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GUEST EDITORIAL

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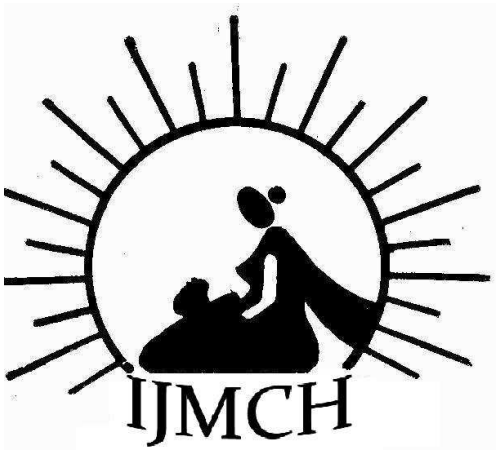

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GUEST EDITORIAL

BIRTH PREPAREDNESS AND COMPLICATION READINESS: IS IT A REALITY?

Dr. S. S. Kushwah

Dean, Professor & Head

Department of Community Medicine

S. S. Medical College, Rewa, MP (INDIA)

Email: drsskushwah@hotmail.com

- *A woman was brought to a rural nursing home. Hemoglobin was 3gms%. System knew she was not going to survive. Paper work done. She collapsed during the second blood transfusion. (January'06)*
- *A woman in labour started to bleed. The Dai was called. Realizing the emergency, she called for a vehicle. The woman's husband walked for several miles to the ANM, brought her back but the woman did not survive.* (Barmer 2003)

The above two cases [(1)] show that the manifestation of ill health is much beyond the institutional arena and physical access to emergency obstetric services is still a challenge for many women in rural areas.

We all know that Maternal Mortality is a substantial burden in developing countries. Data generated by WHO indicated that more than half a million women were dying each year from the complications of pregnancy and childbirth, with nearly 99% of these deaths occurring in the developing world. Across all developing countries for every 100,000 live births, 450 women died during pregnancy, childbirth, or the postpartum period. By comparison, the figure for the developed world was 30.[(2)] A woman's life time risk of dying from pregnancy and child birth is estimated to be 1 in 2800 in developed world compared to 1 in 61 in all developing countries. More than half of all maternal deaths in the world are estimated to occur in these seven countries: Afghanistan, Bangladesh, Congo, Ethiopia, India, Nigeria, and Pakistan.[(3)] The figures states that in every five minutes, one woman somewhere in India dies from pregnancy related complications amounting to one lakh maternal deaths and 10 lakh newborn deaths each year.

The Indian Government estimates that 301 women die annually for every 100,000 live births. In some states the maternal mortality ratio is even higher, 358 in Orissa, 371 in Bihar and 379 in MP. All these data state the poor condition of pregnant women especially in developing countries like India.

Improving maternal mortality has received recognition at the global level as evidenced by the inclusion of reducing maternal mortality in the Millennium Development Goals. To address high level of MMR, RCH II & NRHM were launched on 1st and 5th April 2005 respectively. Its innovative approaches were implemented with objective to improve access to skilled care & emergency obstetric care.(4)

Women and newborns need timely access to skilled care during pregnancy, childbirth, and the postpartum/newborn period. Too often, however, their access to care is impeded by delays—delays in deciding to seek care, delays in reaching care, and delays in receiving care. These delays have many causes, including logistical and financial concerns, unsupportive policies, and gaps in services, as well as inadequate community and family awareness and knowledge about maternal and newborn health issues. For example:

- **Delays in deciding to seek care** may be caused by failure to recognize signs of complications, failure to perceive the severity of illness, cost considerations, previous negative experiences with the healthcare system, and transportation difficulties.
- **Delays in reaching care** may be created by the distance from a woman's home to a facility or provider, the condition of roads, and a lack of emergency transportation.
- **Delays in receiving care** may result from unprofessional attitudes of providers, shortages of supplies and basic equipment, a lack of healthcare personnel, and poor skills of healthcare providers.

The causes of these delays are common and predictable. However, in order to address them, women and families—and the communities, providers, and facilities that surround them—must be prepared in advance and ready for rapid emergency action.(5)

In this context, Birth-preparedness is a comprehensive strategy to improve the use of skilled providers at birth, the key intervention to decrease maternal mortality.

Birth Preparedness and Complication Readiness (BP/CR) is a strategy to promote timely utilization of skilled maternal and neonatal care, based on the theory that preparing for childbirth and being ready for complications reduces delays in obtaining this care. [2] In a skilled care approach, birth preparedness includes identifying a skilled provider and making the necessary plans to receive skilled care for all births. Complication readiness (emergency funds, transport, blood donor and designated decision-maker) receive greater emphasis in emergency obstetric care programs.[2] Birth preparedness has been globally endorsed as an essential component of safe motherhood programs to reduce delays for care.[2]

A birth plan/emergency preparedness plan include identification of following elements: knowledge of danger signs; the desired place of birth; the preferred birth attendant; the location of the closest appropriate care facility; funds for birth-related and emergency expenses; a birth companion; support in looking after the home and children while the woman is away; transport to a health facility for the birth; transport in the case of an obstetric emergency; and identification of compatible blood donors in case of emergency.[2]

Because life-threatening complications can occur during the early postpartum period, birth preparedness also includes preparing/planning for accessing postpartum care during the first week after delivery and at six weeks after delivery. Birth-preparedness (BP) also reduces delays in receiving appropriate care. It calls on providers and facilities to be prepared to attend births and ready to treat complications, which is called Complication Readiness.

Birth preparedness involves not only the pregnant woman, but also her family, community and available health staff & facility. The support and involvement of these persons can be critical in ensuring that a woman can adequately prepare for delivery and carry out a birth plan. Thus Birth-preparedness & Complication Readiness can be used at various levels. It can be at:

- **Individual level**: this includes knowledge of various danger signs of pregnancy & any sign and symptoms leading to some type of complication with them. A woman is considered as prepared for birth and its complication if she had identified place of delivery, saved money and identified a means of transport to place of childbirth or for the time of obstetric emergencies ahead of childbirth.

- **Family level:** Family should arrange for transport, money, blood donor & should identify health personnel who could be a help at the time of transport and at health facility centre or should be prepared for any kind of complication with the pregnant women. They also support pregnant woman's plans during pregnancy, childbirth and the postpartum period. Decision making authority should lie with key person of the family.
- **Community level:** Includes facilities which the community provides to the pregnant women like transport services, financial help etc. There is a need to include the family members in intense IEC activities. Husbands should also be encouraged to accompany wives during antenatal visits. It advocates and facilitates preparedness and readiness actions.
- **Institutional level:** To have birth preparedness and complication readiness at the provider level; nurses, midwives, and doctors must have the knowledge and skills necessary to treat or stabilize and refer women with complications, and they must employ sound normal birth practices that reduce the likelihood of preventable complication. Facilities should have necessary logistics to provide basic and comprehensive emergency obstetric services. It should be equipped, staffed and managed to provide skilled care for the pregnant woman and newborn and should also provide immediate and prompt treatment to any pregnant women seeking health care facility.

Responsibility for BP/CR must be shared among all safe motherhood stakeholders—policymakers, facility managers, providers, communities, families, and women—because a coordinated effort is needed to reduce the delays that contribute to maternal and newborn deaths. Together, stakeholders can plan for the care that women and newborns need during pregnancy, childbirth, and the postpartum/newborn period, prepare to take action in emergencies, and build an enabling environment for maternal and newborn survival.

For India to achieve the Millennium Development Goal of reducing maternal mortality by three quarters by 2015, social and economic factors like the low status of women in communities, the poor understanding of families on when to seek care, a lack of transport, poor roads, the cost of seeking care, multiple referrals to different health facilities and a delay in life-saving measures in rural areas need to be addressed. Therefore the concept of BP/CR should be

integrated into individual, family, community and service provider level for safe motherhood and reduce maternal mortality during pregnancy & postpartum period.

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