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**Assessing the Effectiveness of a Safe Motherhood
Information, Education and Communication
Counseling Strategy
Korangi 8, Karachi, Pakistan**

Final Report

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LIST OF ABBREVIATIONS

IEC	Information, Education and Counseling
JPMC	Jinnah Postgraduate Medical Center
HCPs	Health Care Providers
HIS	Health Information System
SMP	Safe Motherhood Project
SMP technical team	Dr Fariyal F. Fikree, Dr Sadiqua N. Jafarey and Ms Nazo Kureshy

CHAPTER ONE

INTRODUCTION

Rationale:

The rationale for the Safe Motherhood Project took into consideration the findings of a hospital-based study conducted at the Jinnah Postgraduate Medical Center [JPMC] which revealed that socio-cultural factors (34%) and inadequate maternal services (21%) contributed significantly to the causes of the delay for the 150 pregnant or recently delivered women who were brought dead to JPMC over a twelve year period [1981 - 1992]. The major socio-cultural factors highlighted were family hesitancy (16%), husband not present (13%) and lack of awareness of the problem (5%)¹. Consequently, the intervention designed to address the socio-cultural factors that contribute to the largely preventable maternal morbidity and mortality was a community-based Information, Education and Communication [IEC] strategy. The communication strategy focused on increasing knowledge of and ensuring timely and appropriate referral for emergency obstetric complications. In addition, to address the issue of "husband not present" planning for emergencies by the head of the household was emphasized.

The IEC materials [Appendix A] developed after consultation with senior obstetricians, IEC consultant² and the Safe Motherhood Project [SMP] technical team were:

1. An emergency booklet focusing on the reasons for delay, the necessity for making an emergency plan, emergency messages and preventive messages
2. An antenatal card focusing on three antenatal check-ups, the nature of these check-ups, emergency messages for obstetric complications and preventive messages on nutrition, iron and folic acid supplementation and tetanus toxoid immunization.
3. Five posters each depicting one of the five common obstetric complications - antepartum hemorrhage, postpartum hemorrhage, obstructed labor, eclampsia and puerperal sepsis. The story line for each poster was based on a real story of that particular life-threatening obstetric complication and depicted the delay factors associated with moribund women arriving too late at the hospital. The key message displayed at the bottom of each poster was referral to JPMC for that particular obstetric complication.
4. A preventive poster describing key preventive messages regarding antenatal care, diet, iron and folic acid supplementation and tetanus toxoid immunization.

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¹ Jafarey SN and Korejo R. Mothers brought dead: An inquiry into causes of delay. *Soc Sci Med* 1993. 36(3):371-372.

² Mr Richard Pollard

The counseling strategy adopted was direct counseling rather than the original plan of community meetings as this was considered more feasible in the short-term. Mass media, while available, would be both expensive to produce and difficult to utilize and assess as coverage extended far beyond the target area. The counselors were members of the SMP field team who underwent training to facilitate their knowledge and communication skills. The individuals to be counseled were pregnant women and their husbands.

Objectives:

A pre and post survey was designed to assess the effectiveness of the IEC intervention. The purpose of the survey was:

1. To assess change in knowledge regarding when and where to refer for obstetric complications
2. To assess change in knowledge regarding preventive measures during pregnancy.
3. To assess change in knowledge about making appropriate arrangements for an obstetric emergency.

This research report presents the findings of the effectiveness of the IEC intervention.

CHAPTER TWO

METHODS

IEC Counseling Strategy

The communication strategy focused on increasing knowledge of obstetric complications to ensure timely and appropriate referral for emergency obstetric complications. The counseling strategy adopted was direct counseling of pregnant women and their spouses³ rather than the original plan of community meetings as this was considered more feasible in the short-term. The details of the development of IEC materials, IEC materials and IEC field team members are in Appendix A.

Quick count

A rapid assessment [Quick Count] of the catchment area was conducted in late February and early March to identify pregnant women. The main themes in the questionnaire [Appendix B] were:

1. Socio-demographic
2. Parity
3. Date of last menstrual period
4. Pregnancy status
5. Obstetric health seeking behavior for the previous pregnancy

The survey instrument was pre-tested prior to finalization. A team of 20 female interviewers were trained and closely supervised during the conduct of this survey. Details of the survey are in Appendix B.

A total of 630 pregnant women were identified. Among these 630 pregnant women, there were 238 Pathans, 241 Urdu/Punjabi speaking and the remaining 151 belonged to other ethnic groups. Details of the distribution of these 630 pregnant women by ethnicity and trimester are shown in Appendix B.

Training of Counselors

A four day training session was held in early March, 1998 for :

1. Understanding of obstetric complications
2. Familiarity with the IEC materials
3. Enhancement of counseling skills

which combined in-house discussions with field experience. However, training of the counselors continued beyond the formal training program. Specific attention was given to answer queries by medical personnel on obstetric complications which either the counselors were unfamiliar with or

³ We attempted to counsel women and their spouses but we were able to counsel more women than men.

were raised during the implementation of the counseling. Issues/problems identified during the training and implementation phases were discussed and clarifications sought from either the SMP technical team or the field IEC supervisor during the training and implementation phases respectively.

The IEC field team of counselors comprised eight members - six women and two men who were fluent either in Urdu, Punjabi or Pushto.

Implementation of Counseling

Following the training program, counseling of the identified pregnant women and their spouses was implemented. The implementation strategy adopted was that women who were identified in the third trimester and not delivered were counseled first. After completion of the counseling of all identified third trimester women, the counselors approached those identified in their second trimester and finally those identified in their first trimester. Counseling started on April 1, 1998 and ended on June 30, 1998. Pre and post evaluation of the men and women counseled was conducted so as to assess the effectiveness of the counseling.

Each individual counseled was approached at least four times :

1. Administration of pre-evaluation questionnaire
2. Counseling session I - antenatal card and emergency booklet
3. Counseling session II - posters
4. Administration of post-evaluation questionnaire

Each counseling session lasted approximately 50 - 70 minutes. Counselor's structured notes, developed for the counselor and observer, were also completed for each counseling session [Appendix C]. The pre and post evaluation forms were generally completed in under half an hour. Folders were made for all individuals counseled which included the following:

1. Pre-evaluation questionnaire
2. Counselor's notes
3. Observer's notes
4. Post-evaluation questionnaire

A total of 75 women and 28 men were counseled. This included 26 couples.

Problems during field work

There were several problems during the implementation of the counseling. Among the major field problems were:

1. Non-availability of men due to their job requirements that lead them to return home quite late at night.
2. Locations for counseling men were problematic as generally male counseling sessions were not conducted in homes but rather in nearby small teashops, outside homes etc.
3. Refusal rate was comparatively high in the month of June due to summer vacations of the children.
4. Women remarked that it was futile to discuss possible obstetric complications as they perceived that they were not susceptible to such an situation as they had never previously experienced or expected to experience such complications.
5. Reticence in discussing pregnancy related problems with young, unmarried counselors. specially in front of other family members.
6. Inappropriateness⁴ of counseling husbands regarding their wives possible obstetric complications by male counselors.

⁴ In the socio-cultural context

Evaluation Questionnaire

Design of the Questionnaire

The questionnaire development represented an iterative process involving the SMP technical team. The final questionnaire was the result of several revisions. The fundamental themes in the questionnaire were defined based on the objectives of the IEC intervention. These included:

1. Preventive messages as illustrated in the prevention poster as well as the antenatal card and emergency booklet
2. Knowledge regarding serious obstetric complications during antepartum, intrapartum and postpartum periods
3. Knowledge regarding those serious / life-threatening obstetric complications during the three phases of pregnancy which require referral to JPMC.
4. Knowledge regarding arrangements for an obstetric emergency

The questionnaire was open-ended to facilitate as general a response as possible. Later, a review of the responses resulted in a categorization of the responses so as to facilitate data entry and analysis. Re-categorization also meant reducing the “richness” of the data collected in the open-ended questionnaires. Furthermore, a decision had been taken that those questions which were action-oriented⁵ should only have the first action coded though often the action reported for these questions were quite complex. Appendix D illustrates the final questionnaire with the categories listed.

Field work

Two interviewers were recruited to conduct the pre and post evaluation questionnaire. A female doctor with advanced training in Reproductive Health was recruited to conduct the women evaluations whilst a male with advanced degree in Sociology was recruited to conduct the male evaluations.

Two rounds of post-evaluations were conducted :

Round One (henceforth referred to as “*immediate evaluation*”) was generally conducted shortly after the second counseling session. All identified pregnant women and their spouses were administered this round. There were therefore 75 women and 28 men with completed pre and post evaluation questionnaires.

Round Two (henceforth referred to as “*delayed evaluation*”) was generally conducted a few weeks after the second counseling session. This post-evaluation was to be administered to 25%⁶ of women and men with complete pre and post evaluation questionnaires. To achieve

⁵ Question numbers 6, 8, 10, 11, 13, 15

⁶ A sample size of 25% of counseled women and men were taken as the SMP technical group felt that this would be representative of the 75 and 28 counseled women and men. In addition, the interviews of 20 women and 7 men would be completed in a week.

our target of 20 women and 7 men we randomly selected 40 women from the pool of 75 counseled women and 14 men from the pool of 28 counseled men so as to accommodate field problems of migration, not at home and refusals.

Women

The pre-evaluation questionnaire was conducted generally within three days prior to the first counseling session whilst the first post-evaluation questionnaire was administered one to two weeks subsequent to the second counseling session. The second round of post-evaluation questionnaires were administered eight to twelve weeks subsequent to the second counseling session.

Men

The pre-evaluation questionnaire was conducted generally on the same day as the first counseling session whilst the first post-evaluation questionnaire was administered two to four weeks subsequent to the second counseling session. The second round of post-evaluation questionnaires were administered eight to twelve weeks subsequent to the second counseling session.

Editing and coding

The questionnaires were completed in the field as open-ended responses. Prior to leaving the home, the questionnaires were checked to see if any question had been left incomplete. On a daily basis, the questionnaires were edited and coded by the interviewers in the department. Any discrepancies identified were then corrected.

Data Entry and Processing

Once coding was completed and verified, data were double entered by two different data entry operators using the data entry program of *EpiInfo*. The data sets were validated twice using the *EpiInfo* software package. Discrepancies identified were then reconciled through recourse to the original questionnaires. In addition, consistency checks were also run to identify any problems not elicited in the validation process prior to data analysis.

Problems during field work

The problems faced were:

1. Non-availability of the male respondents as the majority of men were either unskilled workers or taxi drivers and returned home quite late at night.
2. Migration
3. Refusals

Analysis

The data was analyzed by the change in knowledge for the information disseminated during the counseling sessions. It is important to note that for the immediate evaluation, the total sample size

pre and post were similar i.e. 75 women and 28 men. For the delayed evaluation, we identified the same men and women on whom we had conducted the post-evaluation for their pre-evaluation responses. The results presented will compare the improvement or lack thereof in knowledge disseminated through the counseling sessions. In addition, we will stress whether this improvement was further improved, maintained or declined by comparing the results of the immediate and delayed evaluations.

CHAPTER THREE

RESULTS

Section I : Preventive Obstetrics

The main areas of counseling regarding preventive measure during pregnancy were antenatal care (specifically minimum number and timings, blood pressure measurements and position of baby), tetanus toxoid injections, iron and folate tables and diet. Furthermore, knowledge whether blood pressure control during pregnancy could prevent convulsions were also elicited. [Appendix D Question # 1 - 3 and 7 - 8]

Women

Overall, there was a marked improvement in knowledge regarding preventive measures during pregnancy both in the immediate and delayed evaluations [Tables I.1 and I.2]. For example, improvement in knowledge of antenatal care rose from no women responding in the pre-evaluation to 17 of 75 women (22.7%) responding in the immediate evaluation and 10 of 20 women (50%) in the delayed evaluation. Improvement on knowledge regarding tetanus toxoid rose by 261.1% and 100% in the immediate and delayed evaluations respectively. Interestingly, knowledge regarding diet [and specifically mentioning of either quantity or quality] rose by 314.3% and 200% in the immediate and delayed evaluations respectively. On the other hand, much fewer women reported that not carrying heavy loads was a preventive measure - the level of knowledge fell by 83.3% and 100% in the immediate and delayed evaluations respectively. [Tables I.1 and I.2].

Specific information regarding three visits as the minimum number of antenatal visits rose by 1,180% and 1,200% in the immediate and delayed evaluations respectively. Furthermore, among those women who reported either once, twice, thrice or more than three times, we specifically asked when these visits should be held. Interestingly, the improvement in knowledge was remarkable both in the immediate (1,933%) and delayed (1,200%) evaluations. [Tables I.1 and I.2].

Improvement in knowledge regarding control of blood pressure during pregnancy controlling convulsions was appreciable - 180% and 157% in the immediate and delayed evaluations respectively. Furthermore, awareness about going to JPMC and specifically the Obstetrics and Gynecology Department of JPMC also rose by 800% and 400% in the immediate and delayed evaluations respectively. Interestingly, resorting to local health care providers (HCPs) fell by 50% and 75% in the immediate and delayed evaluations respectively. [Tables I.3 and I.4].

Men

Overall, there was a marked improvement in knowledge regarding preventive measures during pregnancy both in the immediate and delayed evaluations [Tables I.5 and I.6]. For example, improvement in knowledge of antenatal care rose by 600% and 400% in the immediate and delayed evaluations respectively. Improvement on knowledge regarding tetanus toxoid rose markedly by 1,300% in the immediate evaluation whilst in the delayed evaluation four of seven men (57.1%) reported tetanus toxoid in the post-evaluation with none of the seven men mentioning tetanus toxoid in the pre-evaluation. Whereas there was a 240% increase in level of knowledge regarding quality or

quantity of diet for the immediate evaluation, no change in knowledge was apparent among the seven men in the delayed evaluation. On the other hand, much fewer men reported that not carrying heavy loads was a preventive measure - the level of knowledge fell by 66.7% and 50% in the immediate and delayed evaluations respectively. [Tables I.5 and I.6].

Specific information regarding three visits as the minimum number of antenatal visits rose by 666.7% in the immediate evaluation whilst six of the seven men interviewed in the delayed evaluation reported three antenatal visits when none of them had reported this in their pre-evaluation. Furthermore, among those men who reported either once, twice, thrice or more than three times, we specifically asked when these visits should be held. Interestingly, the improvement in knowledge was remarkable both in the immediate (550%) and delayed (500%) evaluations. [Tables I.5 and I.6].

Improvement in knowledge regarding control of blood pressure during pregnancy controlling convulsions was moderate (136.4%) in the immediate evaluation and high (600%) in the delayed evaluation. However, though improvement in knowledge regarding referral to JPMC for convulsions was high (450%) in the immediate evaluation but only one man responded that he will refer to JPMC in the delayed evaluation. Furthermore, resorting to local health care providers (HCPs) increased by 20% in the immediate evaluation with no change detected in the delayed evaluation. [Tables I.7 and I.8].

Table I.1 : Change in knowledge regarding preventive measures during pregnancy. [Immediate evaluation - female n = 75]. Korangi 8, Karachi, Pakistan

Preventive Measures	Pre		Post		Percent Change
	#	%	#	%	
Preventive Measures					
TT injections	18	24.0	65	86.7	261.1
Iron / Folic Tablets	20	26.7	64	85.3	220.0
Only Check-ups	0	0.0	17	22.7	NA ¹
Blood pressure check-up	0	0.0	26	34.7	NA ¹
Position of baby / fetus	0	0.0	2	2.7	NA ¹
Diet only mentioned	0	0.0	0	0.0	No change
Diet [mention quantity or quality]	14	18.7	58	77.3	314.3
Decrease work load	2	2.7	3	4.0	50.0
Do not carry heavy weight	18	24.0	3	4.0	-83.3
Others	16	21.3	0	0.0	-100.0
Don't know	32	42.7	0	0.0	-100.0
Minimum Antenatal Care Visits					
Once	2	2.7	1	1.3	-50.0
Twice	7	9.3	2	2.7	-71.4
Thrice	5	6.7	64	85.3	1,180.0
More than three times	9	12.0	8	10.7	-11.1
Whenever there are complaints	15	20.0	0	0.0	-100.0
No need	6	8.0	0	0.0	-100.0
Others	20	26.7	0	0.0	-100.0
Don't know	11	14.7	0	0.0	-100.0
	n = 20 ¹		n = 75		
Timings of Antenatal Care Visits					
During 1 st , 2 nd and 3 rd trimesters	3	15.0	61	81.3	1,933.3
Every fortnight / month	4	20.0	2	2.7	-50.0
Others	10	50.3	12	16.0	20.0
Don't know	3	15.0	0	0.0	-100.0

1. NA = undefined as denominator is zero

2. n = 20 as information is missing on three respondents

Table I.2 : Change in knowledge regarding preventive measures during pregnancy. [Delayed evaluation - female n = 20]. Korangi 8, Karachi, Pakistan.

	Pre		Post		Percent Change
	#	%	#	%	
Preventive Measures					
TT injections	7	35.0	14	70.0	100.0
Iron / Folic Tablets	8	40.0	18	90.0	125.0
Only Check-ups	0	0.0	10	50.0	NA ¹
Blood pressure check-up	0	0.0	9	45.0	NA ¹
Position of baby / fetus	0	0.0	0	0.0	No change
Diet only mentioned	0	0.0	0	0.0	No change
Diet [mention quantity or quality]	4	20.0	12	60.0	200.0
Decrease work load	0	0.0	0	0.0	No change
Do not carry heavy weight	6	30.0	0	0.0	-100.0
Others	7	35.0	0	0.0	-100.0
Don't know	5	25.0	0	0.0	-100.0
Minimum Antenatal Care Visits					
Once	0	0.0	0	0.0	No change
Twice	2	10.0	1	0.5	-50.0
Thrice	1	5.0	13	65.0	1200.0
More than three times	4	20.0	5	25.0	25.0
Whenever there are complaints	3	15.0	0	0.0	-100.0
No need	2	10.0	0	0.0	-100.0
Others	6	30.0	1	0.5	-83.3
Don't know	2	10.0	0	0.0	-100.0
Timings of Antenatal Care Visits					
During 1 st , 2 nd and 3 rd trimesters	1	14.3	13	68.4	-92.3
Every fortnight / month	2	28.6	1	5.3	100.0
Others	4	57.1	5	26.3	-20.0
Don't know	0	0.0	0	0.0	No change

1. NA = undefined as denominator is zero

Table I.3 : Change in knowledge regarding preventive measures during pregnancy to prevent convulsions. [Immediate evaluation - female n = 75]. Korangi 8, Karachi, Pakistan

Preventive Measures	Pre		Post		Percent Change
	#	%	#	%	
Prevent convulsions					
Yes	25	33.8	70	93.3	180.0
No	0	0.0	1	1.3	NA ¹
Others [specify]	2	2.7	1	1.3	50.0
Don't know	47	63.5	3	4.0	93.6
Care for woman who is convulsing					
Leave to God	1	1.3	1	1.3	0.0
Cannot go anywhere without husband's permission	3	3.9	0	0.0	-100.0
Go to JPMC	5	6.6	45	60.0	800.0
Go to Obs/Gynae ward; JPMC	0	0.0	3	4.0	NA ¹
Go to nearest hospital	5	6.6	10	13.3	100.0
Go to nearest HCP	30	39.5	15	20.0	-50.0
Others [specify]	4	5.3	1	0.0	-75.0
Don't know	28	36.8	0	0.0	-100.0

1. NA = undefined as denominator is zero

Table I.4 : Change in knowledge regarding preventive measures during pregnancy to prevent convulsions. [Delayed evaluation - female n = 20]. Korangi 8, Karachi, Pakistan

Preventive Measures	Pre		Post		Percent Change
	#	%	#	%	
Prevent convulsions					
Yes	7	35.0	18	90.0	157.1
No	0	0.0	0	0.0	No change
Others [specify]	1	5.0	2	10.0	100.0
Don't know	12	60.0	0	0.0	-100.0
Care for woman who is convulsing					
Leave to God	1	5.0	0	0.0	-100.0
Cannot go anywhere without husband's permission	1	5.0	0	0.0	-100.0
Go to JPMC	3	15.0	15	75.0	400.0
Go to Obs/Gyn ward JPMC	0	0.0	0	0.0	No change
Go to nearest hospital	0	0.0	1	5.0	NA ¹
Go to nearest HCP	8	40.0	2	10.0	-75.0
Others	2	5.0	2	10.0	0.0
Don't know	6	30.0	0	0.0	-100.0

1. NA =undefined as denominator is zero

Table I.5 : Change in knowledge regarding preventive measures during pregnancy. [Immediate evaluation - male n = 28]. Korangi 8, Karachi, Pakistan

Preventive Measures	Pre		Post		Percent Change
	#	%	#	%	
Preventive Measures					
TT injections	1	3.6	14	50.0	1,300.0
Iron / Folic Tablets	1	3.6	9	32.1	800.0
Only Check-ups	3	10.7	21	75.0	600.0
Blood pressure check-up	0	0.0	4	14.3	NA ¹
Position of baby / fetus	0	0.0	0	0.0	0.0
Diet only mentioned	1	3.6	4	14.3	300.0
Diet [mention quantity or quality]	5	17.9	17	60.7	240.0
Decrease work load	3	10.7	1	3.6	-66.7
Do not carry heavy weight	18	64.3	15	53.6	-16.7
Others	22	78.6	13	46.4	-40.9
Don't know	4	14.3	0	0.0	-100.0
Minimum Antenatal Care Visits					
Once	0	0.0	0	0.0	No change
Twice	1	3.6	0	0.0	-100.0
Thrice	6	21.4	23	82.1	666.7
More than three times	11	39.3	5	17.9	-54.5
Whenever there are complaints	0	0.0	0	0.0	No change
No need	0	0.0	0	0.0	No change
Others	7	25.0	0	0.0	-100.0
Don't know	3	10.7	0	0.0	-100.0
	n = 18		n = 28		
Timings of Antenatal Care Visits					
During 1 st , 2 nd and 3 rd trimesters	4	22.2	26	92.9	550.0
Every fortnight / month	7	38.9	1	3.6	-85.7
Others	5	27.8	1	3.6	-80.0
Don't know	2	11.1	0	0.0	-100.0

1. NA =undefined as denominator is zero

Table I.6 : Change in knowledge regarding preventive measures during pregnancy. . [Delayed evaluation - male n = 7]. Korangi 8, Karachi, Pakistan

Preventive Measures	Pre		Post		Percent Change
	#	%	#	%	
Preventive Measures					
TT injections	0	0.0	4	57.1	NA ¹
Iron / Folic Tablets	1	14.3	0	0.0	-100.0
Only Check-ups	1	14.3	5	71.4	400.0
Blood pressure check-up	0	0.0	2	28.6	NA ¹
Position of baby / fetus	0	0.0	0	0.0	No change
Diet only mentioned	0	0.0	1	14.3	NA ¹
Diet [mention quantity or quality]	2	28.6	2	28.6	0.0
Decrease work load	2	28.6	1	14.3	-50.0
Do not carry heavy weight	5	71.4	4	57.1	-20.0
Others	7	100.0	3	42.9	-57.1
Minimum Antenatal Care Visits					
Once	0	0.0	0	0.0	No change
Twice	0	0.0	0	0.0	No change
Thrice	0	0.0	6	85.7	NA ¹
More than three times	5	71.4	1	14.3	-80.0
Whenever there are complaints	0	0.0	0	0.0	No change
No need	0	0.0	0	0.0	No change
Others	2	28.6	0	0.0	-100.0
Timings of Antenatal Care Visits					
During 1 st , 2 nd and 3 rd trimesters	0	0.0	6	85.7	-100.0
Every fortnight / month	2	28.6	0	0.0	-100.0
Others	2	28.6	1	14.3	100.0
Don't know	1	14.3	0	0.0	-100.0

1. NA = undefined as denominator is zero

Table I.7 : Change in knowledge regarding preventive measures during pregnancy to prevent convulsions. [Immediate evaluation - male n = 28]. Korangi 8, Karachi, Pakistan

Preventive Measures	Pre		Post		Percent Change
	#	%	#	%	
Prevent convulsions					
Yes	11	39.3	26	92.9	136.4
No	0	0.0	0	0.0	No change
Others [specify]	1	3.6	0	0.0	-100.0
Don't know	16	57.1	2	7.1	-87.5
Care for woman who is convulsing					
Leave to God	0	0.0	0	0.0	No change
Cannot go anywhere without husband's permission	0	0.0	0	0.0	No change
	2	7.1	11	39.3	450.0
Go to JPMC	0	0.0	0	0.0	No change
Go to Obs/Gynae ward; JPMC	2	7.1	1	3.6	-50.0
Go to nearest hospital	10	35.7	12	42.9	20.0
Go to nearest HCP	8	28.6	4	14.3	-50.0
Others [specify]	6	21.4	0	0.0	-100.0
Don't know					

Table 1.8 : Change in knowledge regarding preventive measures during pregnancy to prevent convulsions. [Delayed evaluation - male n = 7]. Korangi 8, Karachi, Pakistan

Preventive Measures	Pre		Post		Percent Change
	#	%	#	%	
Prevent convulsions					
Yes	1	14.3	7	100.0	600.0
No	0	0.0	0	0.0	No change
Others [specify]	0	0.0	0	0.0	No change
Don't know	6	85.7	0	0.0	-100.0
Care for woman who is convulsing					
Leave to God	0	0.0	0	0.0	No change
Cannot go anywhere without husband's permission	0	0.0	0	0.0	No change
Go to JPMC	0	0.0	1	14.3	NA ¹
Go to Obs/Gynae ward; JPMC	0	0.0	0	0.0	No change
Go to nearest hospital	0	0.0	3	42.9	NA ¹
Go to nearest hospital	1	14.3	1	14.3	0.0
Go to nearest HCP	4	57.1	3	42.9	-25.0
Others [specify]	2	28.6	0	0.0	-100.0
Don't know					

1. NA =undefined as denominator is zero

Section II : Serious Obstetric Problems

Discussions on serious problems during pregnancy and delivery as well as appropriate referral patterns were also part of the counseling sessions. Consequently, we evaluated whether there was any change in the awareness of, and referral patterns for serious obstetric problems. To elicit this information, we specifically asked the counseled men and women to list the serious obstetric problems and whether referrals were needed for any. [Appendix D Question # 5 - 6].

Women [Tables II.1 and II.2]

Knowledge regarding the four major obstetric complications of hemorrhage, obstructed/prolonged labor, eclampsia and puerperal sepsis being serious obstetric complications during pregnancy, delivery and the postpartum period was significantly improved. Level of improvement was least for malpresentation (60%) and highest for puerperal sepsis (2,200%) in the immediate evaluation. However, in the delayed evaluation, the results were even more encouraging. For example, none of the 20 women interviewed reported obstructed/prolonged labor as a serious obstetric complication in the pre-evaluation though 6 of the 20 women (30%) so reported in the post evaluation. Improvement in the knowledge of antepartum (225%) and postpartum (450%) hemorrhage being serious problems though substantial was less than in the immediate evaluation.

JPMC referrals for the four major complications were more often reported both in the immediate and delayed evaluations. For example, the level of improvement for postpartum hemorrhage was 733.3% and 400% in the immediate and delayed evaluations respectively. For convulsions, none of the 75 women reported referrals to JPMC, while 30 of the 75 women (40%) and four of the 20 women (20%) reported such referrals in the immediate and delayed evaluations respectively.

Men [Tables II.3 and II.4]

Knowledge regarding the four major obstetric complications of hemorrhage, obstructed/prolonged labor, eclampsia and puerperal sepsis being serious obstetric complications during pregnancy, delivery and the postpartum period were significantly improved in the immediate evaluations. Level of improvement was least for malpresentation (150%) and most for puerperal sepsis (800%). However, in the delayed evaluation, the results were not encouraging except for hypertension where a 200% improvement was observed. With respect to the other complications, either no improvement or a decrease in the level of improvement was observed.

JPMC referrals for the four major complications were more often reported both in the immediate and delayed evaluations. For example, the level of improvement for malpresentation was 200% in the immediate evaluation. For convulsions, none of the 28 men reported referrals to JPMC in the pre-evaluations, while seven of the 28 men (25%) and one of the seven men (14.3%) reported such referrals in the immediate and delayed evaluations respectively.

Table II.1 : Change in knowledge about serious obstetric problems. [Immediate evaluation - female n = 75]. Korangi 8, Karachi, Pakistan.

Serious Obstetric Problems	Pre		Post		Percent Change
	#	%	#	%	
Knowledge					
Weakness	7	9.3	4	5.3	-42.9
Post maturity	2	2.7	0	0.0	-100.0
Vaginal bleeding	4	5.3	6	8.0	50.0
Antepartum hemorrhage	6	8.0	47	62.7	683.3
Postpartum hemorrhage	4	5.3	42	56.0	950.0
Stillbirth	8	10.7	2	2.7	-75.0
Abortion	13	17.3	0	0.0	-100.0
Obstructed / prolonged labor	1	1.3	13	17.3	1,200.0
Malpresentation	5	6.7	8	10.7	60.0
Puerperal sepsis [fever after delivery]	1	1.3	23	30.7	2,200.0
Low blood pressure	1	1.3	0	0.0	-100.0
Hypertension	0	0.0	18	24.0	NA ¹
Fits [eclampsia]	6	8.0	41	54.7	583.3
Maternal death	17	22.7	3	4.0	-82.4
Others	29	38.7	0	0.0	-100.0
Referral to JPMC					
Weakness	0	0.0	0	0.0	No change
Post maturity	0	0.0	0	0.0	No change
Vaginal bleeding	1	1.3	3	4.0	200.0
APH	3	4.0	20	26.7	566.7
PPH	3	4.0	25	33.3	733.3
Stillbirth	0	0.0	2	2.7	NA ¹
Abortion	1	1.3	0	0.0	-100.0
Obstructed / prolonged labor	10	13.3	13	17.3	30.0
Malpresentation	1	1.3	1	1.3	0.0
Puerperal sepsis [fever after delivery]	1	1.3	7	9.3	600.0
Low blood pressure	0	0.0	0	0.0	No change
Hypertension	1	1.3	10	13.3	900.0
Fits [eclampsia]	0	0.0	30	40.0	NA ¹
Maternal death	0	0.0	0	0.0	No change
Consult doctor	3	4.0	4	5.3	33.3
Others	26	34.7	21	28.0	-19.2
Don't know	31	41.3	0	0.0	-100.0

1. NA =undefined as denominator is zero

Table II.2 : Change in knowledge about serious obstetric problems. [Delayed evaluation - female n = 20]. Korangi 8, Karachi, Pakistan

Serious Obstetric Problems	Pre		Post		Percent Change
	#	%	#	%	
Knowledge					
Weakness	2	10.0	3	15.0	50.0
Post maturity	1	5.0	1	5.0	0.0
Vaginal bleeding	1	5.0	0	0.0	-100.0
Antepartum hemorrhage	4	20.0	13	65.0	225.0
Postpartum hemorrhage	2	10.0	11	55.0	450.0
Stillbirth	3	15.0	1	5.0	-66.7
Abortion	3	15.0	0	0.0	-100.0
Obstructed / prolonged labor	0	0.0	6	30.0	NA ¹
Malpresentation	0	0.0	3	15.0	NA ¹
Puerperal sepsis [fever after delivery]	0	0.0	2	10.0	NA ¹
Low blood pressure	1	5.0	0	0.0	-100.0
Hypertension	0	0.0	0	0.0	No change
Fits [eclampsia]	0	0.0	0	0.0	No change
Maternal death	0	0.0	0	0.0	No change
Others	8	40.0	0	0.0	-100.0
Don't know	4	20.0	0	0.0	-100.0
Referral to JPMC					
Weakness	0	0.0	0	0.0	No change
Post maturity	0	0.0	1	5.0	NA ¹
Vaginal bleeding	1	5.0	0	0.0	100.0
APH	1	5.0	8	40.0	700.0
PPH	1	5.0	5	25.0	400.0
Stillbirth	0	0.0	0	0.0	No change
Abortion	0	0.0	0	0.0	No change
Obstructed / prolonged labor	1	5.0	7	35.0	600.0
Malpresentation	0	0.0	1	5.0	NA ¹
Puerperal sepsis [fever after delivery]	0	0.0	0	0.0	No change
Low blood pressure	0	0.0	0	0.0	No change
Hypertension	0	0.0	7	35.0	NA ¹
Fits [eclampsia]	0	0.0	4	20.0	NA ¹
Maternal death	0	0.0	0	0.0	No change
Consult doctor	1	5.0	0	0.0	-100.0
Others	7	35.0	5	25.0	-28.6
Don't know	9	45.0	0	0.0	-100.0

1. NA = undefined as denominator is zero

Table II.3 : Change in knowledge about serious obstetric problems. [Immediate evaluation - male n = 28]. Korangi 8, Karachi, Pakistan.

Serious Obstetric Problems	Pre		Post		Percent Change
	#	%	#	%	
Knowledge					
Weakness	1	3.6	0	0.0	-100.0
Post maturity	0	0.0	1	3.6	NA ¹
Vaginal bleeding	1	3.6	8	28.6	700.0
Antepartum hemorrhage	2	7.1	13	46.4	550.0
Postpartum hemorrhage	2	7.1	9	32.1	350.0
Stillbirth	2	7.1	2	7.1	0.0
Abortion	5	17.9	5	17.9	0.0
Obstructed / prolonged labor	1	3.6	3	10.7	200.0
Malpresentation	2	7.1	5	17.9	150.0
Puerperal sepsis [fever after delivery]	1	3.6	9	32.1	800.0
Low blood pressure	2	7.1	1	3.6	-50.0
Hypertension	1	3.6	5	17.9	400.0
Fits [eclampsia]	0	0.0	8	28.6	NA ¹
Maternal death	8	28.6	1	3.6	-87.5
Others	3	10.7	11	39.3	266.7
Don't know	11	39.3	1	3.6	-90.9
Referral to JPMC					
Weakness	0	0.0	0	0.0	No change
Post maturity	0	0.0	0	0.0	No change
Vaginal bleeding	1	3.6	6	21.4	500.0
Antepartum hemorrhage	0	0.0	12	42.9	NA ¹
Postpartum hemorrhage	0	0.0	3	10.7	NA ¹
Stillbirth	1	3.6	0	0.0	-100.0
Abortion	0	0.0	1	3.6	NA ¹
Obstructed / prolonged labor	2	7.1	3	10.7	50.0
Malpresentation	2	7.1	6	21.4	200.0
Puerperal sepsis [fever after delivery]	0	0.0	2	7.1	NA ¹
Low blood pressure	0	0.0	1	3.6	NA ¹
Hypertension	0	0.0	3	10.7	NA ¹
Fits [eclampsia]	0	0.0	7	25.0	NA ¹
Maternal death	0	0.0	0	0.0	No change
Consult doctor	1	3.6	2	7.1	100.0
Others	9	32.1	13	46.4	44.4
Don't know	5	17.9	0	0.0	-100.0

1. NA =undefined as denominator is zero

Table II.4: Change in knowledge about serious obstetric problems. [Delayed evaluation - male n = 7]. Korangi 8, Karachi, Pakistan

Serious Obstetric Problems	Pre		Post		Percent Change
	#	%	#	%	
Knowledge					
Weakness	0	0.0	2	28.6	NA ¹
Post maturity	0	0.0	0	0.0	No change
Vaginal bleeding	0	0.0	5	71.4	NA ¹
Antepartum hemorrhage	0	0.0	0	0.0	No change
Postpartum hemorrhage	1	14.3	0	0.0	-100.0
Stillbirth	0	0.0	1	14.3	NA ¹
Abortion	3	42.9	0	0.0	-100.0
Obstructed / prolonged labor	0	0.0	0	0.0	No change
Malpresentation	1	14.3	0	0.0	-100.0
Puerperal sepsis [fever after delivery]	0	0.0	0	0.0	No change
Low blood pressure	2	28.6	0	0.0	-100.0
Hypertension	1	14.3	3	42.9	200.0
Fits [eclampsia]	0	0.0	0	0.0	No change
Maternal death	3	42.9	1	14.3	-66.7
Others	0	0.0	3	42.9	NA ¹
Don't know	1	14.3	0	0.0	-100.0
Referral to JPMC					
Weakness	0	0.0	0	0.0	No change
Post maturity	0	0.0	0	0.0	No change
Vaginal bleeding	0	0.0	6	85.7	NA ¹
Antepartum hemorrhage	0	0.0	0	0.0	No change
Postpartum hemorrhage	0	0.0	0	0.0	No change
Stillbirth	0	0.0	0	0.0	No change
Abortion	0	0.0	0	0.0	No change
Obstructed / prolonged labor	0	0.0	1	14.3	NA ¹
Malpresentation	0	0.0	1	14.3	NA ¹
Puerperal sepsis [fever after delivery]	0	0.0	1	14.3	NA ¹
Low blood pressure	0	0.0	0	0.0	No change
Hypertension	0	0.0	1	14.3	NA ¹
Fits [eclampsia]	0	0.0	1	14.3	NA ¹
Maternal death	0	0.0	0	0.0	No change
Consult doctor	1	14.3	0	0.0	-100.0
Others	5	71.4	2	28.6	-60.0

1. NA =undefined as denominator is zero

Section III: Obstetric Complications

In this section we will present the results of the evaluation of the counseling on three life-threatening obstetric complications of hemorrhage [antepartum and postpartum], prolonged labor, and puerperal sepsis. [Appendix D Question # 9 - 15]

Women

Immediate and delayed evaluations for improvement in knowledge regarding severity and referral patterns were extremely encouraging. For example, though there was minor (6.3%) or no improvement in the level of knowledge for frank bleeding being a severe antepartum complication in the immediate and delayed evaluations, a considerable proportion of women mentioned spotting [\geq one day] as a severe antepartum complication in the post-evaluations for the immediate and delayed evaluations, though this was not mentioned by any women in the pre-evaluations. Furthermore, marked improvement in the awareness of referrals to JPMC, including specifically mentioning taking blood donors, were observed in the immediate and delayed evaluations. A similar pattern was observed for severity or referral pattern for prolonged labor. [Tables III.1 and III.2]

Awareness that genital tract infection was the reason for puerperal sepsis was significantly improved by our counseling strategy. In the immediate evaluation, 52 of the 75 women (69.3%) reported that genital tract infection was the cause of puerperal sepsis whilst none of these women mentioned this in the pre-evaluations. Furthermore, in the delayed evaluation, 13 of the 20 women (65%) still recalled correctly that genital tract infection was the cause of puerperal sepsis. [Tables III.3 and III.4].

Men

Immediate and delayed evaluations for improvement in knowledge regarding severity and referral patterns were encouraging though there were exceptions. For example, though significant improvement in the level of knowledge for frank bleeding (260%) as a severe antepartum complication was observed in the immediate evaluation, there was a 50% decrease in this knowledge in the delayed evaluation. However, a marked improvement in the awareness of referrals to JPMC were observed both in the immediate and delayed evaluations. A similar pattern was observed for knowledge of severity for prolonged labor. [Tables III.5 and III.6]

Awareness that genital tract infection was the reason for puerperal sepsis was significantly improved by our counseling strategy. In the immediate evaluation, 14 of 28 men (50%) reported that genital tract infection was the cause of puerperal sepsis as compared to only one man in the pre-evaluations. Furthermore, in the delayed evaluation, five of the seven men (71.4%) still recalled correctly that genital tract infection was the cause of puerperal sepsis while none of these seven men reported as such in the pre-evaluation.. [Tables III.7 and III.8].

Table III.1 : Change in knowledge regarding obstetric complications during antepartum and intrapartum phases of pregnancy. [Immediate evaluation - female n = 75]. Korangi 8, Karachi, Pakistan.

Obstetric complications	Pre		Post		Percent Change
	#	%	#	%	
Spotting become serious					
Initial one spot	24	32.4	13	17.6	-45.8
Spotting >= 1 day	0	0.0	34	45.9	NA ¹
Frank bleeding	16	21.6	17	23.0	6.3
Others	5	6.8	1	1.4	-80.0
Don't know	11	14.9	13	17.6	18.2
No response	22	29.7	0	0.0	-100.0
Care for postpartum hemorrhage					
Consult doctor	27	36.0	21	28.0	-22.2
Consult LHV/Nurse	9	12.0	5	6.7	-44.4
Consult dai	7	9.3	5	6.7	-28.6
Go to JPMC	3	4.0	16	21.3	+33.3
Go to JPMC with donors	0	0.0	17	22.7	NA ¹
Go to nearest hospital	5	6.7	5	6.7	0.0
Others	12	16.0	6	8.0	-50.0
Don't know	12	16.0	0	0.0	-100.0
	n = 75		n = 73 ²		
Care for Prolonged labor					
Consult doctor	18	24.0	14	19.2	-22.2
Consult LHV/Nurse	7	9.3	3	4.1	-57.1
Consult dai	12	16.0	12	16.4	0.0
Go to JPMC	8	10.7	29	39.7	262.5
Go to JPMC with donors	7	9.3	13	17.8	-85.7
Go to nearest hospital	14	18.7	2	2.7	-85.7
Others	9	12.0	0	0.0	NA ¹
Severity of Prolonged labor					
Primips ≥18 hours	0	0.0	23	30.6	NA ¹
Multips ≥12 hours	0	0.0	26	34.7	NA ¹
Strong labor pains for less than 12 hours	17	22.7	31	41.3	82.4
Others	40	53.3	26	34.7	-35.0
Don't know	18	10.7	0	0.0	-100.0

1. NA = undefined as denominator is zero

2. n = 73 as information is missing on two respondents

Table III.2 : Change in knowledge regarding obstetric complications during antepartum and intrapartum phases of pregnancy. [Delayed evaluation - female n = 20]. Korangi 8, Karachi, Pakistan.

Obstetric complications	Pre		Post		Percent Change
	#	%	#	%	
Spotting become serious					
Initial one spot	6	30.0	4	20.0	-33.3
Spotting >= 1 day	0	0.0	6	30.0	NA ¹
Frank bleeding	6	30.0	6	30.0	0.0
Others	1	5.0	0	0.0	-100.0
Don't know	3	15.0	4	20.0	33.3
No response	5	25.0	0	0.0	-100.0
Care for postpartum hemorrhage					
Consult doctor	5	25.0	5	25.0	0.0
Consult LHV/Nurse	5	25.0	1	5.0	-80.0
Consult dai	2	10.0	0	0.0	-100.0
Go to JPMC	1	5.0	8	40.0	700.0
Go to JPMC with donors	0	0.0	2	10.0	NA ¹
Go to nearest hospital	0	0.0	1	5.0	NA ¹
Others	3	15.0	3	15.0	0.0
Don't know	4	20.0	0	0.0	-100.0
Care for Prolonged labor					
Consult doctor	4	20.0	5	25.0	25.0
Consult LHV/Nurse	3	15.0	1	5.0	-66.7
Consult dai	2	10.0	0	0.0	-100.0
Go to JPMC	1	5.0	13	65.0	1,200.0
Go to JPMC with donors	2	10.0	0	0.0	-100.0
Go to nearest hospital	6	30.0	1	5.0	-83.3
Others	2	10.0	0	0.0	-100.0
Severity of Prolonged labor					
Primips ≥18 hours	0	0.0	4	20.0	NA ¹
Multips ≥12 hours	0	0.0	3	15.0	NA ¹
Strong labor pains for less than 12 hours	7	35.0	11	55.0	57.1
Others	8	40.0	6	30.0	-25.0
Don't know	5	25.0	0	0.0	-100.0

1. NA = undefined as denominator is zero

Table III.3 : Change in knowledge regarding obstetric complications during postpartum phase of pregnancy. [Immediate evaluation - female n = 75]. Korangi 8, Karachi, Pakistan

Obstetric complications	Pre		Post		Percent Change
	#	%	#	%	
Care for Puerperal Sepsis					
Consult doctor	31	41.3	34	45.3	9.7
Consult LHV/Nurse	9	12.0	8	10.7	-11.1
Consult dai	6	8.0	12	16.0	100.0
Go to JPMC	0	0.0	5	6.7	NA ¹
Go to JPMC with donors	0	0.0	1	1.3	NA ¹
Go to nearest hospital	3	4.0	9	12.0	200.0
Others	16	21.3	5	6.7	-68.8
Don't know	10	13.3	0	0.0	-100.0
Reason for Puerperal Sepsis					
Genital tract infection	0	0.0	52	69.3	NA ¹
Breast infection	0	0.0	1	1.3	NA ¹
Others	29	38.7	19	25.3	-34.5
Don't know	45	60.0	4	5.3	-91.1

1. NA =undefined as denominator is zero

Table III.4 : Change in knowledge regarding obstetric complications during postpartum phase of pregnancy. [Delayed evaluation - female n = 20]. Korangi 8, Karachi, Pakistan.

Obstetric complications	Pre		Post		Percent Change
	#	%	#	%	
Care for Puerperal Sepsis					
Consult doctor	5	25.0	6	30.0	20.0
Consult LHV/Nurse	4	20.0	1	5.0	-75.0
Consult dai	3	15.0	2	10.0	-33.3
Go to JPMC	0	0.0	6	30.0	NA ¹
Go to JPMC with donors	0	0.0	3	15.0	NA ¹
Go to nearest hospital	2	10.0	2	10.0	0.0
Others	4	20.0	0	0.0	-100.0
Don't know	2	10.0	0	0.0	-100.0
Reason for Puerperal Sepsis					
Genital tract infection	0	0.0	13	65.0	NA ¹
Breast infection	0	0.0	0	0.0	No change
Others	4	20.0	7	35.0	75.0
Don't know	15	75.0	0	0.0	-100.0

1. NA = undefined as denominator is zero

Table III.5 : Change in knowledge regarding obstetric complications during antepartum and intrapartum phases of pregnancy. [Immediate evaluation - male n = 28]. Korangi 8, Karachi, Pakistan.

Obstetric complications	Pre		Post		Percent Change
	#	%	#	%	
Spotting become serious					
Initial one spot	3	10.7	12	42.9	300.0
Spotting \geq 1 day	0	0.0	0	0.0	No change
Frank bleeding	5	17.9	18	64.3	260.0
Others	3	10.7	1	3.6	-66.7
Don't know	9	32.1	4	14.3	-55.6
No response	12	42.9	0	0.0	-100.0
Care for postpartum hemorrhage					
Consult doctor	15	53.6	8	28.6	-46.7
Consult LHV/Nurse	0	0.0	0	0.0	No change
Consult dai	0	0.0	0	0.0	No change
Go to JPMC	3	10.7	14	50.0	366.7
Go to JPMC with donors	0	0.0	0	0.0	No change
Go to nearest hospital	1	3.6	4	14.3	300.0
Others	4	14.3	2	7.1	-50.0
Don't know	5	17.9	0	0.0	-100.0
Care for Prolonged labor					
Consult doctor	10	35.7	9	32.1	-10.0
Consult LHV/Nurse	0	0.0	1	3.6	NA ¹
Consult dai	1	3.6	1	3.6	0.0
Go to JPMC	7	25.0	11	39.3	57.1
Go to JPMC with donors	4	14.3	2	7.1	-50.0
Go to nearest hospital	5	17.9	4	14.3	-20.0
Others	1	3.6	0	0.0	-100.0
Severity of Prolonged labor					
Primips \geq 18 hours	1	3.7	10	37.0	900.0
Multips \geq 12 hours	1	3.7	10	37.0	900.0
Strong labor pains for less than 12 hours	13	48.1	12	44.4	-7.7
Others	3	11.1	6	22.2	100.0
Don't know	11	40.7	1	3.7	-90.0

1. NA =undefined as denominator is zero

Table III.6 : Change in knowledge regarding obstetric complications during antepartum and intrapartum phases of pregnancy. [Delayed evaluation - male n = 7]. Korangi 8, Karachi, Pakistan.

Obstetric complications	Pre		Post		Percent Change
	#	%	#	%	
Spotting become serious					
Initial one spot	1	14.3	1	14.3	0.0
Spotting >= 1 day	0	0.0	1	14.3	NA ¹
Frank bleeding	2	28.6	1	14.3	-50.0
Others	1	14.3	3	42.9	200.0
Don't know	3	42.9	1	14.3	-66.7
No response	2	28.6	0	0.0	-100.0
Care for postpartum hemorrhage					
Consult doctor	4	57.1	1	14.3	-75.0
Consult LHV/Nurse	0	0.0	0	0.0	No change
Consult dai	0	0.0	0	0.0	No change
Go to JPMC	1	14.3	2	28.6	100.0
Go to JPMC with donors	0	0.0	0	0.0	No change
Go to nearest hospital	0	0.0	0	0.0	No change
Others	2	28.6	4	57.1	100.0
Care for Prolonged labor					
Consult doctor	2	28.6	0	0.0	-100.0
Consult LHV/Nurse	0	0.0	0	0.0	No change
Consult dai	0	0.0	0	0.0	No change
Go to JPMC	2	28.6	3	42.9	50.0
Go to JPMC with donors	2	28.6	4	57.1	100.0
Go to nearest hospital	1	14.3	0	0.0	-100.0
Severity of Prolonged labor					
Primips ≥18 hours	0	0.0	2	28.6	NA ¹
Multips ≥12 hours	5	71.4	2	28.6	-60.0
Strong labor pains for less than 12 hours	1	14.3	3	42.9	200.0
Others	1	14.3	0	0.0	-100.0

1. NA = undefined as denominator is zero

Table III.7 : Change in knowledge regarding obstetric complications during postpartum phase of pregnancy. [Immediate evaluation - male n = 28]. Korangi 8, Karachi, Pakistan

Obstetric complication	Pre		Post		Percent Change
	#	%	#	%	
Care for Puerperal Sepsis					
Consult doctor	20	71.4	11	39.3	-45.0
Consult LHV/Nurse	0	0.0	0	0.0	No change
Consult dai	0	0.0	2	7.1	NA ¹
Go to JPMC	2	7.1	12	42.9	500.0
Go to JPMC with donors	0	0.0	0	0.0	No change
Go to nearest hospital	2	7.1	3	10.7	50.0
Others	1	3.6	0	0.0	-100.0
Don't know	3	10.7	0	0.0	-100.0
Reason for Puerperal Sepsis					
Genital tract infection	1	3.6	14	50.0	1,300.0
Breast infection	0	0.0	0	0.0	No change
Others	10	35.7	11	39.3	10.0
Don't know	17	60.7	3	10.7	-82.4

1. NA =undefined as denominator is zero

Table III.8 : Change in knowledge regarding obstetric complications during postpartum phase of pregnancy. [Delayed evaluation - male n = 7]. Korangi 8, Karachi, Pakistan

Obstetric complications	Pre		Post		Percent Change
	#	%	#	%	
Care for Puerperal Sepsis					
Consult doctor	7	100.0	3	42.9	-57.9
Consult LHV/Nurse	0	0.0	0	0.0	No change
Consult dai	0	0.0	0	0.0	No change
Go to JPMC	0	0.0	3	42.9	NA ¹
Go to JPMC with donors	0	0.0	0	0.0	No change
Go to nearest hospital	0	0.0	1	14.3	NA ¹
Reason for Puerperal Sepsis					
Genital tract infection	0	0.0	5	71.4	NA ¹
Breast infection	0	0.0	0	0.0	No change
Others	5	71.4	2	28.6	-60.0
Don't know	2	28.6	0	0.0	-100.0

1. NA = undefined as denominator is zero

Section IV : Emergency Plan

A considerable proportion of a counseling session was expended in discussing the necessity of having an emergency plan in the advent of an obstetric complication [session where the emergency booklet was discussed]. Thus, we wanted to evaluate whether we were able to raise the level of awareness regarding discussion with family members and permission given or arrangement made for referral to hospital in case of an obstetric emergency. During the pre-evaluations, we had earlier decided not to ask this question as we considered it redundant but later on included this question. Consequently, 41 of the 75 women were not asked this question. However, all the counseled men were asked this question in the pre-evaluation. [Appendix D Question No 4]

Women

Discussions and permission given or arrangement made if an obstetric emergency occurred was improved by 460% and 240% in the immediate and delayed evaluations. However, there was a decrease of 15.8% and 60% in the immediate and delayed evaluations for no discussion on an emergency plan which is quite encouraging. [Tables IV.1 and IV.2]

Men

Though only a moderate level of improvement in the immediate (19%) and delayed (40%) evaluations for discussions and permission given or arrangement made if an obstetric emergency occurred was observed but a significant decrease in the immediate (71.4%) and delayed (100%) evaluations for no discussion on an emergency plan was observed. [Tables IV.3 and IV.4].

Table IV.1 : Change in knowledge regarding emergency plan for an obstetric emergency. [Immediate evaluation - female n = 75].
Korangi 8, Karachi, Pakistan

Emergency plan	Pre ¹		Post ²		Percent Change
	#	%	#	%	
Husband / elder family member discussed and permission given or arrangement made	10	13.9	56	75.7	460.0
Husband / elder family member discussed and permission not given or arrangement not made	0	0.0	1	1.4	NA ¹
Not discussed	19	26.4	16	21.6	-15.8
Others	2	2.8	1	1.4	-50.0
Not asked	41	56.9	0	0.0	-100.0

1. NA =undefined as denominator is zero

Table IV.2 : Change in knowledge regarding emergency plan for an obstetric emergency. [Delayed evaluation - female n = 20], Korangi 8, Karachi, Pakistan.

Emergency plan	Pre		Post		Percent Change
	#	%	#	%	
Husband / elder family member discussed and permission given or arrangement made	5	25.0	17	85.0	240.0
Husband / elder family member discussed and permission not given or arrangement not made	0	0.0	0	0.0	No change
Not discussed	5	25.0	2	10.0	-60.0
Others	0	0.0	1	5.0	NA ¹
Don't know	0	0.0	0	0.0	No change
Not asked	10	50.0	0	0.0	-100.0

1. NA =undefined as denominator is zero

Table IV.3 : Change in knowledge regarding emergency plan for an obstetric emergency. [Immediate evaluation - male n = 28], Korangi 8, Karachi, Pakistan.

Emergency plan	Pre		Post		Percent Change
	#	%	#	%	
Husband / elder family member discussed and permission given or arrangement made	21	75.0	25	89.3	19.0
Husband / elder family member discussed and permission not given or arrangement not made	0	0.0	0	0.0	No change
Not discussed	7	25.0	2	7.1	-71.4
Others	0	0.0	1	3.6	NA ¹
Don't know	0	0.0	0	0.0	No change

1. NA =undefined as denominator is zero

Table IV.4 : Change in knowledge regarding emergency plan for an obstetric emergency. [Delayed evaluation - male n = 7]. Korangi 8, Karachi, Pakistan.

Emergency plan	Pre		Post		Percent Change
	#	%	#	%	
Husband / elder family member discussed and permission given or arrangement made	5	71.4	7	100.0	40.0
Husband / elder family member discussed and permission not given or arrangement not made	0	0.0	0	0.0	No change
Not discussed	2	28.6	0	0.0	-100.0

1. NA =undefined as denominator is zero

CHAPTER FOUR

DISCUSSION

The IEC intervention was implemented by way of one-on-one counseling sessions covering preventive obstetrics and serious / life-threatening obstetric complications. The sessions were held with pregnant women and their spouses. The IEC materials used and disseminated among the counseled clients are in Appendix A.

Overall, there was a marked improvement in knowledge regarding preventive measures during pregnancy both in the immediate and delayed evaluations. From our perspective, a significant improvement was in the change in knowledge regarding the minimum number of antenatal visits [three] as recommended by the counselors. This marked improvement was observed in the immediate and delayed evaluations from both men and women [Tables I.1, I.2, I.5 and I.6]. Furthermore, knowledge of tetanus toxoid improved among both men and women in the immediate and delayed evaluations but considerably more among men [Tables I.1, I.2, I.5 and I.6]. We feel that this change in knowledge could possibly reflect the keen interest of men and women in acquiring knowledge on maternal health.

The level of improvement regarding serious obstetric problems was more pronounced among women than men. This was particularly true for prolonged / obstructed labor and puerperal sepsis where the improvement among women was 1,200% and 2,200% respectively but among men was 200% and 300% respectively [Tables II.1 and II.3]. This marked difference in change in knowledge may reflect women being able to subjectively relate such events to themselves, and more so as they are currently pregnant, but men unable to make this sort of "connection".

A similar pattern of improvement in knowledge was observed for obstetric complications during antepartum, intrapartum and postpartum periods. Generally, improvement in the level of awareness was higher among women than men with minimal change in the level of improvement when comparing responses from the immediate evaluation to the delayed evaluation. Surprisingly, improvement in knowledge of referral to JPMC and taking a blood donor was very encouraging and, we believe, does reflect the skills of our counselors in conveying the importance of blood donors. [Tables III.1]

Finally, the improvement in knowledge regarding discussing and taking permission from family elders / husband for referral to a hospital in the advent of an obstetric emergency was most inspiring. Not surprisingly, the level of improvement was more marked among women [460% and 240% in the immediate and delayed evaluations respectively - Tables IV.1 and IV.2]] than men [19% and 40% in the immediate and delayed evaluations respectively - Tables IV.3 and IV.4]. This difference among women and men could possibly be related to the power dynamics within households in our patriarchal societies.

Though the IEC intervention phase was shortened from our original plan of a year to only three months, nevertheless our results do demonstrate substantial change in knowledge in preventive obstetrics and serious / life-threatening obstetric complications. However, the "true" effectiveness of

our IEC counseling could only have been demonstrated by a critical assessment of behavior change in the context of documented improvement in routine antenatal care, tetanus toxoid immunization, and prompt and timely referral to JPMC for life-threatening obstetric complications. The lack of an assessment of behavior change is mainly due to our inability to implement the clinic and JPMC based health information system⁷ [HIS] and not because of the short time span of the IEC intervention. However, a few case studies which demonstrate a behavior change for seeking antenatal care (Case Study 1), tetanus toxoid shots (Case Study 2), referring to JPMC for eclampsia (Case Study 3) or prolonged labor (Case Study 4) are described in Appendix E.

In summary, the improvement in knowledge regarding Safe Motherhood among both men and women is substantial and extremely encouraging. However, due to our inability to assess behavior change in preventive and referral patterns for Safe Motherhood we cannot suggest that such campaigns will increase the number of women with obstetric complications who utilize appropriate medical services which was the goal of our project. Thus, though we cannot assess behavior change, our results clearly demonstrate a marked improvement in raising awareness about Safe Motherhood in this community.

⁷ Due to bureaucratic issues in instituting the HIS in JPMC and lack of support from the clinics in the catchment area.

Development¹

Development of IEC Materials

Development and production of IEC materials was not originally conceptualized in the Safe Motherhood Project, since awareness building with the community women and men, regarding symptoms of major obstetric complications and desired actions, was going to take place through small gatherings. However, some significant shifts in the communication strategy for the Safe Motherhood Project in Korangi 8 took place due to Mr. Richard Pollard's (Manoff Group Inc.) input. Mr Pollard made two consultancy trips to Karachi, and highlights of these are shown in the table below.

	<i>Main Achievements</i>
<i>Consultancy Trip #1</i> (May 24 - June 7, 1997)	<ul style="list-style-type: none"> • review and discussion of formative research findings/visit with community stakeholders • development of communication strategy (2 day workshop) and technical messages • development of preliminary drafts of counseling booklet, antenatal card and posters with field team • development of working plan for pre-testing, finalization and production of IEC materials
<i>Consultancy Trip #2</i> (October 30 - November 6, 1997)	<ul style="list-style-type: none"> • review of pre-testing results of IEC materials • review of IEC materials production and distribution plans • discussion of counseling monitoring and evaluation strategies • preparation for and launch of IEC campaign counseling

The two day workshop conducted during Mr Pollard's first visit was a comprehensive discussion of the desired behavior change, technical messages and overall communication strategy. It was attended by all team members as well as Dr. Shereen Bhutta and Dr. Razia Korejo, both of whom practice at the Department of Obstetrics and Gynecology at JPMC. The desired behavioral action that was agreed upon was: *A pregnant woman will know when an emergency exists and will refer herself to JPMC and will also know when symptoms are not an emergency and will consult a local health care provider (preferably doctor)*. Appropriate technical messages focusing on four major complications (hemorrhage, eclampsia, obstructed, puerperal sepsis) and preventive care were developed by Dr. Sadiqua Jafarey, with input from Dr. Shereen Bhutta and Dr. Razia Korejo. Much debate was precipitated due to the specificity and clinical technicalities of the messages, especially for a

¹ Compiled by Nazo Kureshy

community with low literacy levels. Although messages were simplified, they maintained a certain degree of technical detail in order to ensure accuracy in self diagnosis and immediate referral to JPMC in a major obstetric emergency. These messages are highlighted in the description of the IEC materials that follow.

The team reached an agreement that the target groups of interest would include pregnant women, their husbands, and health care providers. It was also decided that health care providers, lady health workers (Prime Ministers Lady Health Worker Program), and community positive contacts would need to be trained to assist as one-to-one counselors in order to ensure that a large portion of identified pregnant women and their husbands would be reached in the project time frame for implementation of the IEC campaign. [Note: this proved to be logistically impossible due to time constraints faced after the prolonged time required for development and production of IEC materials].

Drafts of the emergency booklet and posters (eclampsia, postpartum hemorrhage, obstructed labor, puerperal sepsis) were sketched by Mr Pollard, with the assistance of Dr. Shehla Naseem and all individuals involved in the formative research data collection (Dr. Sipar Zia Zaidi, Ms Fainaana Farnaam, Ms Shahida Parveen, Mr Salim Simon and Mr Dildar Baloch). Information collected from Korangi 8, particularly from women with obstetric complications (as well as in the structured interviews with women, men and health care providers), was utilized in development of stories and graphics for the IEC materials (i.e. the story presented in the emergency booklet is based on an actual antepartum hemorrhage case witnessed by the project coordinator in Korangi 8). Moreover, in order to boost the image and credibility of JPMC, the messages would state that due to the intervention at JPMC, the life of the woman was saved. All IEC materials were closely reviewed by Dr. Sadiqua Jafarey for technical accuracy as well as the translations in Urdu. Graphics were created on the computer by Mr. Aslam Bashir, of the Aga Khan University AudioVisual Department, with assistance from Dr. Shehla Naseem.

Pre-testing of the IEC materials (emergency booklet, antenatal card, four complication posters) was conducted by the field team (Ms Fainaana Farnaam, Ms Shahida Parveen, Mr Salim Simon and Mr Dildar Baloch) in various low socio-economic urban communities similar to Korangi 8 for eight days, from mid to late October, 1997 (prior to Mr Pollard's second visit on October 30, 1997). The pre-testing sample was approximately 10 women and 10 men, and the primary purpose of the pre-testing was to assess comprehension of messages and graphics developed for the IEC materials. Some minor changes were made after discussing the results of this pre-testing with Mr Pollard.

All IEC materials were reviewed by the SMP technical team (Dr. Fariyal Fikree, Dr. Sadiqua Jafarey, Nazo Kureshy) several times and also reviewed by the trainers in the health care provider training program. The process of IEC material development spanned almost nine months. Several minor modifications to enhance the IEC materials, in both wording and graphics, continued to be made well after implementation of counseling (*Urdu versions were utilized for counseling*) for the English versions of the IEC materials, with Dr. Abdul Latif Tareen's assistance.

These IEC materials were utilized by six female and two male counselors in counseling 75 pregnant women and 28 men, yielding a total of 103 individuals, which consisted of 26 couples.



SAFE MOTHERHOOD



SOME IMPORTANT MESSAGES

Acknowledgment

We would like to thank all the individuals who provided assistance in conceptualizing and producing this booklet and the other IEC materials (antenatal card and posters) as well as the agencies involved in providing administrative (The Department of Community Health Sciences, The Aga Khan University) and financial support (MotherCare/USAID and The World Bank) for the IEC component of the Safe Motherhood Intervention in Korangi 8, Karachi. In particular, we are indebted to the leadership provided by Mr. Richard Pollard, for technical input, and Dr. Shehla Naseem, Mr. Aslam Bashir, and the field team members, for development of the IEC materials.

We also wish to thank the women of Korangi 8, who participated in the process of sharing their painful experiences in order to provide sound material necessary to create appropriate IEC materials and to meet the objectives of the Safe Motherhood Intervention.

Dr. Fariyal Fikree Dr. Sadiqua Jafarey Nazo Kureshy

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During pregnancy, check-ups are essential for maintaining the health of a pregnant woman and her baby. These check-ups should be done by a doctor at least three times, i.e during 3-4 months, 6-7 months, and 8-9 months of pregnancy. Check-ups will ensure normal progression of pregnancy and will reveal any complications in a timely manner.



Every pregnant woman should take iron and folic acid tablets. These tablets will make her healthier and reduce tiredness. These tablets are not expensive and can be obtained from a chemist.



A pregnant woman sometimes cannot eat a full meal. In such instances, she should try to eat less but more frequently. A pregnant woman needs more food than normal to ensure proper development of the baby. If possible, lentils, vegetables, eggs, meat, and fruit should be included in a pregnant woman's diet.



During pregnancy, tetanus toxoid vaccination is important for the protection of the mother and her baby against tetanus. These injections should be given during the 6th and 7th months of pregnancy.



The doctors and staff of The Department of Community Health Sciences at The Aga Khan University are holding community meetings in our area to help our pregnant women in prevention, early diagnosis and treatment of obstetric emergencies. Simultaneously, they are implementing a training program for all the health care providers in our area in order to improve their ability to manage life threatening obstetric complications. This training will assist them in providing better care/services to our pregnant women who may experience complications during pregnancy, delivery, and postpartum periods.

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Even if a pregnant woman has regular checkups, takes iron and folic acid tablets every day, eats well, and has tetanus toxoid injections, emergency situations can arise either during her pregnancy, at the time of delivery, or after delivery. A wise family understands this and makes a plan for actions they would take if an emergency arises.

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In order to understand what can happen in an obstetric emergency, we would like you to listen to a story about a pregnant woman who experienced a complication.



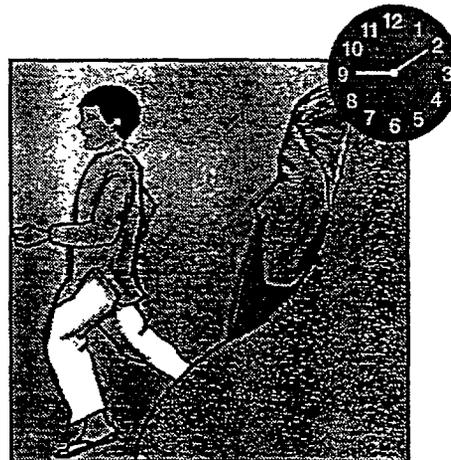
Shaista was pregnant for the first time. During the 7th month of her pregnancy, she woke up and found some blood on the bedsheet.



Shaista's husband had to go to work, so Shaista's mother-in-law prepared a tiffin (lunch box) for him to take to work.

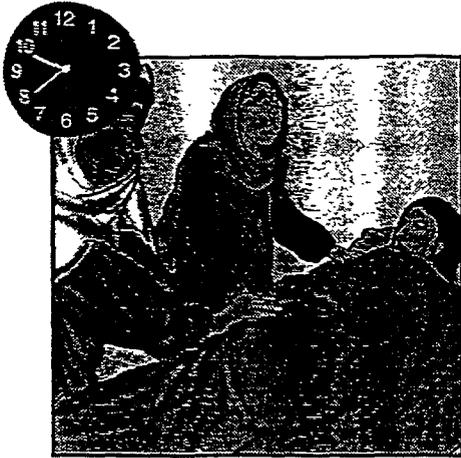


Two hours after Shaista's husband's departure, her bleeding and weakness increased so her mother-in-law assisted her to get into bed.

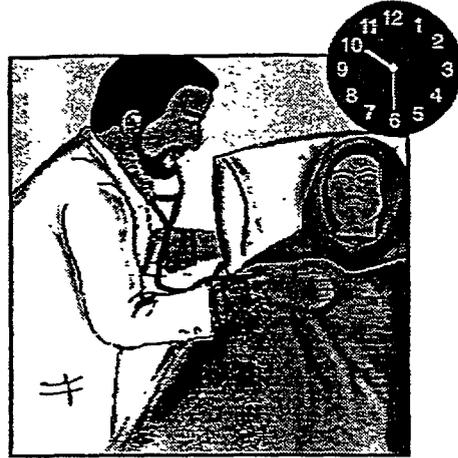


Shaista's mother-in-law then sent her younger son, Arif, to ask the dai to come to their home.

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Seeing Shaista's condition, the dai sent for the nearest local doctor.



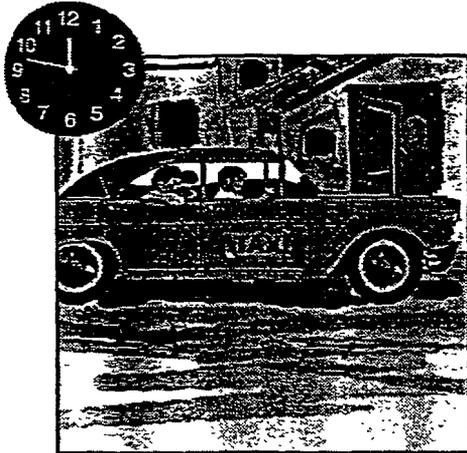
After examining Shaista, the doctor advised the family that she needed to be taken to a nearby maternity home/clinic.



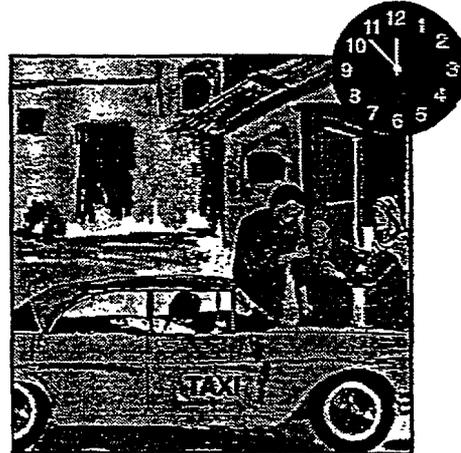
Since Shaista's husband, Jamal, was not home, Arif, his younger brother, was sent to his workplace to bring him home.



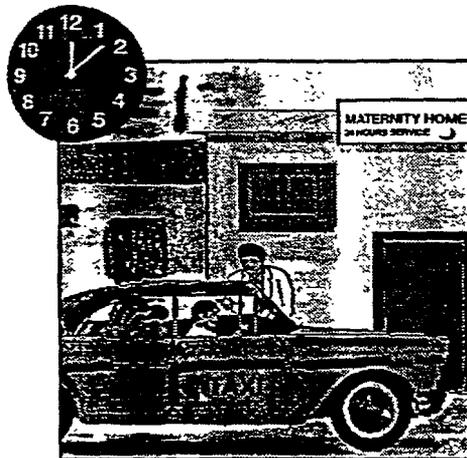
Arif found Jamal busy at work in the factory.



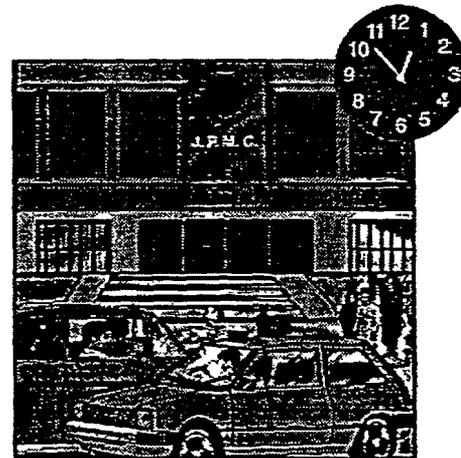
Both brothers took a taxi home.



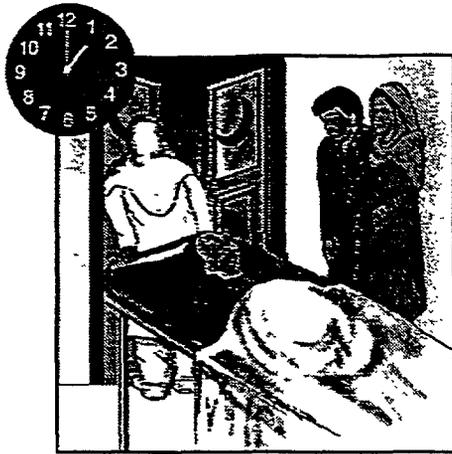
Jamal and his mother escorted Shaista to the taxi.



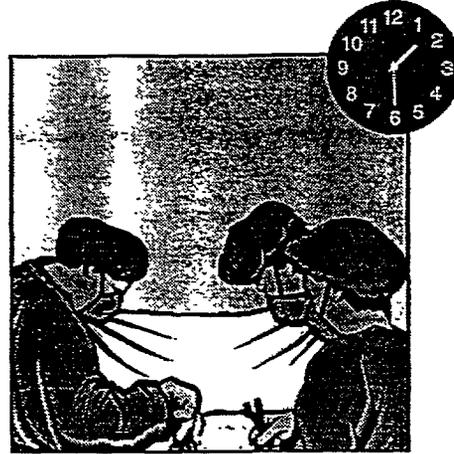
Shaista was taken to a maternity home nearby. Upon hearing Shaista's history, the doctor there advised the family to take her to Jinnah Post Graduate Medical Centre (JPMC) immediately.



Shaista was taken to the Main Emergency at JPMC and was directed to the Obstetrics & Gynecology Emergency (Wards 8 & 9).



By that time, Shaista had bled a lot. She was immediately received by the Department of Obstetrics & Gynecology (Wards 8 & 9).



After making necessary arrangements for blood and anesthesia, an emergency operation was performed.



The doctor at JPMC informed Shaista's family that she was all right but the baby was delivered dead. The doctor also told the family that if Shaista had been brought to the JPMC (Wards 8 & 9) earlier, the life of the baby could have been saved.

WHAT CAUSED THE DELAY?

Shaista experienced a serious bleeding problem at six in the morning. From that time until two in the afternoon, when she was operated upon, eight hours had elapsed. The doctor at JPMC told her family that the baby could have been saved if they had brought her to the hospital earlier.

What delayed the arrival of the woman to the hospital?



When Shaista initially began to bleed, her family could have recognized it as a serious condition and called a doctor immediately.



When Shaista's husband, Jamal, was going to work, he could have given permission to his family that if an emergency arose, they could take her immediately to the hospital in his absence. It is essential for families to discuss emergency plans.



Shaista's mother-in-law called a dai to the home, when she could have called a doctor.



The local doctor should have referred Shaista directly to JPMC (Wards 8 & 9) rather than sending her to a small maternity home/clinic with inadequate facilities.



Arif lost valuable time in going to the factory and searching for his brother, Jamal. Jamal should have given permission and arranged for his wife to be taken to the hospital even if he was not at home.



Shaista was first taken to the Main Emergency at JPMC. Her family should have taken her directly to Obstetrics & Gynecology Emergency (Wards 8 & 9) within JPMC.



ANTEPARTUM HEMORRHAGE



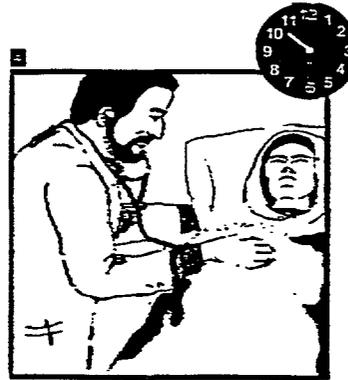
1 Shamim was pregnant for the first time. One evening, during her 7th month of pregnancy, she experienced some spotting, which turned to frank bleeding by the next morning.



2 Her husband worked in a nearby factory, and he left for work, as usual, early in the morning.



3 Shamim's mother-in-law sent her younger son, Arif, to call a *doi* to their house. The *doi* came but suggested that they call a doctor also.



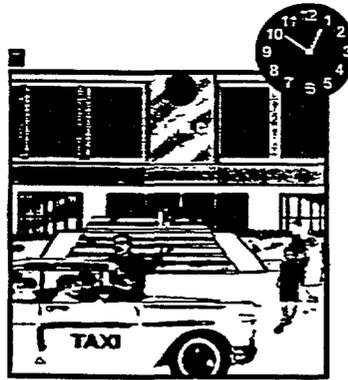
4 When the doctor came and saw Shamim's condition, he advised that she should be taken to JPMC immediately.



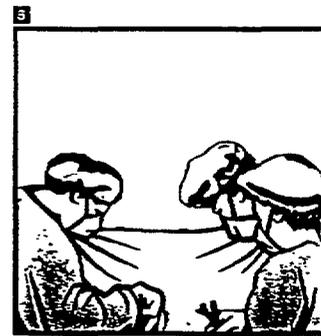
5 Arif was sent to the factory to look for Saleem and, after some time, found him working on a machine.



6 Both of them arrived home in a taxi and took Shamim to JPMC in a taxi.



7 When they reached the Obstetrics & Gynaecology Emergency (Wards 8 & 9) at JPMC, Shamim's condition was poor.



8 She was admitted there and operated upon. The efforts of the doctors saved her life but the baby could not be saved.



9 The hospital surgeon told Shamim's family that the serious situation could have been avoided, and the life of the baby could have been saved also, if the family had brought her to the JPMC (Wards 8 & 9) earlier.

IF A PREGNANT WOMAN HAS SPOTTING THAT CONTINUES FOR MORE THAN ONE DAY OR FRANK BLEEDING, WITH OR WITHOUT PAIN, SHE SHOULD IMMEDIATELY BE TAKEN TO JPMC (WARDS 8 & 9)





POSTPARTUM HEMORRHAGE



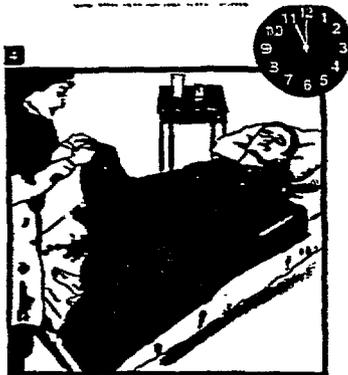
1 Samina delivered her fifth baby at home with a dai's assistance. There was a delay in the delivery of the placenta but the dai managed to remove it. It was 7 o'clock in the evening when the dai left for her own home.



2 Samina's family was excited by the newborn and gathered around him. Samina was lying on the bed, covered by a blanket, and she was feeling weak.



3 Around 10 PM, Samina started having cold sweats. She told Anjum, her sister-in-law, that she was feeling faint. Anjum became worried and immediately sent for the dai.



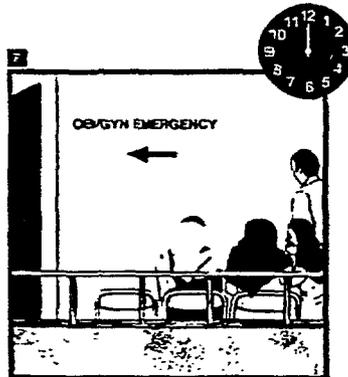
4 When the dai arrived at 11 PM and removed Samina's blanket to examine her, she found the bed sheet soaked with blood.



5 The dai became worried and immediately asked the family to call a doctor.



6 The doctor came, and upon seeing Samina's condition, he advised the family members that Samina should be taken to JPMC immediately since she was in shock and had lost a lot of blood.



7 Samina's husband, Shafiq, took her to JPMC Obstetrics & Gynecology Emergency (Wards 8 & 9), where she was admitted.



8 Samina was given three bottles of blood and the doctors explored and evacuated the uterus.



9 The doctors told Samina's family that a piece of the placenta had been left in the uterus, due to which she lost a lot of blood. They explained to her dai that the placenta should not be removed forcibly and that it should be examined for completeness after it is expelled. Moreover, patients such as Samina should be observed for a while for occurrence of bleeding. If bleeding is heavy, then they should immediately be referred to JPMC (Wards 8 & 9).

IF A WOMAN BEGINS TO BLEED HEAVILY DURING CHILD BIRTH, OR SOON AFTERWARDS, SHE SHOULD IMMEDIATELY BE TAKEN TO JPMC (WARDS 8 & 9)



ECLAMPSIA



1 Ameena was full term pregnant with her first baby. She often suffered from headaches. Her hands and feet had also become swollen.



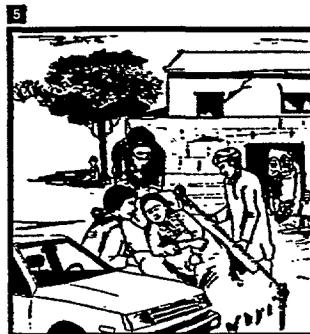
2 One night her husband, Saeed, woke up hearing noises. He saw that Ameena's condition was abnormal. Froth was coming out from her mouth and she was having fits.



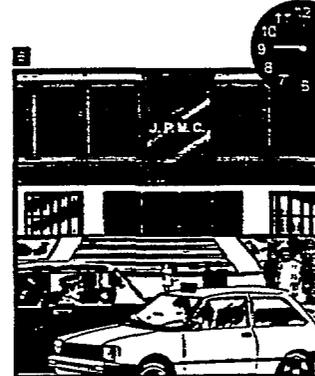
3 Saeed woke up his family and they called an *Amil Baba* to dispel the evil spirits. Despite the *Amil Baba's* attempts, Ameena's condition did not improve.



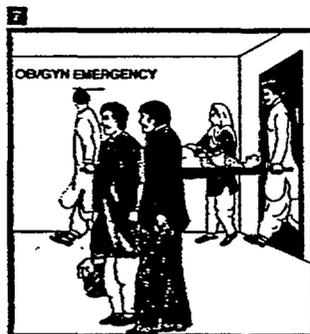
4 The family then called a doctor, who advised them to take Ameena to JPMC immediately.



5 Ameena was taken to the hospital in a taxi.



6 They reached the main emergency at JPMC.



7 From there, they were sent to the Obstetrics & Gynaecology Emergency (Wards 8 & 9) at JPMC, where Ameena was admitted.



8 Ameena was kept in isolation, and a drip was started immediately. She was also given some medications. One hour later, she delivered a baby who died soon after being born.



9 The doctors at JPMC told Ameena's family that her condition could have been prevented if she had prenatal check-ups, especially blood pressure checks, done during her pregnancy. The baby could also have been saved if the family had brought Ameena to JPMC (Wards 8 & 9) earlier.

IF A PREGNANT WOMAN HAS FITS, SHE SHOULD IMMEDIATELY BE TAKEN TO JPMC (WARDS 8 & 9)





OBSTRUCTED LABOR



1 Salma was expecting her third baby any day. She wanted to have her baby delivered at home by a midwife. Her husband, Ahmed, was a pick-up driver and sometimes remained away from home for several days.



2 Early one morning, Salma started to have labor pains. Ahmed was not home, so she sent her son to call Rubina, her sister-in-law, and Sakina, a doctor.



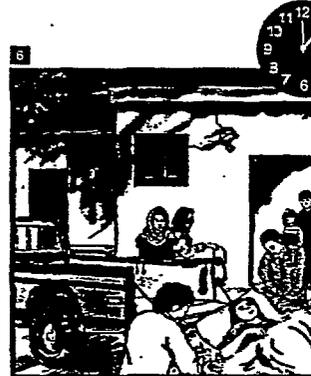
3 Both of them lived nearby and arrived soon. *Dr. Sakina* examined her and said that the delivery would most probably take place in the evening and went away.



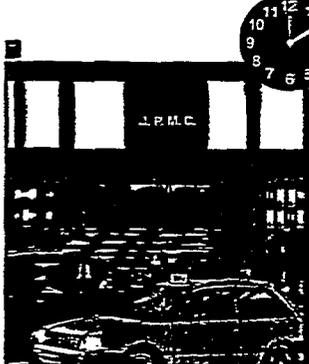
4 Salma experienced labor pains all day. When *Dr. Sakina* came to see her again in the evening, she was surprised since there was no progress in labor. She called the more experienced *Dr. Halem*, who gave Salma an injection to hasten the delivery.



5 Some more hours passed and Salma's condition became worse. She started sweating and felt drowsy. Therefore, both *doctors* advised that Salma should be taken to JPMC. Since it was midnight, Rubina wanted for Salma's husband Ahmed, or her brother Hakeem, to arrive. Salma asked Rubina to wake up her children so she could see them one last time.



6 Around 1 AM, Hakeem arrived with a pick up and began to make preparations to take Salma to the hospital. Some of the neighbours also accompanied them so that they could donate blood at the hospital, if needed.



7 At approximately 2 AM, they arrived at the Obstetrics & Gynecology Emergency (Wards 8 & 9) at JPMC.



8 Salma was immediately taken in and examined. The doctors decided to operate immediately, since the baby's position was wrong and the uterus had ruptured. Salma needed three bottles of blood and delivered a dead baby by an abdominal operation.



9 The timely efforts of the doctors saved Salma's life. The doctors told her family that the baby could have been saved if they had brought Salma to JPMC (Wards 8 & 9) earlier.

ANY WOMAN WITH A FIRST BABY HAVING LABOR PAINS FOR MORE THAN 18 HOURS, AND THOSE WITH SUBSEQUENT BABIES HAVING PAINS FOR MORE THAN 12 HOURS, SHOULD IMMEDIATELY BE TAKEN TO JPMC (WARDS 8 & 9)

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Ministry of Health
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PUERPERAL SEPSIS



1
Shahida delivered a live baby boy in a small clinic near her house. It was a difficult delivery.



2
Shahida was feeling weak and unwell, but she was very anxious to go home. Therefore, she left the hospital two days after the delivery.



3
The day after Shahida came home, she felt feverish.



4
When her husband, Hameed, arrived home from work in the evening, Shahida's face was flushed due to high fever and she had severe pain in the abdomen, due to which she was unable to move. Hameed's mother was worried and was sitting by Shahida's side.



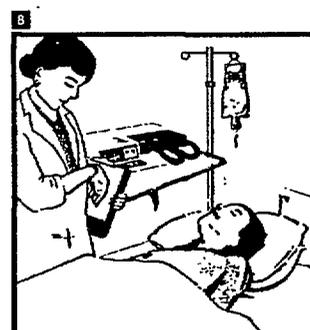
5
Hameed became very worried and immediately rushed to call a doctor from the nearby clinic. The doctor, after examining Shahida, said that she had a severe infection and advised that she should immediately be taken to JPMC.



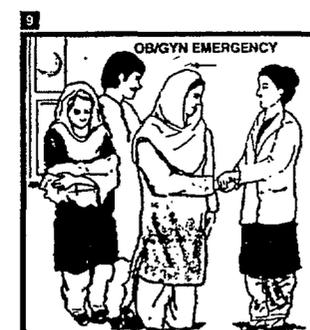
6
Hameed did not delay taking Shahida to JPMC Obstetrics & Gynecology Emergency (Wards 8 & 9).



7
She was admitted to the Obstetrics & Gynecology (Wards 8 & 9) at JPMC.



8
Shahida was given several drips, injections and a bottle of blood. She remained in the hospital for approximately one week.



9
The doctors appreciated the quick decision taken by Hameed to bring his wife to JPMC (Wards 8 & 9) without delay. Due to Hameed's timely decision, Shahida was able to receive treatment at the hospital. Otherwise, she could have died of complications due to infection.

**IF A WOMAN HAS SEVERE PAIN IN ABDOMEN OR HIGH FEVER AFTER
CHILD BIRTH, SHE SHOULD IMMEDIATELY BE TAKEN TO JPMC
(WARDS 8 & 9)**



CARE OF PREGNANT WOMEN



During pregnancy, check-ups are essential for maintaining the health of a pregnant woman and her baby. These check-ups should be done by a doctor at least three times, during 3-4 months, 6-7 months, and 8-9 months of pregnancy. Check-ups will ensure normal progression of pregnancy and will reveal any complications in a timely manner.



Every pregnant woman should take iron and folic acid tablets. These tablets will make her healthier and reduce tiredness. These tablets are not expensive and can be obtained from a chemist.



Pregnant women sometimes cannot eat a full meal. In such instances, she should try to eat less but more frequently. A pregnant woman needs more food than normal to ensure proper development of the baby. If possible, lentils, vegetables, eggs, meat, and fruit should be included in a pregnant woman's diet.



During pregnancy, tetanus toxoid vaccination is important for the protection of the mother and her baby against tetanus. These injections should be given during the 6th and 7th months of pregnancy.



Field Team

IEC Coordinators:

Ms Nazo Kureshy
Dr. Shehla Naseem
Dr. Abdul Latif Tareen

Counselors

Ms Asia Masood
Ms Saima Saeed
Ms Fainaaana Farnaam
Ms Shahida Parveen
Ms Nargis Asfandyar
Ms Shaheen Asfandyar
Mr Salim Simon
Mr Aijaz Qureshi

Counselor Training:

(Initial) Technical Content

Dr. Sadiqua Jafarey
Dr. Abdul Latif Tareen

(Initial) Process of Counseling

Ms Kausar S. Khan
Ms Farah Mawani

(On-going) Quality of Counseling Sessions & Note taking

Ms Nazo Kureshy
Dr. Abdul Latif Tareen
Ms Fatima Sajan

Data Collection for Counseling Evaluation:

Dr. Nilofar Sami
Mr Zulfiqar Rao

Questionnaire

1. Date Identified: / /

2. CHS#: _____

3. Address: _____

4. Sector: _____

1. 8A

2. 8B

3. 8C/MAG

4. 8D

5. 8E

6. 8F

5. Ethnicity: _____

1. Urdu

2. Baluchi

3. Sindhi

4. Hindko

5. Punjabi

6. Pushto

7. Other (specify) _____

6. Women's name: _____

7. Husband's name: _____

8. Wife's age: _____

9. Gravidity: _____

(Note:-Please include Abortion, Still births, Live births, pregnancy count)

10. Are you currently pregnant? _____

1. Yes => Q11

2. No => Q12

11. Month of gestation: _____

12. Last Menstrual Periods (LMP): _____

13. Expected date of delivery (EDD) / /

14. Expected place of delivery: _____

15. Was a dai present during your last delivery? _____

1. Yes =>Q16 2. No =>Q17

16. Name of the dai: _____

17. Name of health Care Provider (HCP) (During illness): _____

1. Doctor 2. Non-Doctor 3. LHV/Midwife 4. TBA 5. Others (specify) 6. None

18. Name of health Care Provider (HCP) (During pregnancy): _____ 1.

Doctor 2. Non-Doctor 3. LHV/Midwife 4. TBA 5. Others (specify) 6. None

19. Name of Interviewer: _____

Signature of Interviewer

Date:

Signature of Supervisor

Date:

Details of Field Work

Total households attempted	5,911
Total number of identified pregnant women:	630
First Trimester	208
Second Trimester	233
Third Trimester	189
Total number of non-pregnant women	3,260

Distribution of Pregnant women by ethnicity and period of gestation

Ethnicity	Period of Gestation			Total
	First Trimester	Second Trimester	Third Trimester	
Pushto	68	82	88	238
Urdu / Punjabi	94	88	59	241
Others	46	63	42	151
Total	208	233	189	630

Counselor's Notes

Date: ----/--/--

CHS # : -----

Time: _____ to _____

COUNSELOR:

Session Number:

OBSERVER:

COUNSELING SETTING

Introduction:

[what reaction did the respondent &/or family give on your introduction]

Environment:

[where you sat, how you were welcomed etc]

Obstacles & Barriers:

[interruptions by children, preparation of food, other guests coming in, other members of the family, primary respondent not paying attention and why not ...]

PREVENTION

Previous Pattern:

[has the woman received ANC previously and why did she go]

Obstacles:

[what were the reasons that she did not go....costs, lack of knowledge, transport not available, chaperone needed, family beliefs that ANC or TT shots not necessary , mobility restrictions...]

Feedback on response:

[understanding of preventive care, what this means in terms of ANC, how the primary respondent understands preventive care...]

EMERGENCY PLAN

Prior emergency plan:

[Describe whether an emergency plan was made prior to counseling, what would they do if such an obstetric emergency or any other health related emergency occurred when husband or elder male member not home, describe the plan made if not made why not ... what were the barriers to making such a plan like they did not think it necessary, never been exposed to such an emergency]

Previous delivery:

[was any sort of emergency plan made in her previous delivery; also comment if the couple/family have now been convinced or otherwise of making an emergency plan]

HEALTH SEEKING BEHAVIOR**Health care providers:**

[General information about who the primary respondent usually goes to for health care and then specifically who does she generally go to for ANC or problems during pregnancy, does she make an independent decision as to from whom she can seek care or if this a decision made by others - if made by others then list by whom and who makes the final decision]

Local clinics:

[impression of local clinics and why]

JPMC:

[impression and why ... if have had or have heard of an unfavorable experience then describe]

Other large hospitals:

[impression of local clinics and why]

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Attendant and Place of delivery for last delivery:

[Who was the attendant and place of last delivery, who decided to opt for the attendant, was the woman involved in the decision making process]

Names of health care provider consulted during last pregnancy:

[List the names and whether they were visited at home or went to a facility]

AFTER COUNSELING

JPMC :

[will they now refer to JPMC and why will they now go to JPMC so as to depict the reason for the change in attitude]

OTHERS

Attitude:

[how did they welcome us, the woman and family members response overt and covert to our presence, pay attention to the counseling]

Comments on IEC material:

Comments on Project:

Questions asked:

[list significant questions asked during counseling which you could and could not answer

Counselors Comments:

[describe in your own words how you felt that the counseling went, were you satisfied that the main messages that you were trying to get across was conveyed]

Observer's Notes

DATE ---/---/--- CHS # TIMEto..... SESSION #

RESPONDENT :

COUNSELLOR :

OBSERVER :

Others present during counseling: [Name + relationship]

IEC MATERIAL COVERED.

ANC
E. BOOKLET.....
PPH
APH
ECLAMPSIA
OBS. LABOR
SEPSIS
PREVENTION

Interruption : [List how many, for what reason ... child needing attention, for clarification etc]

Summarization conducted : Y / N

Assessment of understanding : Good / Average / Poor

Obstacles : [mother-in-law dominating, young children needing attention, husband present etc.]

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ITEMS TO BE CHECKED DURING OBSERVATION

Item to be Observed	Parameters	Participatory	Speech Flow	Overall Assessment		
Introduction	Self	Y / N		Fast	Good	
	Project	Y / N		Moderate	Average	
	Asked for time	Y / N		Slow	Poor	
Antenatal card	Check-up	Y / N	Woman allowed to talk	Y / N	Fast Moderate Slow	Good Average Poor
	Diet	Y / N	Listened to what woman said	Y / N		
	Folic Acid	Y / N	Gave opportunity to ask question/s	Y / N		
	TT injections	Y / N	Encouraged woman to ask questions	Y / N		
	Emergency messages	Y / N	Flow of conversation directed to woman	Y / N		
Emergency booklet	Background of SMP	Y / N	Woman allowed to talk	Y / N	Fast Moderate Slow	Good Average Poor
	Preventive messages	Y / N	Listened to what woman said	Y / N		
	Emergency plan	Y / N	Gave opportunity to ask question/s	Y / N		
	Time delay	Y / N	Encouraged woman to ask questions	Y / N		
			Flow of conversation directed to woman	Y / N		
PPH poster	Quantity of blood	Y / N	Woman allowed to talk	Y / N	Fast Moderate Slow	Good Average Poor
	Time delay	Y / N	Listened to what woman said	Y / N		
	Blood donors	Y / N	Gave opportunity to ask question/s	Y / N		
	Referral to JPMC	Y / N	Encouraged woman to ask questions	Y / N		
	Gynae ward	Y / N	Flow of conversation directed to woman	Y / N		
APH poster	Emergency plan	Y / N	Woman allowed to talk	Y / N	Fast Moderate Slow	Good Average Poor
	Time delay	Y / N	Listened to what woman said	Y / N		
	Referral to JPMC	Y / N	Gave opportunity to ask question/s	Y / N		
	Gynae ward	Y / N	Encouraged woman to ask questions	Y / N		
			Flow of conversation directed to woman	Y / N		
Eclampsia poster	Signs & symptoms	Y / N	Woman allowed to talk	Y / N	Fast Moderate Slow	Good Average Poor
	Cause	Y / N	Listened to what woman said	Y / N		
	Time delay	Y / N	Gave opportunity to ask question/s	Y / N		
	Referral to JPMC	Y / N	Encouraged woman to ask questions	Y / N		
			Flow of conversation directed to woman	Y / N		
Prolonged / obstructed labor poster	Check-up	Y / N	Woman allowed to talk	Y / N	Fast Moderate Slow	Good Average Poor
	Emergency plan	Y / N	Listened to what woman said	Y / N		
	Time delay	Y / N	Gave opportunity to ask question/s	Y / N		
	Blood donors	Y / N	Encouraged woman to ask questions	Y / N		
	Referral to JPMC	Y / N	Flow of conversation directed to woman	Y / N		
	Gynae ward	Y / N				
Puerperal sepsis poster	Signs & symptoms	Y / N	Woman allowed to talk	Y / N	Fast Moderate Slow	Good Average Poor
	Quick decision-making	Y / N	Listened to what woman said	Y / N		
	Cause Referral to JPMC	Y / N	Gave opportunity to ask question/s	Y / N		
			Encouraged woman to ask questions	Y / N		
			Flow of conversation directed to woman	Y / N		

Evaluation Questionnaire

Name _____ w/o or h/o _____

I.D. Code _____ Form _____
Pre [1]
Post [2]

CHS Number _____ Gender _____
Male [1]
Female [2]

MODULE ONE : PREVENTION

Question One

What are the important preventive measures that a woman can take during pregnancy?

1. Tetanus toxoid injections
2. Iron / Folic Tablets
3. Only Check-ups [general]
4. Blood pressure check-up
5. Position of baby / fetus
6. Diet mentioned
7. Diet [mention quantity or quality]
8. Decrease work load
9. Do not carry heavy weight
10. Others [Specify]
11. Don't know
12. No response

Question Two

What is the minimum number of check-ups a woman should have during pregnancy?

1. Once
2. Twice
3. Thrice
4. More than three times
5. Whenever there is a need / problem
6. No need
7. Others [Specify]
8. Don't know
9. No response

Question Three

When should she have these check-ups?

1. **During first, second and third trimester [3 - 4; 6 - 7 and 8 - 9 months]**
2. **Every fortnight / month**
3. **Others [Specify]**
4. **Don't know**
5. **No response**

Question Four

Have you discussed/made and emergency plan with your family? [*Post counseling only*]

1. **Husband / elder family member discussed and permission given or arrangement made**
2. **Husband / elder family member discussed and permission not given or arrangement not made**
3. **Not discussed**
4. **Others [specify]**
5. **Don't know**
6. **No response**
7. **Not asked**

MODULE TWO : PREGNANCY AND DELIVERY

Question Five

What kinds of serious pregnancy and delivery related problems can a woman experience?

1. Weakness
2. Post maturity
3. Vaginal bleeding
4. Antepartum hemorrhage
5. Postpartum hemorrhage
6. Stillbirth
7. Abortion
8. Obstructed / prolonged labor
9. Malpresentation
10. Puerperal sepsis [fever after delivery]
11. Low blood pressure
12. Hypertension
13. Fits [eclampsia]
14. Maternal death
15. Others [Specify]
16. Don't know
17. No response

Question Six

For which of the above serious problems would a woman have to go to JPMC?

1. Weakness
2. Post maturity
3. Vaginal bleeding
4. Antepartum hemorrhage
5. Postpartum hemorrhage
6. Stillbirth
7. Abortion
8. Obstructed / prolonged labor
9. Malpresentation
10. Puerperal sepsis [fever after delivery]
11. Low blood pressure
12. Hypertension
13. Fits [eclampsia]
14. Maternal death
15. Consult doctor
16. Others [Specify]
17. Don't know
18. No response

Question Seven

Could blood pressure control during pregnancy prevent fits?

1. Yes
2. No
3. Others [Specify]
4. Don't know
5. No response

Question Eight

What should be done if a woman has fits during pregnancy childbirth or soon after?

1. Leave to God
2. Cannot go anywhere without husband's permission
3. Go to JPMC
4. Go to Obs/Gynae ward; JPMC
5. Go to nearest hospital
6. Go to nearest health care provider
7. Others [Specify]
8. Don't know
9. No response

ANTEPARTUM HEMORRHAGE

Question Nine

When could spotting during pregnancy become serious?

1. Initial one spot
2. Spotting \geq one day
3. Frank bleeding
4. Others [specify]
5. Don't know
6. No response

POSTPARTUM HEMORRHAGE

Question Ten

What should be done if there is heavy bleeding after delivery?

1. Consult doctor
2. Consult LHV/Nurse
3. Consult dai
4. Go to JPMC
5. Go to JPMC with donors
6. Go to nearest hospital
7. Others [Specify]
8. Don't know
9. No response

OBSTRUCTED LABOR

Question Eleven

What should be done if labor pains begin but delivery does not take place?

1. Consult doctor
2. Consult LHV/Nurse
3. Consult dai
4. Go to JPMC
5. Go to nearest hospital
6. Others [Specify]
7. Don't know
8. No response

Question Twelve

What time period (hours) between onset of labor pains and lack of delivery is considered dangerous?

1. Primips ≥ 18 hours
2. Multips ≥ 12 hours
3. Strong labor pains for less than 12 hours
4. Others [Specify]
5. Don't know
6. No response

MODULE THREE : POSTPARTUM PERIOD

Question Thirteen

What should be done if there is bleeding a few days after delivery?

1. Consult doctor
2. Consult LHV/Nurse
3. Consult dai
4. Go to JPMC
5. Go to JPMC with donors
6. Go to hospital
7. Others [specify]
8. Don't know
9. No response

Question Fourteen

After delivery, what is the reason a woman could have high fever and abdominal pain?

1. Genital tract infection [include retained piece of placenta]
2. Breast infection
3. Others [Specify]
4. Don't know
5. No response

Question Fifteen

What should be done in such a case?

1. Consult doctor
2. Consult LHV/Nurse
3. Consult dai
4. Go to JPMC
5. Go to JPMC with donors
6. Go to nearest hospital
7. Others [specify]
8. Don't know
9. No response

Note: In all responses of action [Question numbers 6, 8, 10, 11, 13, 15 put in the first response]

Case study

Antenatal care

Mrs X, a Punjabi primigravida, listened carefully to the preventive messages regarding antenatal care and tetanus toxoid injections conveyed to her during the counseling session. On subsequent visits, she stated that she had convinced her husband to take her to a nearby clinic for a check-up and even had tetanus toxoid immunizations.

Tetanus toxoid immunization

Counseling Mr Y, a Pathan shop-keeper regarding Safe Motherhood inspired him to take an interest in the quality of antenatal care offered to his wife. Realizing that tetanus toxoid immunization is part of the package of antenatal care and had not been offered to his wife, routinely attending a nearby hospital for antenatal care, lead Mr Y to accompany his young wife to the hospital and demand that she be immunized.

Eclampsia

Mr K, a Pathan factory worker, took his primigravida wife to a nearby clinic for antenatal care following our counseling sessions. Though the care offered by the clinic included blood pressure measurements, tetanus toxoid immunization, iron and folate acid tablets, his wife complained of severe headache followed by convulsions a couple of days later. Realizing that this could lead to a life-threatening obstetric complication and remembering that he had been strongly advised to take his wife urgently to a nearby hospital, Mr K immediately took this wife to a nearby private hospital where he was advised cesarean section. However, he transferred his wife immediately to JPMC where a cesarean section was performed. When the male counselor visited the hospital, Mr K warmly welcomed him and emphasized that without our counseling he would not have realized the gravity of the situation.

We confirmed this information by examining the hospital records. Mrs K, was admitted on May 21, 1998 with the admitting diagnosis of eclampsia and fetal distress. A cesarean section was performed and a 2.5kgs baby girl was delivered with one and five minute Apgar scores of 2 and 4 respectively. Condition of both mother and baby were satisfactory on discharge.

Prolonged labor

A young Bengali woman, Mrs Z, gravida 3, para 1, planned a home delivery with the assistance of a TBA. However, when labor lasted for over eight hours, Mrs Z perceived that the delay in delivery could have serious consequences. She remembered discussing the various possible obstetric complications with the counselors. Furthermore, she reflected over the fact that discussions and re-examining the posters and emergency booklet had lead her husband to make an emergency plan in case of such an eventuality. She then took the decision to call her husband into the “laboring room” and discuss with him her desire to go to a hospital as she had the foreboding that the prolonged labor could have life-threatening consequences either for herself or her unborn child. Transfer to JPMC was immediately undertaken accompanied by the dai. Mrs Z had a safe vaginal delivery under the care of obstetricians at JPMC.