. Will Marva's pregnancy cause any changes in her health?

Yes\_\_\_ No\_\_\_

5. IF YES, ASK What will these changes to her health be?

\_\_\_\_\_

6. Anything else?

\_\_\_\_\_

7. Will she need any type of care or assistance during the pregnancy?

Yes\_\_\_ No\_\_\_ GO TO Q13

8. IF YES, ASK What kind?

\_\_\_\_\_

9. Where will she go for this care? \_\_\_\_\_

10. How early in the pregnancy should she go? \_\_\_\_\_

11. How often should she go? \_\_\_\_\_

12. Who will provide this care? \_\_\_\_\_

13. Did you yourself get any special type of care during your pregnancy? \_\_\_\_\_
14. What type? \_\_\_\_\_
15. Where did you go? \_\_\_\_\_
16. How did you know you should go?  
\_\_\_\_\_
17. Do you think your pregnancy would have been different if you had not gotten this care?  
\_\_\_\_\_
18. Why yes/no? \_\_\_\_\_
19. What is it really that this special care during pregnancy is for?  
\_\_\_\_\_

Knowledge of Pregnancy Risks

20. Have you ever heard of any problem that can occur during pregnancy?

Yes\_\_\_ No\_\_\_

21. IF YES, ASK: What are these?  
\_\_\_\_\_

22. Anything else? \_\_\_\_\_

23. PROMPT FOR ANY OF THE FOLLOWING NOT MENTIONED ABOVE

Have you ever heard of pregnant women suffering from:

	Yes	No		Yes	No
Nausea/Vomiting	___	___	A malformed foetus	___	___
Dizziness	___	___			
Hypertension	___	___			
Miscarriage	___	___			
Backache/constipation	___	___			
Tiredness	___	___			

24. Did you suffer from any of these?

Yes\_\_\_ No\_\_\_

25. IF YES, ASK: Which ones did you suffer from:  
\_\_\_\_\_

26. Do you think the problems are common and happen frequently to pregnant women?

Yes\_\_\_ No\_\_\_

27. IF YES, ASK: Which happen most commonly?

\_\_\_\_\_

28. Do you know what causes any of these things to happen to pregnant women?

\_\_\_\_\_

29. Do you think you could experience these problems if you were to become pregnant again?

Yes\_\_\_ No\_\_\_

30. Why Yes/No \_\_\_\_\_

31. How would Marva know if a problem she is having is serious?

\_\_\_\_\_

32. What should she do about the problem?

\_\_\_\_\_

33. Where would she be able to get help? \_\_\_\_\_

### Childbirth

34. Marva is now ready to have her baby, where would you recommend that she should have the baby?

\_\_\_\_\_

35. Are there other places that she could have had the baby?

Yes\_\_\_ No\_\_\_

36. IF YES, ASK: Where \_\_\_\_\_

37. Why did you select \_\_\_\_\_ for her? \_\_\_\_\_

\_\_\_\_\_

38. Who will attend to her here? \_\_\_\_\_

39. What would her experience be like if she delivered at \_\_\_\_\_ instead?

\_\_\_\_\_

40. Is it possible that there could be problems during delivery?

Yes\_\_\_ No\_\_\_

41. What type of problems could Marva have during delivery?

\_\_\_\_\_

42. ASK ONLY THOSE NOT MENTIONED ABOVE

Have you ever heard of -

	Yes	No
Haemorrhage (bleeding)	___	___
Fits	___	___
Difficult delivery	___	___
Pain	___	___
Long Labour	___	___
Fever	___	___

43. Have you ever had any of these problems? Yes\_\_\_ No\_\_\_

IF YES Which? \_\_\_\_\_

44. Have you known anyone who has had any of these problems?

Yes\_\_\_ No\_\_\_

45. If you were to give birth again, do you think any of these things could happen to you?

Yes\_\_\_ No\_\_\_

46. Why Yes/No? \_\_\_\_\_

47. Thinking of your last birth experience at hospital/home, how would you describe what happened to you there?

\_\_\_\_\_

48. Was it a good experience? \_\_\_\_\_

49. Why yes/no? \_\_\_\_\_

50. Who assisted you? \_\_\_\_\_

51. Did the attendant arrive in time for the birth? Yes\_\_\_ No\_\_\_

52. IF NO, how long after did they arrive? \_\_\_\_\_

53. At what stage did you send for them?

\_\_\_\_\_

54. Did you have to provide transportation for them? Yes\_\_\_ No\_\_\_

12

55. What type of assistance did they provide for you?  
\_\_\_\_\_
56. Were you satisfied with the level of assistance? Yes\_\_\_ No\_\_\_
57. Could the assistance have been better? Yes\_\_\_ No\_\_\_
58. What did you like the most? \_\_\_\_\_  
\_\_\_\_\_
59. What did you like the least? \_\_\_\_\_  
\_\_\_\_\_
60. Was it different from what you had expected? \_\_\_\_\_
61. IF DIFFERENT, ASK: How was it different? \_\_\_\_\_  
\_\_\_\_\_
62. Would you like your next birth experience to be the same?  
\_\_\_\_\_
63. What would make your next birth better for you? \_\_\_\_\_  
\_\_\_\_\_
64. What are some of the things that you think most women want to have a good childbirth experience?  
\_\_\_\_\_
65. Do you think it is possible to have these things? \_\_\_\_\_

Reaction to Alternate Birth Location

It is now two years later and Marva is ready to give birth to her next child. She has heard of this new room which has been added to the clinic in her town. It is used only for delivery. A mid- wife is there to assist. It is not likely to have more than 3-4 beds and she can leave soon after delivery if there are no problems.

Marva decides to use this room.

66. What kind of birth experience do you think she will have there?  
\_\_\_\_\_
67. Do you think it will be very different from her previous hospital/home delivery? \_\_\_\_\_
68. Why yes/no? \_\_\_\_\_

69. Do you think you would deliver at a place like this? \_\_\_\_\_
70. Why yes/no? \_\_\_\_\_  
\_\_\_\_\_
71. What do you think would make mothers choose this location?  
\_\_\_\_\_
72. What would make mothers not want to use this location?  
\_\_\_\_\_
73. How soon after having the baby would you like to go back home provided there are no complications? \_\_\_\_\_
74. Would it be easy for you to arrange transportation on to the hospital or back home should you need it? \_\_\_\_\_
75. Would you expect to pay the same as a home delivery or a hospital delivery? \_\_\_\_\_
76. Do you think you would have to provide any extra things here that you would not need to provide if you delivered at hospital/home? \_\_\_\_\_
77. IF YES, ASK: What would these be?  
\_\_\_\_\_
78. Do you think your friends would like to go there? \_\_\_\_\_
79. Why yes/no? \_\_\_\_\_

## SCREENER QUESTIONNAIRE

NOTE: THIS QUESTIONNAIRE MUST BE FILLED IN FOR ALL PARTICIPANTS

AREA: \_\_\_\_\_

Participant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Age: \_\_\_\_\_

1. When was your last delivery? \_\_\_\_\_

NOTE: LAST DELIVERY MUST HAVE BEEN WITHIN AUG. 1989 AND JAN. 1990  
INCLUSIVE

2. Was it a normal pregnancy and delivery? YES \_\_\_ NO \_\_\_

NOTE: TERMINATE INTERVIEW IF ANSWER IS NO

3. How many other childbirth experiences have you had? \_\_\_\_\_

NOTE: LAST DELIVERY MUST NOT BE MORE THAN HER FOURTH CHILD BIRTH  
EXPERIENCE

4. Was your baby delivered at the hospital? YES \_\_\_ NO \_\_\_

NOTE: TERMINATE IF ANSWER IS NO

### IF RESPONDENT QUALIFIES, PROCEED:

I would like to include you in a small group of women I am recruiting for some researchers who would like to talk to you about your last pregnancy and delivery experience.

Are you willing to participate? YES \_\_\_ NO \_\_\_

IF YES, PROCEED:

The discussion will be about 2 hours long and they would like to meet you on \_\_\_\_\_  
at \_\_\_\_\_ at (time) \_\_\_\_\_

You will receive \$50.00 for attending .

THANK YOU!

## **RECRUITING CRITERIA FOR MOTHERCARE PROJECT**

### **MULTIPS - A**

- have had a delivery within the last 6 months
- had a normal pregnancy and delivery last time
- have not had more than 4 childbirth experiences including this one
- had this last delivery in a home

### **MULTIPS - B**

- have had a delivery within the last 6 months
- had a normal pregnancy and delivery last time
- have not had more than 4 childbirth experiences including this one
- had this last delivery in a hospital

### **GRAND MULTIPS**

- have had a delivery within the last 6 months
- had either a normal or problem pregnancy last time
- have had at least 4 other childbirth experiences apart from this one
- place of delivery unimportant

### **NULLIPS**

- have never delivered before
- are currently pregnant

### **METHODOLOGY**

- a) Discussions with groups of 8-10 women
- b) Individual Interviews

# ALTERNATE BIRTHING FACILITIES

## RESPONDENT ID INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

1. Age Group: 15 - 18 \_\_\_1      26 - 35 \_\_\_3  
                  18 - 25 \_\_\_2      35+     \_\_\_4

2. Date of most recent delivery \_\_\_\_\_

3. Did you receive antenatal care with your last baby?

Yes \_\_\_ No \_\_\_

- Where did you go? \_\_\_\_\_

- How often did you go? \_\_\_\_\_

4.	No. of Previous Births	Date	Where Delivered	Complications
	1	_____	_____	_____
	2	_____	_____	_____
	3	_____	_____	_____
	4	_____	_____	_____
	5	_____	_____	_____
	6	_____	_____	_____
	7	_____	_____	_____
	8	_____	_____	_____
	9	_____	_____	_____

5. Level of Education:

Primary     \_\_\_ 1                      Junior Sec. \_\_\_ 2  
Secondary \_\_\_ 3                    All Age     \_\_\_ 4  
High School \_\_\_ 5                  Other        \_\_\_ 6

6. Employed:      Yes \_\_\_ 1    No \_\_\_ 2

7. Weekly Income: \_\_\_\_\_

8. Occupation if employed \_\_\_\_\_

9. Marital Status:  
Married  1  
Widowed  2  
Steady live-in relationship  3  
Steady visiting relationship  4  
Other  5

10. Living Conditions:  
No. of rooms \_\_\_\_\_  
No. of people \_\_\_\_\_  
Water in home  Yes  No

11. How far do you live from the nearest clinic? \_\_\_\_\_

How far do you live from the nearest hospital? \_\_\_\_\_

12. Is there public transportation available from your district?

Yes  No

13. IF NO: How far away do you have to go to get it? \_\_\_\_\_

14. Is it easy to get it from there? Yes  No

15. If you were to get pregnant again, how likely would you be to use the delivery room if it was built, in place of delivery at home or hospital?

Very Likely \_\_\_\_\_ Maybe \_\_\_\_\_ Not likely \_\_\_\_\_

16. Why? \_\_\_\_\_

**APPENDIX II: PICTURES OF MARVA**



Marva





What now??

10/10/92

HERE?

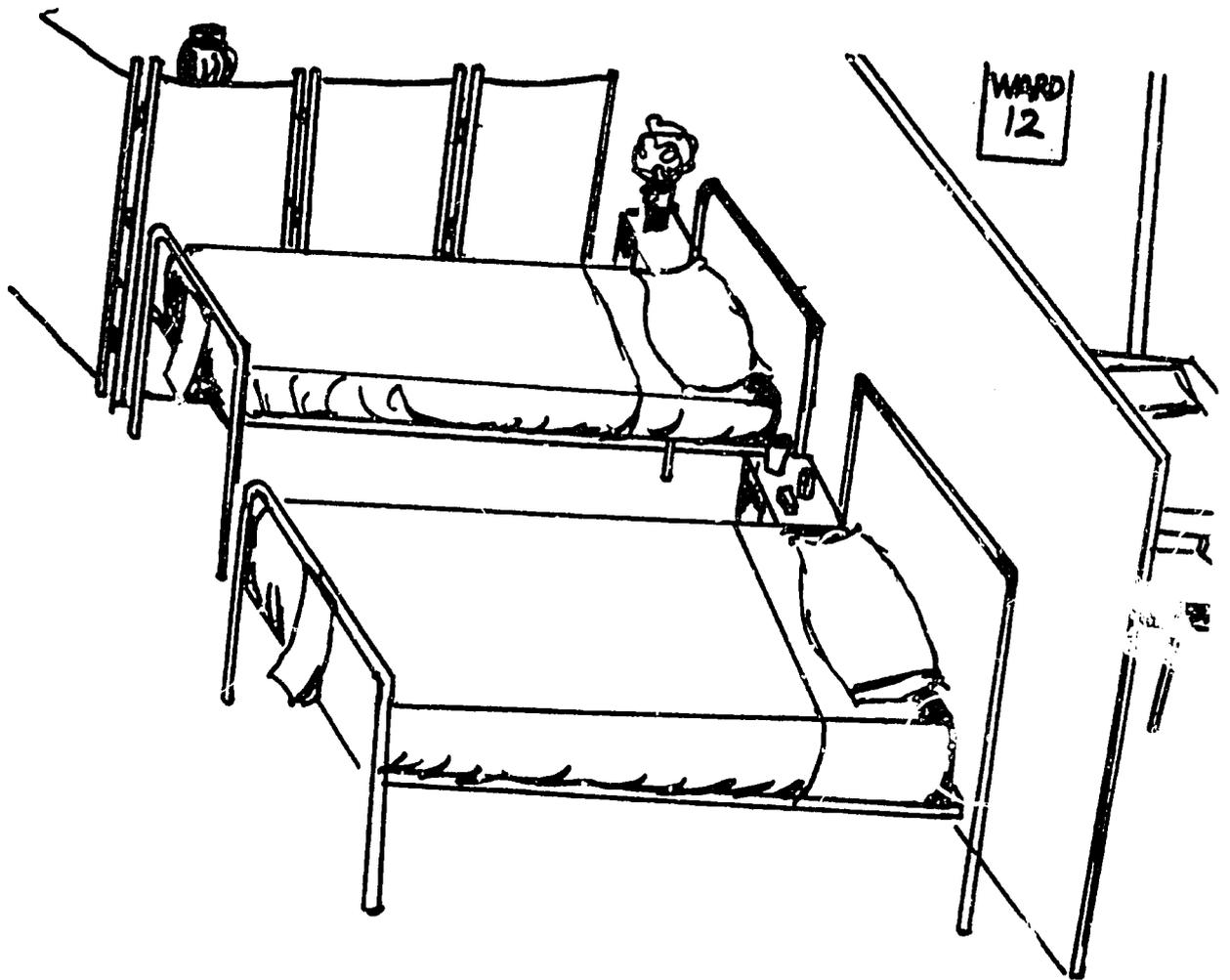


HERE?

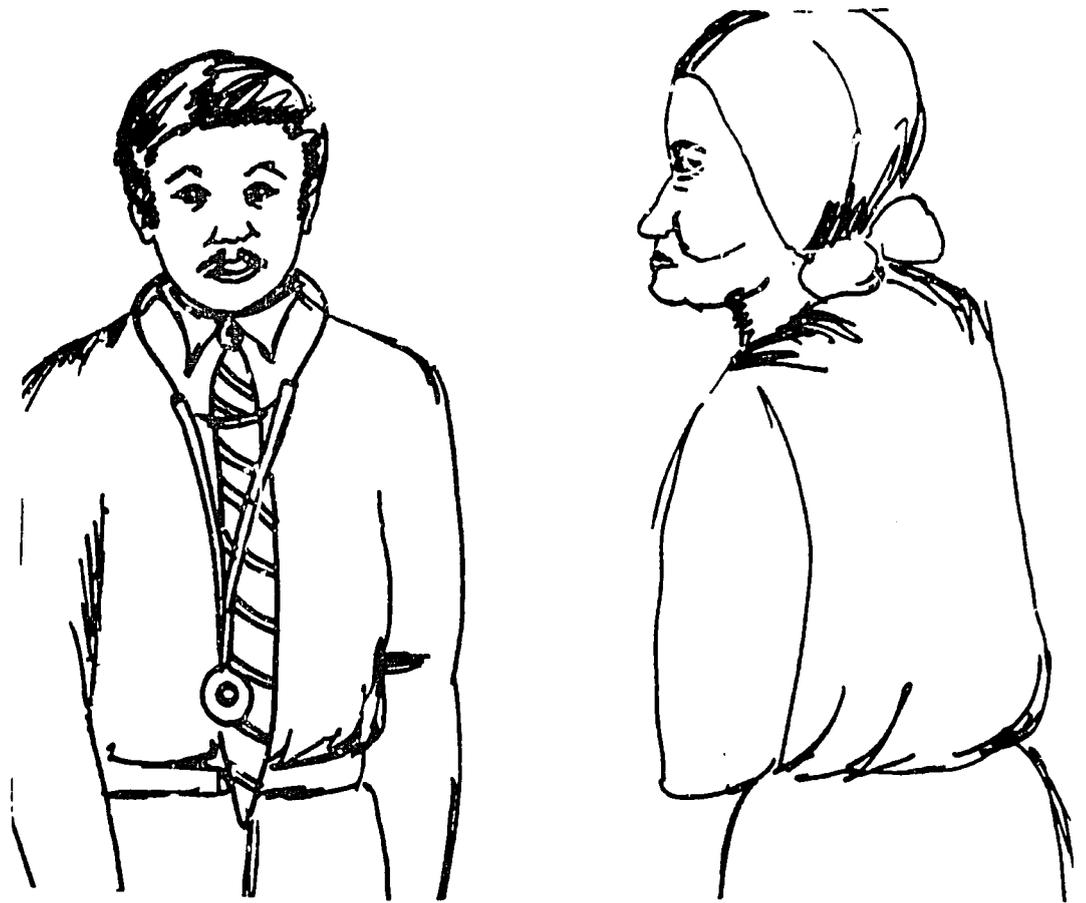
WHERE SHOULD SHE HAVE HER BABY?

97

OR HERE?

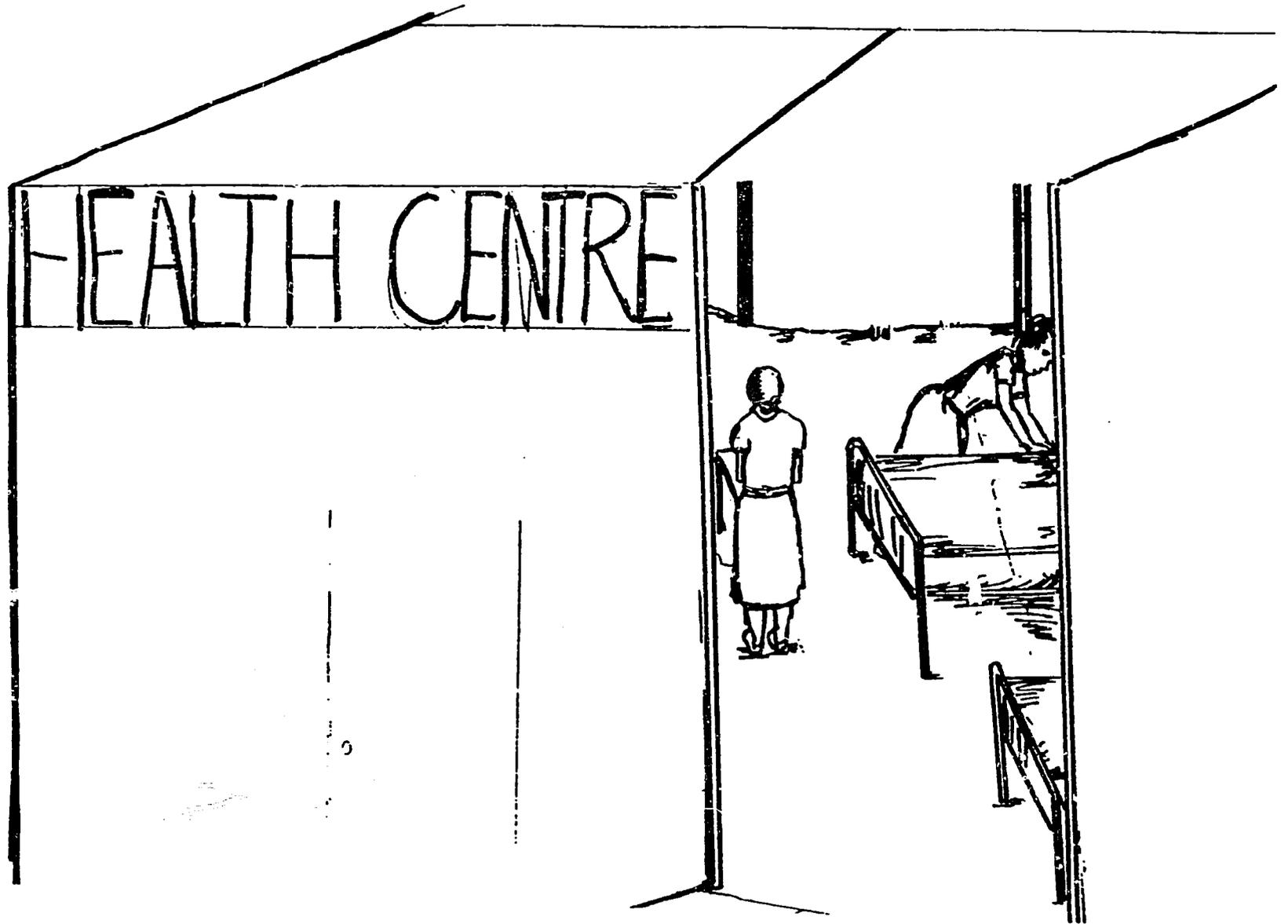


34



WHO WOULD YOU LIKE TO ATTEND MARVA IN LABOUR?

85



CONCEPT OF ALTERNATE DELIVERY ROOM BEING PROPOSED