WOMEN'S BIRTH PREPAREDNESS PLANNING AND SAFE MOTHERHOOD AT A HOSPITAL IN SWAZILAND

by

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DECLARATION

I, Khetsiwe Reginah, Joyce Dlamini, student number: 46852654, hereby declare that this study **"Women's Birth Preparedness Planning and Safe Motherhood at a Hospital in Swaziland"** is my own work with assistance from my Supervisor. All sources have been duly cited and acknowledged.

I further declare that this study has not been submitted to any institution for academic purposes.

3rd December 2020.

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ABSTRACT

Background

Pregnancy and childbirth are normal physiological processes but the internal and external circumstances in which the child is conceived and born affect the life of the mother and child. Every pregnancy is associated with unpredictable risks and complications. Therefore, having a birth preparedness and complication prevention plan including safe motherhood are paramount to reduce maternal and infant mortality rates.

Purpose of the study

This study aimed to establish the pregnant women's knowledge, perceptions and practices regarding birth preparedness planning, complication readiness and safe motherhood at Raleigh Fitkin Memorial Hospital to help reduce some of the avoidable causes of maternal and infant mortality rates.

Research design and methods

An exploratory, descriptive and qualitative research design was used for the study. Women who had delivered within a period of one week were purposively selected from the research site and interviewed using a structured interview guide until saturation of data. Ethical considerations were adhered to and measures of trustworthiness were applied. Giorgi's analytic method was used for data analysis.

Findings

The findings revealed that most participants were not well informed about birth preparedness although some had managed to save for baby requirements and hospital fees. Transportation to the hospital for ANC and delivery was a problem to those who ended up delivering their babies at home or on the way to hospital. Knowledge about complications of birth was poor and only a few participants could name bleeding and prolonged labour. Most participants were not sure about safe motherhood, whilst some mentioned contraception and post-natal care.

Conclusion

Evidence from the study reveal that as much as pregnant women prepare baby's clothes and money for labour and delivery, psychological preparation and transport preparation seemed poor. Complication readiness was not known by most participants.

Key concepts:

Antenatal care; birth preparedness plan; delivery; maternal mortality rate; neonatal mortality rate; safe motherhood.

TABLE OF CONTENTS

DECLARATION.. Error! Bookmark not defined.

ACKNOWLEDGEMENTS ii

ABSTRACT i

LIST OF FIGURES i

LIST OF TABLES.. ii

LIST OF ANNEXURES iii

CHAPTER 1 1

ORIENTATION OF THE STUDY.. 1

1.1 Introduction... 1

1.2 Background to the Research.. 2

1.3 Statement Of The Research Problem 5

1.5 Objectives.. 6

1.6 Significance of the Study.. 7

1.7 Definition of key Concepts 7

1.8 Foundations of the Study 9

1.9 Research Design and Methods 10

1.10 Scope of the study... 11

1.11 Ethical Considerations 11

1.12 Outline of the Content 11

CHAPTER 2 13

RESEARCH DESIGN AND METHODS 13

2.1 Introduction... 13

2.2 Research Design..13

2.2.1 Advantages of Qualitative Studies 14

*2.2.2.*Limitations of qualitative studies 14

2.3 RESEARCH SETTING...15.

2.4 TARGET POPULATION..16

2.5 SAMPLING 16

2.6 DATA COLLECTION..17

2,7 RECRUITMENT OF PARTICIPANTS.......................................17

2.8 DATA COLLECTION PROCESS...18

2.9 DATA ANALYSIS..19

2.10 MEASURES TO ENSURE TRUSTWORTHINESS.........................21

2.11 ETHICAL CONSIDERATIONS...22

2.12 CONCLUSION..24

CHAPTER 3 25

RESEARCH FINDINGS 25

3.1 INTRODUCTION 25

3.2 Research Findings... 25

3.2.1 DEMOGRAPHIC INFORMATION 28

3.2.2 REPRODUCTIVE HEALTH INFORMATION 28

3.2.3 ANCCARE ATTENDANCE 29

3.2.4 INFORMATION RECEIVED DURING ANC VISITS......................... 30

3.2.5 PLACE OF DELIVERY 31

3.2.6 PERCEPTIONS ABOUT BIRTH PREPAREDNESS 32

3.2.7 SAVING MONEY FOR BABY REQUIREMENTS............................ 34

3.2.8 IDENTIFICATION OF SIGNS OF LABOUR 35

3.2.9 PSYCHOLOGICAL PREPARATION FOR LABOUR 36

3.2.10 COPING WITH LABOUR AND DELIVERY 37
3.2.11 KNOWLEDGE ABOUT POST-DELIVERY COMPLICATIONS..................... 38
3.2.13 PERCEPTIONS ABOUT SAFE MOTHERHOOD 40
3.2.14 CONCLUSION... 41
CHAPTER 4 42
4.1 DISCUSSION OF ESEARCH FINDINGS……………………………42
4.2.1 DEMOGRAPHIC DATA 43
4.2.1.1 Age 43
4.2.1.2 Marital status 43
4.2.1.3 Level of education.. 44
4.2.1.4 Religious affiliation 44
4.3 BIRTH PREPAREDNESS AND SAFE MOTHERHOOD 45
4.3.1 PARITY OF PARTICIPANTS 45
4.3.2 ANC ATTENDANCE 45
4.3.3 CHOOSING A SAFE PLACE FOR DELIVERY 46
4.3.4 TRANSPORT PREPARATION.. 46
4.3.5 SAVING FOR MOTHER AND BABY 47
4.3.6 PSYCHOLOGICAL PREPARATION FOR LABOUR 47
4.3.7 COMPLICATION READINESS 48
4.3.8 KNOWLEDGE REGARDING SAFE MOTHERHOOD 48
4.4 CONCLUSION.. 49
CHAPTER 5 50
JUSTIFICATION, LIMITATIONS, CONLUSION AND RECOMMENDATIONS..50
5.1 Introduction.. 50
5.2 Research Design and Methods 50

5.3 Justification Of The Study 50

5.4 Limitations Of The Study 50

5.5 Recommendations 51

56 CONCLUSION 53

REFERENCES 54

ANNEXURES 61

LIST OF FIGURES

Figure 1.1 Six pillars of safe motherhood.. 4

Figure 2.1: Map of Swaziland... 15

Figure 3.1: Parity of participants 26

LIST OF TABLES

Table 3.1 Themes and Subthemes……………………………………………36

Table 3.2 Attendance of ANC…………………………………………………37

LIST OF ANNEXURES

Annexure 1: UNISA Ethical Clearance Certificate 61

Annexure 2: RFMH Permission letter 64

Annexure 3: Request Letter to SNHRU 65

Annexure 4: Participant Consent Form.. 66

Annexure 5 SNHRU Clearance Certificate 68

Annexure 6 Research Site Request Letter.. 69

Annexure 7 Language and Editing Certificate...................................... 71

Annexure 8 Interview Guide 72

List of Abbreviations

ANC…………Antenatal care

JHPIEGO…. Johns Hopkins Program for International Education in Gynaecology and Obstetrics

MDG5……..Millenium Development Goal 5.

RFMH…….. Raleigh Fitkin Memorial Hospital.

SNHRU……Swaziland National Health Research Unit.

SDGs………Sustainable Development Goals.

SRH……….. Sexual and Reproductive Health

SSA………..Sub Saharan Africa.

UNICEF……United Nations Children's Fund.

UNFP………United Nations Population Fund.

UNISA…….. University of South Africa

WHO………. World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Childbirth is a normal physiological process for majority of women and a process that like other events is looked upon with a mixture of anticipation and happiness. Acharya, Kaur, Prasuna and Rasheed (2015:127) acknowledge that every pregnancy is a joyful moment for all mothers who dream of a safe pregnancy and healthy baby. However, for many thousands of women each day, child bearing is experienced as a miserable event. Every pregnancy is associated with unpredictable risks and complications. Therefore, having a birth preparedness and complication readiness plan including safe motherhood is considered as one the ways to reduce maternal and infant mortality rates (Affipuguh & Laar 2016: 121; Idowu, Deji, Aremu et al 2015: 47). Countries have a mandate to ensure that maternal and neonatal mortality rates are kept as low as possible. Swaziland is doing her best through the Sexual Reproductive Unit under the Ministry of Health to reduce its mortality rates.

Birth preparedness and complication readiness entail a process of promoting skilled maternal and neonatal care utilisation in a timely manner, based on a series of ideas and general principles that are being prepared for complications in childbirth, reduces delays in obtaining care. Birth preparedness in a skilled care approach includes identifying a skilled provider and making the necessary plans to receive skilled care for all births (Kaur, Kaur & Kaur 2015: Tura, Afework & Yalew 2014).

Birth preparedness and complication readiness include knowledge of obstetric danger signs, plan to deliver at a health facility, identify skilled birth attendant, transportation arrangement, preparation of vital items for delivery, such as clean delivery kit, knowledge of obstetric danger signs for mother and new born, when to seek help, knowledge of where and whom to go to for assistance, arranging for

funds and identify a blood donor (Ekabua, Ekabua, Odusolu, Agan, Iklaki & Etokideml 2011; JHPIEGO 2004).

Affipuguh and Laar (2016: 21) propose that all pregnant women should have a written plan for birth and for dealing with unexpected adverse events such as complications and emergencies that may occur during pregnancy, childbirth or immediate postnatal period. They should discuss and review this plan with a skilled attendant at each antenatal assessment and at least one month prior to child birth.

1.2 BACKGROUND TO THE RESEARCH

According to the 2010 Service Availability Mapping (SAM), Swaziland has experienced an increase in the number of births which are attended by skilled personnel (82%). These percentages may look encouraging but more effort for improvement is a necessity. When the number of births attended by skilled personnel increases, one expects a reduction in maternal and neonatal morbidity and mortality. The researcher believes that a reduction of maternal and neonatal mortality rates cannot be achieved by having skilled birth attendants only. The pregnant women can also contribute by having and sticking to birth preparedness plans.

These plans could also include preparing the mind for delivery; this could improve cooperation between the pregnant women and birth attendants as some poor maternal outcomes are reportedly owing to poor cooperation between pregnant women and birth attendants (Ekabua et al 2011). The 2013 Swaziland National Policy on Sexual and Reproductive Health has policy statements on maternal, neonatal and child health which state that “competent and skilled service providers shall provide quality maternal, neonatal and child health services in adequately equipped health facilities. All individuals, families and communities shall have access to evidence based comprehensive sexuality education, information and services on maternal, neonatal and child health. This is essential in the reduction of maternal, neonatal and child morbidity and mortality. “

Comprehensive health services and evidence-based information are some of the vital considerations to promote maternal and child health therefore reducing morbidity and mortality (Swaziland Ministry of Health 2013). In this study, ANC

falls under comprehensive services and information includes birth preparedness, complication readiness and safe motherhood. There is global recognition in improving maternal mortality following its inclusion in the Sustainable Development Goals (SDGs) which aim to attain a global maternal mortality rate of less than 70 deaths per 1,000 live births by 2030 (Stanton, Kwast, Shaver et al 2018).

Several health promotion interventions including birth preparedness, have been recommended to ensure increased access to skilled care for maternal and new born health (Tiku, 2015; WHO 2015). The World Health Organisation (WHO) (2015) urges that a birth preparedness and complication plan should include several factors such as: "the preferred birth attendant, the desired place of birth, supplies and materials necessary to bring to the facility, the location of the closest facility for delivery in case of complications, an identified labour and birth companion, funds for any expenses related to birth in case of complications". These further include an identified support to look after the home and other children while the woman is away, identification of compatible blood donors in case of complications and transport to a facility for birth. These recommendations further suggest for the preparation of birth and complication readiness for mother and new-born (Markos & Bogale 2014: WHO 2015).

Birth preparedness and complication plan have led to the high use of trained birth providers during childbirth and facility delivery. Other positive impact of the birth preparedness includes the participation of communities, male partners and other family decision makers in discussions to improve the quality of service delivery (Hudson, Gatongi, Nyonga, Makwali & Mudany 2015; WHO 2015). Furthermore, it also promotes choosing trained birth attendants to attend to the child's birth at home, preparing a delivery place at home, preparing for clean delivery kits, preparation for emergency transportation and essential new-born care. This also includes "delayed first bathing, drying of neonate before the delivery of the placenta, initiation of breastfeeding within one hour after birth and a person to be with the woman for 24 hours in areas where the use of skilled birth attendants is extremely low" (WHO 2015).

In 1987, the International Public Health Community launched a Safe Motherhood Initiative to raise awareness about the scope and consequences of poor maternal health and mobilise action to address high rates of death and disability from complications of pregnancy and childbirth. The tenth anniversary conference held in Colombo, Sri Lanka in 1997 concluded that skilled attendants to assist

childbirth, is the single most critical intervention to reduce maternal mortality. Following the 30th anniversary of the launch of the global Safe Motherhood Initiative, there was a call to renewing visionary goal of ending preventable maternity mortality. Safe motherhood is a positive experience and expresses normal physiological state. It decreases maternal and infant mortality and morbidity (Sandesh, 2018; Stanton et al 2018). The authors assert that safe motherhood encompasses a series of initiatives, practices, protocols, and service delivery guidelines designed to ensure that women receive high quality gynaecological, family planning, prenatal, delivery, and postpartum care, achieve optimal health for the mother, foetus and infant during pregnancy, childbirth, and postpartum. Figure 1.1 illustrates the pillars or principles of safe motherhood.

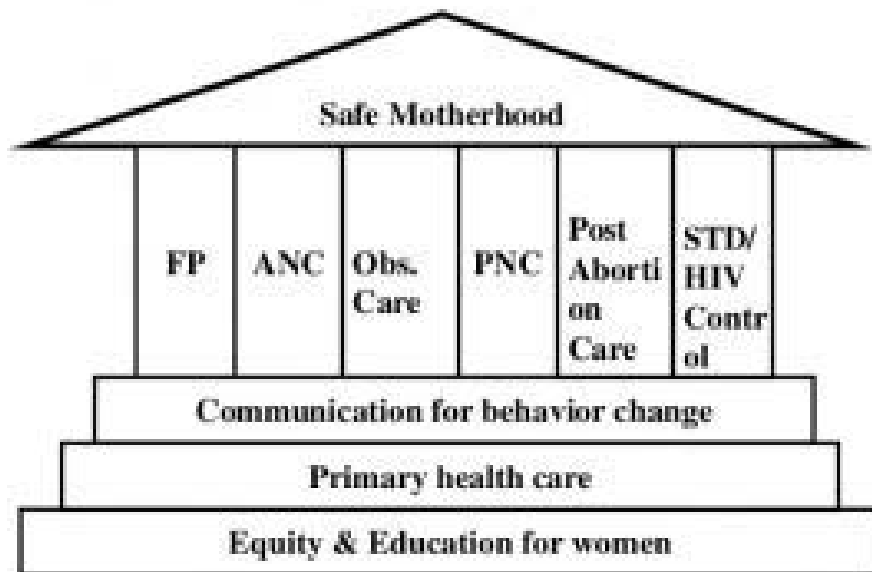


Figure 1.1 Six pillars of safe motherhood (Sandesh Adhikari 2018).

1.3 STATEMENT OF THE RESEARCH PROBLEM

Globally, maternal mortality rates are still high despite successive interventions established by the international community and local governments at reducing this phenomenon. The WHO and its affiliate bodies estimate that more than 292,000 women died in 2013 from pregnancy and child-birth related causes globally (WHO, UNICEF, UNFPA, World Bank, & United Nations Population Division 2014). In 2000, the world leaders in a global summit declared Millennium Development Goal five (MDG5), which was intended to reduce maternal mortality rate by 75% and also achieve universal access to reproductive health by the end of 2015. Maternal and infant mortality have been a burden in Africa and Swaziland is among countries with high rates. Each year, an estimated 303,000 women die from pregnancy and childbirth-related complications globally. Out of this number, 99% of these deaths are recorded in low income countries (Mgawadere, Unkels, Kazembe & van den Broek 2017). Maternal mortality ratio in sub-Saharan Africa (SSA) is 920 per 100,000 live births and that of lifetime risk of maternal death is one in 16 compared to 1 in 2,400 in Europe (Kaur et al., 2015). By 2015, Swaziland had an estimate of 389 deaths per 100,000 live births, cited by CIA World Fact book (last mortality rate**.** [online] Available: http://www.indexmundi.com/swaziland/maternal_mortality_rate.html (Accessed 20 October 2016). Swaziland's high maternal mortality rate indicates a crucial need for prompt action.

Infant mortality in Swaziland was reportedly 56 deaths per 1,000 live births in 2012 with an under-five mortality rate of 80 deaths per 1,000 live births. Mortality ratio was 590 deaths per 1,000 live births estimated at 320 deaths per 100,000 (Swaziland Ministry of Health 2013). This could be attributed to several reasons including inadequacy or lack of birth and emergency preparedness, which is a key component of the globally accepted safe motherhood programme. Labour and delivery usually come unexpected and are often accompanied by risks which can lead to irreversible complications.

Most maternal deaths are preventable, as health care solutions to prevent or manage complications are known. All women need access to ANC services, skilled care during childbirth, and care and support in the weeks after childbirth (Argawal, Sethi, Srivasta, Jha & Baqku 2010). Say, Chou, Gemmil, Tuncalp, Moller et al (2014) note that the high number of maternal deaths in some areas of

the world reflects inequities in access to these health services. Knowledge of pregnant women on BPCR improves recognition of any problem in pregnancy, reduces the delay in deciding to seek care and provides information on appropriate sources of care, making the care-seeking process more efficient (Agarwal et al 2010; WHO 2015)

The importance of preparing for birth, awareness and readiness of complications including safe motherhood to prevent such complications cannot be emphasised. The researcher observed that some women find themselves delivering in the hands of unskilled birth attendants outside hospitals while those that deliver in hospitals may be uncooperative and poorly prepared for labour and delivery. Furthermore, no study could be found in Swaziland regarding birth preparedness planning, complication readiness and safe motherhood, hence the researcher embarked on this study.

1.4 PURPOSE OF THE STUDY

The aim of this research was to establish women's birth preparedness planning during the antenatal period in preparation for delivery, complication readiness and safe motherhood at Raleigh Fitkin Memorial Hospital (RFMH) to help reduce some of the avoidable causes of maternal and infant mortality rates.

1.5 OBJECTIVES OF THE STUDY

The objectives of this research were to:

- Assess the pregnant women's knowledge about birth preparedness planning, complication readiness and safe motherhood.
- Describe the pregnant woman's perceptions regarding birth preparedness planning, complication readiness and safe motherhood.
- Establish the practices of pregnant women in relation to birth preparedness plan, complication readiness and safe motherhood.

1.6 RESEARCH QUESTIONS

The following research questions were posed:

- How much do pregnant women know about birth preparedness planning, complication readiness and safe motherhood?
- What are pregnant women's perceptions of birth preparedness planning, complication readiness and safe motherhood?
- What are practices of pregnant women in relation to birth preparedness plan and safe motherhood?

1.7 SIGNIFICANCE OF THE STUDY

It was envisaged that the outcome of the study could increase women's awareness of birth preparedness, complication readiness and safe motherhood plan to reduce high maternal and infant mortality and morbidity rates in Swaziland. Furthermore, the findings may assist in educating women and encouraging pregnant women to utilise ANC and creating awareness about danger signs during pregnancy and childbirth.

Promoting the awareness and practice of utilising ANC services are crucial for the reduction of high maternal and infant mortality rates. The findings may also contribute to the body of knowledge in midwifery and inform further research.

1.8 DEFINITION OF KEY CONCEPTS

1.8.1 Antenatal Care (ANC)

Antenatal care (ANC) is defined as care given to a pregnant woman from the time conception is confirmed until the beginning of labour (Fraser & Cooper 2014:231).

1.8.2 Birth Preparedness Plan

Birth preparedness plan refers to an overall plan pertaining labour, delivery and immediately after delivery, made by the pregnant woman, with assistance of a midwife, in readiness for labour, delivery, the post-partum period, and emergency awareness (Marcos & Bogale 2014).

1.8.3 Complication Readiness

Complication readiness implies preparing and arranging for emergency funds, transport, blood donor, and designated decision maker in emergency obstetric

care programmes (JHPIEGO 2004). According to Marcos and Bogale (2014), complication readiness includes plan to deliver at a health facility, identify skilled birth attendant, preparation of vital items for delivery, such as clean delivery kit, knowledge of obstetric danger signs for mother and new born, when to seek help, knowledge of where and whom to go to for assistance.

1.8.4 Delivery

Delivery refers to the birth of the baby, the placenta and membranes (Sellers 2015:755). For the purpose of this study, delivery refers to birth of babies at the selected site, RFMH.

1.8.5 Knowledge

Wikipedia defines knowledge as a familiarity awareness, or understanding of someone or something, such as facts (descriptive knowledge), skills (procedural knowledge), or objects (acquaintance knowledge). In this study, knowledge refers to women's awareness and understanding of birth preparedness, complication readiness and safe motherhood.

1.8.6 Midwife

According to Fraser et al (2014:5), the International Council of Midwives defines a midwife as "a person who having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery."

1.8.7 Maternal Mortality Rate

Maternal mortality rate refers to the number of women per hundred thousand, who die during pregnancy and the post-partum period (Sellers 2012: 280).

1.8.8 Neonatal Mortality Rate

Neonatal mortality rate is the number of babies who die between 28 weeks gestation to 28 days post-partum per hundred thousand (Sellers 2012: 9).

1.8.9 Perception

Perception refers to the way in which something is understood. For this study, perception refers to the way women understand birth planning, complication readiness and safe motherhood.

1.8.10 Post-partum

Post- partum refers to the period after childbirth up to six weeks (Sellers 2012:275). For this study, post-partum refers to the period after birth at RFMH and encompasses safe motherhood.

1.8.11 Practice

Practice is defined by Oxford dictionary as habitual or expected way of doing something. In the context of this study, practice implies how women act or behave in relation to SRH issues, such as ANC attendance.

1.8.12 Safe Motherhood

Safe motherhood is the concept or initiatives to ensure that women receive high quality care for the mother and infant (Sellers 2012: 4). Sandesh (2018) and Stanton et al (2018) indicate that safe motherhood encompasses a series of initiatives, practices, protocols, and service delivery guidelines designed to ensure that women receive high quality gynaecological, family planning, prenatal, delivery, and postpartum care, achieve optimal health for the mother, foetus and infant during pregnancy, childbirth, and postpartum.

1.8 FOUNDATIONS OF THE STUDY

The study is founded on the WHO Recommendations on Health Promotion Interventions for Maternal and New-born Health of 2015. Birth Preparedness and Complication Readiness (BPCR) is one of the highly emphasized recommendations. Health care workers are encouraged to increase BPCR awareness to women, families and the community (WHO 2015). This study is aimed at establishing women's birth preparedness and safe motherhood which may assist in reducing mortality and thus promote maternal and new-born health.

Swaziland has high infant and mortality rates despite having a high percentage of women accessing ANC. This is evident in the Central Statistics Office's 2007 report whereby 94% pregnant women accessed ANC and 74% delivered in health facilities. The researcher believes that if all the women who attend ANC would be assisted to have birth preparedness plans, maternal and infant mortality rates could be reduced.

1.9 RESEARCH DESIGN AND METHODS

1.9.1 Research design

An exploratory, descriptive and qualitative research design was used for the study. According to Grove, Burns and Gray (2013:66), an exploratory and descriptive qualitative research often indicates that a study is needed with a specific population to understand the needs of, desired outcomes of, or views on appropriate interventions held by the members of the group.

1.9.2 Population

Population is defined as the entire set of individuals or objects having some common characteristics in which a researcher is interested and would like to generalise the study results Lobiondo-Wood & Haber 2014; Polit & Beck 2014). Women aged above 18 years who had given birth within a week, irrespective of neonatal outcome, comprised the population of this study.

1.9.3 Sample

A sample is the subset of a population selected to participate in a study (Lobiondo-Wood & Haber 2014). Purposive sampling was used to select participants of the study. Purposive sampling is a non-probability sampling method whereby the researcher selects participants based on personal judgement depending on particular characteristics or circumstances (Polit & Beck 2014: 388). Women who met the sampling criteria were interviewed to determine their knowledge and perceptions about birth preparedness plan and complication readiness including safe motherhood. A detailed description of the research design and methods is presented in Chapter 2 of this study.

1.10 SCOPE OF THE STUDY

The study investigated women's preparedness for labour, complication readiness, delivery, and safe motherhood at Raleigh Fitkin Memorial hospital in Swaziland. Women who had given birth were interviewed to determine their knowledge, perceptions and how they were assisted during pregnancy to develop a birth preparedness plan and how they were prepared for safe motherhood.

1.11 ETHICAL CONSIDERATIONS

Polit and Beck (2012:709) advise that if data are collected from human sources, similar to this study, protection of the subjects must be ensured. Research procedures were adhered to professional, legal and social obligations. Permission to conduct the study was sought and approved by Research Ethics Committee of Unisa and Raleigh Fitkin Memorial Hospital. Ethical principles were considered and adhered to throughout the study. Detailed information on ethical consideration is covered in chapter 2 of this study.

1.12 OUTLINE OF THE CONTENTS

Chapter 1: Introduces the research problem, presents a background of the study, outlines the study purpose and objectives and the significance of the study.

Chapter 2: Outlines the research methodology, including the research design, setting, sampling, data collection procedures and analysis. The chapter also discusses measures to ensure trustworthiness of the study and ethical considerations.

Chapter 3: Presents the study findings and their interpretation.

Chapter 4: Presents the discussion of research findings.

Chapter 5: Concludes the study, outlines limitations and the recommendations based on the findings of the study.

1.13 CONCLUSION

Pregnancy is meant to lead to a time of joy and happiness to every family. However, in some instances, owing to lack of knowledge about birth preparedness, complication readiness and safe motherhood, pregnancy often leads to pain and grief as a result of morbidity and mortality of the mother, foetus and/or new born. This chapter outlined the background to the research problem, the research problem, the purpose, objectives, and significance of the study, definition of key concepts, foundations of the study, research design and methods, scope of the study, and ethical considerations.

CHAPTER 2

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

This chapter presents the research design and methodology used in the study. Also discussed in the chapter are the measures to enhance trustworthiness and ethical considerations of the study. A research method entails the techniques used by a researcher to structure a study and to gather and analyse relevant information (Polit & Beck 2014: 8). The chapter reveals the methods used to gather information on birth preparedness, complication readiness and safe motherhood of women accessing maternity services at the RFMH.

The purpose of the study was to establish women's birth preparedness planning during the antenatal period in readiness for delivery, complication readiness and safe motherhood at the RFMH to help reduce some of the avoidable causes of maternal and infant mortality rates. The objectives of this research were to:

- Assess the pregnant woman's knowledge about birth preparedness planning, complication readiness and safe motherhood.
- Describe the pregnant woman's perceptions regarding birth preparedness planning, complication readiness and safe motherhood.
- Establish the practices of pregnant women in relation to birth preparedness plan and safe motherhood.

2.2. Research Design

Research design is defined as the overall plan for addressing a research question, including specifications for enhancing the study's integrity (Polit & Beck 2014: 391). An exploratory, descriptive and qualitative research design was used for the study. According to Grove et al (2013:66), an exploratory and descriptive qualitative research often indicates that a study is needed with a specific population to understand the needs of, desired outcomes of, or views on appropriate interventions held by the members of the group. The researcher believed that an exploratory and descriptive qualitative design would be suitable

for understanding the needs and desired outcomes of pregnant women and also to gather views on appropriate interventions that can be incorporated to improve health care services rendered to women of child bearing age and more specifically pregnant women. Women who had given birth during time of the study, irrespective of new born outcome, were interviewed to assess their knowledge and perceptions about birth preparedness, complication readiness and safe motherhood.

2.2.1 Qualitative design

Qualitative design refers to the use of a flexible research design through in-depth and holistic manner to collect rich and narrative information to investigate phenomena (Polit & Beck 2014:389). Burns and Grove (2010:24) explain that qualitative research is based on the premise that knowledge about human beings is not possible without their lived experience and hence focuses on the qualitative aspects such as meaning, experience, perception, and understanding.

2.2.1.1 Advantages of Qualitative Studies

Qualitative studies have the following advantages as opined by (Polit & Beck 2014: 8,9):

- Use of few study participants to generate large yet rich information about attitudes, feelings and behaviour.
- Focuses on subjective and non-quantifiable information; no assumptions are necessary, only peoples' feelings and experiences are interpreted.
- The design is flexible thus creating openness which leads to new information being gathered during the study. When conditions that affect behaviour change, even the theory changes.
- Seeks in-depth understanding of peoples' attitudes, feelings and behaviours.

2.2.1.2 Limitations of qualitative studies

- Qualitative studies use human beings as data sources yet humans are capable of making errors.

- Uses a limited number of research participants
- Data collected is bulky
- Qualitative studies can be costly (Polit & Beck 2014:9).

2.2.2 Exploratory and descriptive designs

According to Grove et al (2013:66), an exploratory and descriptive qualitative research often indicates that a study is needed with a specific population to understand the needs of, desired outcomes of, or views on appropriate interventions held by the members of the group. The researcher identified the need for an enquiry pertaining to birth preparedness, complication readiness and safe motherhood for women during pregnancy, delivery and the post-partum period.

2.3 Research Setting

A research setting is the physical location and conditions where a study is undertaken (Polit & Beck 2014:392). This study was conducted at the RFMH which is a regional referral hospital located at the hub of Eswatini. Swaziland is a small land-locked country located in southern Africa with the Republic of South Africa and Mozambique as neighbouring countries. The country's population is estimated at around 1.02 million and is divided into four regions, namely, Hhohho, Manzini, Shiselweni and Lubombo regions. Each region has a referral hospital with RFM being the referral hospital for Manzini region and Mbabane Government Hospital being Hhohho Regional Referral Hospital and also the National Referral Hospital. RFM Hospital is the only referral hospital for Manzini region and is the second main referral hospital in Swaziland. RFMH has a bed capacity of 450 and a catchment area of 350,000. It is both a regional and a referral hospital, meaning that patients access health services as first level health facility and also when referred from other health facilities. In this study, the setting is considered in both functions as a regional and as a referral hospital.

The researcher opted for the RFMH setting because it is centrally located, accessible and has high patient volume. This setting is accessed by people from all the regions of Eswatini and therefore can somehow represent a large proportion of Swati women of child bearing age. Women in the maternity ward

were targeted because they had gone through pregnancy and delivery. Therefore, they could better explain their birth plans, explore the degree of usefulness of those plans and point out suggestions on how birth preparedness, complication readiness and safe motherhood can be achieved.

Figure 2.1: Map of Swaziland

https://www.pinterest.cem/pin/270708627576190187/

2.4 Target population

A target population is defined as the entire set of individuals or objects having some common characteristics in which a researcher is interested and would like to generalise the study results (Polit & Beck 2014:387,393).

All women aged above 18 years who had given birth within a week, at the time of data collection at the study site, comprised the population of this study.

2.5 Sampling

A sample is the subset of a population selected to participate in a study (Lobiondo-Wood & Haber 2014). Purposive sampling was used to select individuals to

represent the entire population. Purposive sampling is a non-probability sampling method whereby the researcher selects participants based on personal judgement depending on particular characteristics or circumstances (Polit & Beck 2014: 388; Brink et al 2010:163). Non-probability purposive sampling approach was used because of the selection of elements through non-random methods. Purposive sampling is used when data are collected from selected participants because they exhibit certain features that are of interest for a particular study (Silverman 2000 in De Vos et al. 2011).

2.5.1 Criteria for inclusion in the study

Criteria for the study included:

- Women who were 18 years and above;
- Those who had delivered within seven days at the selected setting;
- Willingness to describe their experience; and
- Had consented to participate in the study.

2.5.2 Exclusion criteria

- Women who had babies after a week during data collection; and
- Women who had not delivered their babies at RFMH.

2.6 Data collection instrument

A semi structured interview guide was developed for the study. The questions were based on the research objectives, the available literature on women's preparation for birth, complication readiness, and safe motherhood. The main purpose of the interview guide was to help focus the interview on the main phenomenon being studied and also to make the interview comprehensive, devoid of irrelevant information. The interview guide was divided into two sections: with Section A comprising the background information while Section B included birth preparedness, ANC, health facility delivery, complication readiness, and safe motherhood. The questions were adapted accordingly for the study. The rationale for the qualitative and more especially an in-depth interviewing was to allow the participants the opportunity to express and describe their knowledge, perceptions and experiences in their own words (Polit & Beck 2014: 177).

2.7 Recruitment of participants

Participants were recruited from the selected study setting, antenatal cards were used and also confirmed with the research participants to identify their ages and the date of delivery. This was done to ensure that the research participants met the inclusion criteria.

The total number of participants interviewed was 20 determined by data saturation. Also in a qualitative study, saturation is important during data collection to determine the number of participants needed for the study of a particular phenomenon. Saturation is the point at which participants keep repeating the same information as of previous data collected. Hence, there is no new information being added, and at that point, the researcher stops interviewing more participants (Polit & Beck 2014).

2.8 Data collection process

Data collection is the approach used to gather information aimed at answering the research question (Brink et al 2018:133). Interviews are often used in exploratory research and are the most direct method of obtaining facts from interviewees which are useful in ascertaining values, preferences, attitudes, and experience (Brink et al 2018:143). Data collection was conducted from December 2018 to March 2019. The interviews were initially planned to be conducted at the maternity department, specifically in the post-partum ward. However, owing to renovations that were on-going in the hospital's maternity wing at that time, the interviews were then done at the Maternal and Child Health Department because pregnant women were sent to other hospitals for delivery. At the Maternal and Child Health Department, women and neonates had come for post-natal care. Women who met the inclusion criteria were interviewed in a room requested for this process.

Research participants were approached individually and briefed about the study and its purpose. They were assured of privacy, confidentiality, anonymity, and informed consent. Those who agreed to be interviewed were made to sign the informed consent and the interviews commenced.

Eligible clients who declined to participate in this study were thanked and allowed to continue with their different business at the hospital. A total number of 20 clients were interviewed and the number was determined by data saturation meaning that additional participants provided no new information (Brink et al 2018:160). An audio tape recorder was used to record the data from participants upon their approval. This was to enable the researcher play back the voices of the participants and have the data transcribed verbatim for analysis. Field notes were kept during the interview session by the researcher. Each participant was given an identification number or code to ensure that data collected from each of them could easily be identified without the use of the participant's name. To ensure that the participants felt much comfortable and willingly expressed their views and opinions, they were encouraged to answer questions at their own pace and not to rush in giving responses.

The researcher ensured that there were general questions about the participant's background to help them be at ease and ready for the main section of the interview at the beginning of each interview session. During the interview process, participants were encouraged to talk and express their views freely without any interruption or interference. This was done to redirect the participant's focus on the main subject being discussed and also to seek clarification about answers that are not clear enough or answers that were not well understood. In addition to the audio tape-recording, field notes were taken during and after the interview to capture the participant's verbal and non-verbal communication such as mannerisms, including facial expression that the audio recorder will not be able to capture. Each interview lasted between 40 to 50 minutes.

2.9 Data analysis

Data analysis is described as "the systematic organisation and synthesis of research data" (Polit & Beck 2014: 286). Qualitative data analysis is described as "the organisation and interpretation of narrative data for the purpose of discovering important underlying themes, categories and patterns" (Polit & Beck 2014:378, 389). In qualitative studies, data analysis begins as soon as data collection starts. The recorded data was transcribed verbatim after every interview in preparation for analysis. According to Polit and Beck (2014:378}, thematic content data analysis technique employs inductive analysis which

generates categories to support the main themes. This method was appropriate to the study because it helped the researcher to discover meaning of specific group of data and ideas within the context of the study. The data from the participants were analysed to identify the sub-themes within the narratives provided by the participants to support the main themes.

An independent coder was engaged to assist in sorting the data into themes and sub-themes. Notes from the researcher and those from the independent coder were compared to ensure credibility of the research findings. The data were analysed following Giorgi (1985)'s descriptive phenomenological method. This method follows four basic steps (Polit & Beck 2014: 309).

- *Getting a sense of the whole*

The researcher got a sense of the whole by reading the entire interviews which were transcribed verbatim. Reading was done repeatedly to better understand and be familiar with the participant's feelings and expressions.

- *Discriminating units*

Then discriminated units from the participant's description of phenomenon were studied. This entailed noting similar and different experiences as expressed by the participants. Thereafter, the researcher came up with themes.

- *Articulating psychological insight*

Thereafter, the researcher broke down the discriminated units to derive sub-themes relating to the phenomenon being researched.

- *Synthesis*

The sub-themes were combined to come up with coherent generalised information pertaining the participants' BPCR.

2.10 Data management

Data management is the process of keeping the information from the participant safe to prevent loss or third person other than the supervisors of the study from accessing the information (Brink et al 2018). Data collected from the participants included audio tape recording, field notes and transcripts. The audio recordings were copied onto a personal computer. Recorded interviews were also transcribed verbatim by typing into a personal computer using Microsoft Word document. Errors and omissions were checked in the transcribed document by playing back the recorded interview to make sure that the transcribed documents were the same as the recordings.

Each of the transcribed documents was labelled with the participant's unique identification number or code as a pseudonym of the participant and saved in the computer with a password. Hard copies of the data were also made and kept in safe place and all soft copies of the data were also sent into a personal email. All these were done to ensure safety, prevent loss and unauthorised individuals from accessing the data.

2.11 Measures to ensure trustworthiness

Trustworthiness is defined as the degree of confidence that qualitative researchers have in their data analysis and often referred to as scientific rigour ((LoBiondo-Wood & Haber 2014:166)). In qualitative research, trustworthiness is assessed using concepts cited as major criteria which other researchers have termed as a 'gold standard'. These criteria include credibility, transferability, dependability, confirmability, and authenticity (Polit & Beck 2014:394).

- *Credibility*

Credibility is achieved when the data findings reflect reality or truthfulness (Polit & Beck 2014:323). Participants who met the inclusion criteria of the study were recruited to provide in-depth information on their knowledge, perceptions and practices regarding birth preparedness, complication readiness and safe motherhood. The researcher maintained prolonged engagement with participants prior to data collection to build trust. Moreover, member checking was done after

interviews to confirm the findings and comprehensive field notes together with voice recordings were kept.

- *Dependability*

Dependability refers to the strategy to achieve consistency of the data stability or reliability over time and conditions (Holloway & Wheeler 2013: 254). An audit trail and in-depth description of the research design, background of participants and the methods used in collecting and analysing data were maintained.

- *Confirmability*

The researcher ensured that the data reflected the participant's lived experiences and not the researcher's perspectives to achieve objectivity of the study. There was careful documentation throughout the study and audit trails were kept intact for verification purposes. An experienced independent coder was engaged to reach consensus with the researcher in the findings of the study.

- *Transferability*

Transferability is achieved when the findings are applicable to other settings. Descriptive information that is of high quality pertaining the setting, study participants and observations was provided (Holloway & Wheeler 2013:255; Polit & Beck 2014: 323). Transcribed data was kept safe for reference purposes.

- *Authenticity*

Authenticity is the portrayal of research participants' mood, experience, feelings, language, and context. To achieve authenticity of the study, the researcher kept recordings of the interviews for purposes of reference (Polit & Beck 2014). Authenticity is shown when it conveys the participants' lives as they are lived. The researcher maintained reflexivity strategies throughout the study period to ensure authenticity. Also, during data collection audio tape recordings and verbatim transcriptions were used, and in the analysis, thick clear description was employed to bring out or show live participants mood, feelings and perceptions about the phenomenon.

2.12 Ethical Considerations

Researchers are guided by certain standards and norms as they collect, analyse data and disseminate findings. Academic and professional codes of conduct during the process of conducting the research were adhered to. Protection of human subjects, balancing benefits and risks in a study as well as obtaining an informed consent from study participants are essential in conducting research (Grove et al 2013: 159).

Research governing bodies require every researcher to adhere to ethical considerations for the protection of research participants and for the study to meet acceptable quality standards. Ethical principles specified by Unisa Research Policy, the Swaziland National Health Research Unit and universal ethical principles were adhered to. Ethical clearance was obtained from Unisa's Ethical Clearance Committee (Annexure 1, Reference: HSHD 797/2017. More importantly, permission to access the research setting was obtained from the National Health Research of Swaziland and the RFMH Administrator granted permission to conduct the study in the hospital (Annexure 2). The universal ethical principles that guide social and health research were adhered to. These include autonomy, the right to privacy and confidentiality, justice, and non-maleficence.

- *Autonomy*

Autonomy involves the capacity to make an informed decision without coercion or the risk of penalty or prejudicial treatment (Brink et al 2018: 29). The researcher ensured autonomy by allowing eligible participants to sign an informed consent that has an allowance for them to opt out of the interview anytime the felt uncomfortable without fear of denial of health services or victimization. Therefore, no form of coercion, deceit or threat was levelled against the participants. Participants were ensured that the collected data would be treated as confidential information and would be used for professional decision making.

- *The right to privacy and confidentiality*

All research with humans involves intruding into their personal lives. As a result, it is the responsibility of researchers to ensure that the intrusion does not exceed the expected limit and that privacy is maintained (Polit & Beck 2014:85). Participants in this study were treated anonymously; their names were not used, instead they were identified by participant codes. The interview was done in a private room to avoid unnecessary exposure and distraction. The consent form signed by the participant stated that the data obtained from the interview will be kept confidential and will be used for professional purposes.

- *Justice*

Justice was ensured by having an informed consent for all eligible women who agreed to participate. All participants fitted the inclusion criteria. Women above 18 years, post-partum women within seven days and willing to anonymously share their experiences. Women who opted not to participate in the study were granted their wishes not to participate; no coercion was done to make them change their minds. Participants who declined during the course of the interview were allowed to exit peacefully without any denial of health services (Brink et al 2018: 30).

- *Non-maleficence*

Non-maleficence is translated as inflicting no harm or evil. Brink et al (2018:48) indicate that doing no harm include anything from physical discomfort, emotional stress, humiliation or embarrassment. Therefore, in this study, no form of harm or evil was inflicted to the research participants. Participants were allowed to decline at any time they felt uncomfortable with the interview.

2.13 CONCLUSION

This chapter described in detail, the research methodology that guided the study, measures used to enhance trustworthiness and ethical principles adhered to while conducting the study.

CHAPTER 3

RESEARCH FINDINGS

3.1 INTRODUCTION

This chapter presents the research findings on data collected from women who had delivered within seven days before data collection irrespective of their neonatal outcome. Data collection took place at the RFMH in Swaziland. The purpose of the study was to establish women's birth preparedness planning during the antenatal period in readiness for delivery, complication readiness and safe motherhood at the RFMH to help reduce some of the avoidable causes of maternal and infant mortality rates. Data are categorised according to participants' biographic information, reproductive health information, birth preparedness, complication readiness, and safe motherhood.

3.2 RESEARCH FINDINGS

Giorgi (1985)'s descriptive phenomenological method was used to analyse data according to the four basic steps (Polit & Beck 2014: 309). Identified codes were collated resulting in patterns which used themes and subthemes. These themes were used to represent the opinions of participants regarding birth preparedness, complication readiness and safe motherhood.

Upon completion of data analysis, clean transcripts were given to an independent analyst. After the analysis of data by the independent analyst, a meeting between the researcher and the independent analyst was arranged to compare and reach consensus about the findings. Themes and subthemes derived from the analysed data are presented in Table 3.1

Table 3.1: Themes and sub-themes

THEMES	SUB-THEMES
Participants' knowledge regarding birth preparedness planning.	• Attendance of ANC • Information received from ANC visits • Choosing a safe place for delivery • Transport preparation • Financial preparation for mother and baby • Preparing baby requirements • Psychological preparation for labour • Delivery of the baby.
Perceptions of birth preparedness	• Positive attitudes towards birth preparedness • Negative attitudes • Ambivalence.
Knowledge of complications related to pregnancy and childbirth.	• Inadequate information about complications of pregnancy and childbirth • Lack of information • Cultural beliefs.
Knowledge about safe motherhood. Perceptions about safe motherhood	• Contraception • Breastfeeding • Desired family size. • Quality care of mother and baby. • Prevention of infections and diseases.

3.2.1 Demographic Information

The research participants' ages ranged between 18 and 38 years. Most participants (13) were single, three were cohabiting and only four were married. In terms of education, categories ranged from primary, secondary, high school, and some had attained tertiary education. All the participants were Christians. Most participants resided in the Manzini region with only three who came from the Lubombo region. Regarding employment, 12 participants were unemployed, self-employed were 4 and 4 were full time employed.

3.2.2 Reproductive health information

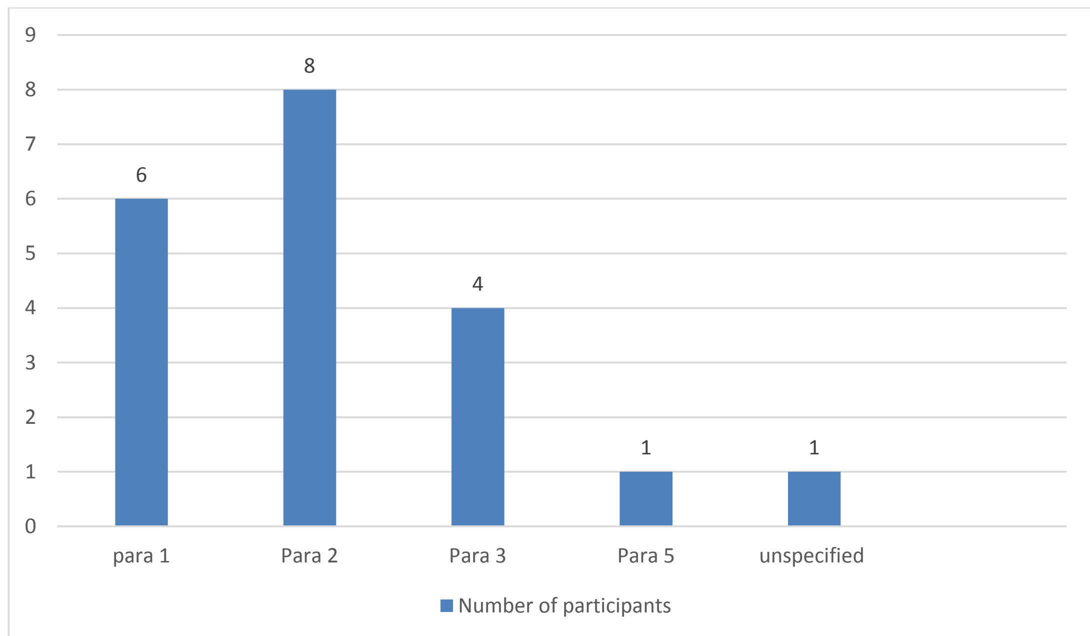


Figure 3.1: Parity of participants

Figure 3.1 depicts the parity of the participants. Most, (8) participants had delivered a baby for the second and first (6) time, with few who had delivered for the third time (4). Only one participant had her fifth child and another did not disclose her parity.

3.2.3 Antenatal care attendance

The number of ANC visits explains the extent of the pregnant woman's exposure to health care providers.

Table 3.2: Antenatal care attendance

Number of ANC Visits Attained	Number of Research Participants	Percentage
0 visits	1	5%
2 visits	4	20%
3 visits	3	15%
4 visits	7	35%
6 visits	3	15%
7 visits	1	5%
Unspecified	1	5%
TOTAL	20	100%

As depicted in Table 3.2, seven participants had four ANC visits, followed by four who had two visits, three who had six visits each and another three participants who attended three ANC visits. One participant had seven visits, another had not attended any ANC visits, and the other did not specify. During ANC visits, health care providers are expected to assess the wellbeing of the pregnant woman, the unborn baby and also provide health education to the pregnant woman pertaining to pregnancy, delivery and beyond.

A mother of two, with one delivery at the health facility and had attended ANC six times said:

"*I was able to attend all ANC visits to protect myself and my baby. Each time I went, I learnt about what type of food to eat for my baby's good health, rest and relaxation, avoiding bad habits like smoking and drinking alcohol…P2.*"

Another mother of one stated:

"*Attending ANC is good for mother and baby. It's better than hearing myths about pregnancy. Stories that pregnant women should not eat certain types of food that eggs will cause prolonged labour...P1.*"

"*I could not attend any ANC because we stay far from the hospital and transport is expensive. I am not working and my partner is working part time getting very little money. I was praying to get a healthy baby and God answered my prayers...P5.*"

A primigravida teenage mother expressed this way:

"*I learnt more from these visits that's why I kept on going to have all the knowledge about my pregnancy and what to do during labour and delivery. Nurses were always teaching us about how to care for ourselves and our babies...P3.*"

Another mother who had three babies felt it was not necessary to attend ANC:

"*I did not attend ANC because this is my fourth baby. They always repeat the same topics so I knew what to do when labour starts and how to behave myself during delivery*…P6"

3.2.4 Information received during Antenatal care visits

Some participants mentioned that they were informed about methods of contraception, HIV testing including partner testing, danger signs during pregnancy, infant feeding, early signs of labour, how the baby grows, breast feeding, choosing a place of delivery, buying the baby's clothes and have a plan for the birth process. A few participants mentioned prevention-of-mother-to-child transmission, early infant male circumcision and sexually transmitted infections.

A first time mother who had attended four ANC visits said:

"*I think it's important to attend ANC services. I learnt a lot from these classes especially if its' your first baby and you have no clue of what you should do and avoid bad habits like smoking and drinking alcohol that could harm the baby. I learnt about this plan of preparing for my baby...P13.*"

Other participants stated this way:

"*I was relieved when the nurses told me that my baby was doing well when I went for check-up because I missed his movements for two days…. I thought my baby was not alive anymore…P7"*

"*I did not want to breastfeed but the nurses advised me to do so and told me many good things about breastfeeding. So, I am now breastfeeding and enjoying the growing bond between me and my baby...P2.*"

"*I did not learn much from the clinic because I went when my baby was due. I did not have money for transport and I could not prepare for my baby as I was not working and my boyfriend just disappeared…P9.*"

"*We were told about the birth preparedness plan and that it should be done with the nurse to ensure that we understand what is expected and whether we should correct where necessary...P4.*"

3.2.5 Place of delivery

Most of the women delivered at RFM, Mbabane government hospital with only one who delivered at home and one delivering in a van along the way to hospital. Hospital deliveries are generally considered safe compared to home deliveries because hospitals have qualified personnel and equipment to conduct deliveries and complications are better managed. One of the determinants of birth preparedness is choosing a safe place for delivery.

A mother of four, who had attended ANC three times said:

:

"*I was so happy when I got to the hospital on time to deliver my baby. The nurses told me to come even before time as it was my first baby and I*

needed more help from the nurses. I waited in the labour room for the whole night and the baby came the following day…P11."

Other participants stated:

"*Yes, we were informed during ANC that we should deliver our babies at the hospital so as to avoid complications. The nurses told us that if the woman or baby is not well during and after labour the doctors will help because they are always available…P16.*"

"*I had my baby by caesarean section and I'm feeling better and happy that my child is alive. If I did not come to hospital in time, I would have lost my baby or I also would not be alive. They told me that my baby was in distress and blue and I bled a lot…P12.*"

"*We stay far from the hospital and my husband was at work when my labour pains started. I could not reach the hospital on time and my mother-in-law came to help me. It was tough and when I screamed of pain, she told me to be strong as this was the beginning of motherhood......P13.*"

3.2.6 Perceptions about birth preparedness

Participants indicated their views about birth preparedness regarding transport to clinic, saving money for baby needs, identifying signs of labour, identifying complications, and safe motherhood. Few participants felt positive about birth preparedness and had made prior transport arrangements. Some were not sure about their delivery dates and were caught unaware. Few participants had to use public transport and others organised available cars, one consequently delivered at home and another delivered along the way to hospital.

None of the participants utilised the waiting facilities in the different hospitals in order to be nearer to a safe place of delivery and therefore avoid delivering at home under unskilled birth attendants. Only one chose to wait for labour and delivery by visiting her sister who resides close to the hospital when her days of labour drew near.

A mother of two expressed her views this way:

> "*We started preparing for the baby after I visited the clinic when I was three months pregnant. My husband works at a grocery shop and did not earn much. We sacrificed and cut some goodies and saved for the baby. When the time came for my delivery we paid for transport and were able to buy things for our baby…....P5".*

Other participants felt:

> "*I could not go to the hospital for the birth of my baby and ended up giving birth at home because there was no money. I feel guilty now that my baby is sickly and nurses say I lost a lot of blood during delivery which could have been saved…P1.*"

> "*I did not have transport to go to hospital in time for delivery. I was worried about complications of labour and did not want to lose my child. I arranged and went to my sister's place to be near the hospital. My baby was delivered normally and I got all the help from hospital staff…. P14"*

> "*I was worried about signs of labour. We were once told about some signs of labour pains but was not sure whether I would be able to report on time or late when the baby is arriving…My friends had told me of women who delivered their babies when doing shopping or visiting…..P16.*"

> "*I started preparing when it was rushing me. I had a plan but the scan deceived me; gave me a later date and my means of transport was far. There was a car at home, so I requested them to assist me...P15.*"

A first time mother who did not specify her ANC visits, stated her view as follows:

> "*I was totally against preparing for my baby as I kept my pregnancy a secret. I had two previous miscarriages and my family were very upset because we have nasty neighbours who could do anything to upset us again… P19.*"

3.2.7 Saving money for baby requirements

Most of the participants had saved enough money, or their partners contributed towards the baby's birth expenses. Two teenage respondents had not prepared anything though their parents had offered the necessary financial support. One respondent went to the extent of saving money using the husband's mobile facility.

A teenage mother who had attended ANC three times expressed:

> "*I am thankful to my parents who helped with all what was needed for me and my baby. I had no money as I was still at school when I fell pregnant. My parents were very angry and disappointed but now they accepted me…it's really bad at times to take from my family when they should be spending on my sibling. They bought all baby clothes for me…P3.*"

Other participants stated:

> "*My partner is very strict about savings. He discouraged me from buying every time I received my salary. I used to buy and not save for rainy days. I am now happy that we managed to pay for all requirements for the baby and hospital fees…P4.*"

Another mother expressed similar sentiments about her partner:

> *"I was given money by the father of my child on the day I went for delivery, I don't know when he had saved the money. I had nothing prepared… I had a small amount of money and my partner gave me his. The money was enough for everything and some remained unused…P17.*"

> "*I was anxious about the costs of everything…from transport, hospital fees and doctors; fees in case my child would need high care or operation. The money I saved would not be enough for all these…..P18*"

"*Before you go there as they had taught us to reserve the baby's clothes and money, not to wait for labour because one does not know the exact date and you can't rely on ultrasound for the date because it happens that labour comes seven days before or seven days after the due date. I kept the money and baby's clothes together, then I took my bag and left…P10.*"

"*I had prepared E200 for hospital fees and for transport. E100 was from my mother, the other E100 I was given by the father of my child. I had money kept in Mobile Money belonging to the father of my child. Labour started on Thursday slowly; he withdrew it and gave us when we left on Friday morning; I was also going to get paid on the same day; I received the in contact telephone message while in labour…..P20.*"

3.2.8 Identification of signs of labour

Some participants mentioned that they did not expect the pains they experienced. Those who had babies already knew about labour pains but felt they could not relax because it is always different.

Participants expressed how they identified labour as follows:

"*Eish! you cannot predict these labour pains. Even if you come to the labour room for the third or fourth time, that pain is somehow intense…you don't know whether to scream or try to be bold….P7.*"

"*The nurses explained to us that we must be brave, but when that pain comes, you forget about being brave…it's hot and moves around your waist and back ooh terrible…...P8*"

"*I just took a deep breath when the pain started and felt a bit better. Those were the nurses' instructions and it's better to do what they tell you otherwise you'll be frantic……P2.*"

"*It's better when labour does not take long. My granny told me that in their family they used to have short periods of labour with minimal pain. She consoled me that I may take after them, but when it started, it was intense and dragged for hours…so her consolation did not work…. P6.*"

A participant who had caesarean section and had not attended ANC stated how lucky she felt:

"*My baby struggled to be delivered and I went for operation after a very lengthy labour. I did not know what to expect, I was not told anything about complications of labour. It was painful because even after operation I saw my baby the next day because I was not awake for a long time…..P12*"

3.2.9 Psychological preparation for labour

Less than half the number of participants stated that they were psychologically prepared and that this helped them to go through labour without fear. They added that the only problem they had was about the health of their babies. Some participants claimed that despite attendance of ANC, they were anxious, fearful and not sure of the outcome of their pregnancies.

Participants stated:

"*Really, labour is painful but I persevered….You cannot just explain how it Happens, but when those contractions come…P7.*"

"*No, I hadn't prepared because people were saying labour is painful and others said it differs with people so, I didn't know what to do….P8.*"

"*I wasn't prepared, the pain, I thought giving birth was easy, even the labour, I thought it was something minor considering that I have no experience of even period pains.…..P2.*"

"*Aw! I prayed that if only my child can come out alive, I prayed and accepted because it was not my first time, I didn't have a problem. I was praying all the time to go and come back with the baby. My first-born had died, the second born is at home staying with my dad. I locked my rented flat and left….P6.*"

"*It was tough because I found one lady who had an intra-uterine foetal death. I just told myself to accept whatever was going to happen...P12.*"

A mother of two said:

"*I had not prepared myself, I had told myself that it would be like the previous labours I had experienced. This time, it was more painful and for a shorter period…..P7.*"

"*I think I was prepared because anxiety made me ask people about delivery, what to expect. I asked nurses and people so I think I was prepared although much of the advice was from my family…P11.*"

3.2.10 Coping with labour and delivery

When asked about how they coped with labour and delivery, most participants were reluctant to explain their experiences because they were either embarrassed about their behaviours or blamed nurses for having not explained fully about labour pains and the delivery process. Few participants coped well probably because they had experienced labour with their previous babies and knew what to expect.

Some of the responses were as follows:

"I behaved well; I shouted briefly. I cried quietly so that nobody should notice and ask questions…..P6".

"Because it was not my first time, I found it fine and coped well…. P10"

“Silence with laughter… I am afraid of pain; if I could show up now, they would not want to see me again. I was doing all sorts of things when that pain came. I screamed, I pulled all linen from the bed and waited for another wave…P14”

Some participants who had no experience of labour pains or were not informed about what to expect when in labour were surprised when experiencing contractions and said:

“*Hmm…I was so restless when the labour pains came. I could not resist, just screaming for help from anyone who came next to me, I will never forget this intense pain in my life…Nobody explained this type of pain to me, even at ANC visits…..P17*”

“*Labour is very painful; that is why my sister had all her kids by operation. If I knew before, I would have asked for one. I suffered a lot for a long time before delivering my baby. When I called the nurses, they told me that I still had more hours before delivering…it was like a circus!...P16*”

3.2.11 Knowledge about post-delivery complications

Pregnancy and labour complications are life-threatening to expectant mothers and the unborn baby. Not all participants knew about complications that could arise from pregnancy and labour. Some of the mothers mentioned that they were not aware of any risks of pregnancy and labour complications. Those who were informed, demonstrated some understanding of pregnancy and labour complications by mentioning bleeding and prolonged labour as complications of labour. They added that these complications could be life-threatening to the mother and the baby.

A mother of two stated about prolonged labour:

"*I was in labour for two days and it was so painful. I could not sleep at night, moaning and crying at times. My partner called an ambulance and when I arrived at the hospital, the nurses were angry at me saying why did I take so long to come to hospital because my baby was lying across in my womb. So I lost my baby because I did not know what was happening to me and what to do.…..P18.*"

"*Hmm, I was bleeding so much after delivery that I don't think I would still be alive. I thank the doctors and nurses for saving my life. If I was not in hospital, I would not be talking to you now. I still don't know what caused such heavy bleeding….... P19.*"

"*I did not know anything about birth complications. Nobody told me about that. So it helped me because I did not worry about those complications…P11.*"

"My labour was complicated but the nurses were very helpful and my baby was saved. I can't explain in those terms but they told me she was blue and did not cry at birth So the nurses did all their best care to save my baby..P7."

3.2.12 Knowledge about safe motherhood

Most elderly women were better informed about safe motherhood than young mothers who failed to attend ANC. Some young mothers felt they were discriminated when told to get HIV test when visiting the health care centres.

Some participants stated their fears about being tested for HIV and nurses' judgemental attitudes:

"*I did not want to be tested for HIV because I was scared that if I am positive my partner would leave me..P20.*"

"*At times when you go to these clinics you get embarrassed especially if you go late when the baby is due…nurses will be asking why you only came now or even neglect you when you're having labour pains...P9.*"

"*We were taught about coming for check-up after six weeks and taking the baby for immunisations and weighing…P8.*"

"*I only know that you must be a good mother, breast feed your baby and avoid bad behaviours. We were not told much about some of these topics...P2.*"

3.2.13 Perceptions about safe motherhood

Participants believed that it is important to care for the baby well to prevent diseases, and creating space between children by using contraception, breast feeding and had information on how to bath a baby. Most of them reported to have been told by nurses about safe motherhood except a few who said nobody talked to them about it.

Participants expressed as follows:

"*My view about safe motherhood is that I should take care of my baby at all times and avoid diseases as much as I can like taking my baby for weighing, immunisations and use contraceptives to prevent another pregnancy…P6.*"

"*I think to be a good mother you must prevent diseases and always keep your baby clean. If your baby is bottle fed, every utensil and bottles must be sterilized to avoid infections…. P3.*"

"*I am using condoms to protect myself and my baby as I am breastfeeding. It is up to one to decide how many children she wants to have. I am planning to have two children in all. I am planning to breastfeed exclusively for six months….P1.*"

“Three children will be enough for me, but my partner wants four. It is not always easy to get what you want in a relationship….P8”

“*It is wise to decide on the desired number of children to have we would love to have five in total…..P9.*”

3.2.14 CONCLUSION

This chapter presented research findings on a study conducted at RFMH pertaining women’s birth preparedness, complication readiness and safe motherhood. The information was categorised according to data collection information, participants’ biographic information, reproductive health information, birth preparedness, complication readiness, and safe motherhood. The research findings are presented in themes and sub-themes including narrations by participants.

CHAPTER 4

DISCUSSION OF RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents the discussion of the research findings regarding women's birth preparedness planning, complication readiness and safe motherhood at RFMH in Swaziland. Women who had delivered within a space of seven days, regardless of neonatal outcome, were recruited to participate in the study. The aim of this research was to establish women's birth preparedness planning during the antenatal period in preparation for delivery, complication readiness and safe motherhood at RFMH hospital to help reduce some of the avoidable causes of maternal and infant mortality rates. The researcher opted for the RFMH setting because it is centrally located, accessible and has high patient volume. This setting is accessed by people from all the regions of Swaziland and thus can somehow represent a large proportion of Swati women of child bearing age. Women in the maternity ward were targeted because they had gone through pregnancy and delivery. Therefore, they could better explain their birth plans, the degree of usefulness of those plans and point out how complication readiness and safe motherhood can be achieved.

Twenty participants who met the sampling criteria were selected to participate in the study. Interviews were conducted and transcribed verbatim. Data obtained from the interview were analysed based on thematic content analysis. Main themes and sub-themes were generated from the coding and categorisation to describe women's birth preparedness, complication readiness and safe motherhood.

4.2 Discussion of the Findings

4.2.1 Demographic Data

4.2.1.1 Age

Participants were aged between 18 to 38 years. Women of child bearing age ranged from 18 to 40 years. Anyone who falls pregnant below 20 years of age is categorised under teenage pregnancies. This indicates that the society still has the problem of teenage pregnancies which contribute to the high maternal and neonatal mortality rates as in this study 10% of the participants were teenagers. One of the teenage mothers had a neonatal death which was a very painful experience for a first time mother. In the reproductive health field, it is considered risky to fall pregnant after age 35 and yet in the study 20% of the participants were aged 35 years and above. In order to curb avoidable causes of maternal and neonatal morbidity and mortality safe motherhood practices which include planning families bearing in mind the woman's age is important. A woman's age also plays an important role in birth preparedness and complication readiness (Kuganab-Lem, Dogudugu & Kanton 2014). The age of a mother may serve as an indirect means for her accrued knowledge in health care services, which would have an influence on birth preparedness

4.2.1.2 Marital status

Of the 20 participants, 13 were single, only four were married and three were cohabiting. Marital status can be used as an indicator of the availability of family support, especially from the partner. What is worth noting from the study is that the married, cohabiting and single women reported spousal support except for the single teenagers who reported parental support from their mothers.

Nothing was mentioned of the boyfriends that were fathers-to-be. In their study, Kakaire, Kaye and Osinde (2011) argue that male involvement will enable men to support their spouses to utilise emergency obstetric services early and the couple will adequately prepare for birth and be ready for complications. Similarly, Tadesse, Boltena and Asamoah (2018) point out that the involvement of male partners becomes even more critical in patriarchal societies if considerable improvement in maternal health outcome is to be realised. Strategies for involving men in maternal health services should aim at raising their awareness about

emergency conditions and engaging them in birth preparedness and complication readiness.

4.2.1.3 Level of education

It is worth noting that the level of literacy is improving because the study portrays none of participants who have never been to school. A few had reached primary and secondary education with some having reached high school and tertiary education. Sustainable Development Goal number 4, lobbies for quality education and this is an indication that Swaziland is gradually meeting this goal as free primary school education commenced in 2010 in the country. The participants in this study, judging from their ages might not have benefitted from the free primary school exercise but had basic education and some even up to tertiary level. People who can read and write are able to receive and understand health education on sexual reproductive health (SRH) from charts and flyers available in health care facilities including information on danger signs during pregnancy (Urassa, Pembe & Mganga 2012)

Similar findings were reported that women who had primary education were more likely to be prepared for birth and complications than those who lacked basic education (Bintara, Mohamed, Mghamba et al 2015; Seeiso & Maja 2019:41).

4.2.1.4 Religious affiliation

Religious affiliation is important in health service delivery because some religions do not believe in all or part of Western medicine package. Having knowledge of such beliefs arms health care providers with information so that patients and clients are treated with respect to their beliefs. The participants in this study were all under the Christian umbrella of faith. None of the participants indicated her religion as a factor in birth preparedness, complication readiness and safe motherhood.

4.3 BIRTH PREPAREDNESS, COMPLICATION READINESS AND SAFE MOTHERHOOD

4.3.1 Parity of participants

Parity in SRH context describes the number of times a woman has carried a pregnancy to a viable gestational age (Sellers 2012:182). Most participants had delivered for the second time with a few who had their first and third babies.

Only one had her fifth child and another participant's parity was not disclosed. Parity is a high predictor of saving money. Women who had babies knew how money was needed in preparing for birth and any associated dangers as was reported in this study. Neupane and Doku (2013) report that birth parity influenced the level of preparedness of pregnant women. The study emphasised that women who had parity between two and four were more likely to be prepared for birth as compared to women who have not had such deliveries.

4.3.2 ANC attendance

ANC is essential in the fight against high maternal morbidity and mortality. Most of the participants had visited health facilities for ANC four times (35%), followed by those who made two visits (20%), a few who had three (15%) and six (5%) visits. One participant did not specify if she attended ANC services. Only one participant did not attend ANC services and stated she thought that her pregnancy was still early. From this study, ANC attendance of at least one visit accounts for 95%; yet, the Swaziland Demographic Health Survey boasts of 97%. According to Bintara et al (2015), attending many ANC visits provides an opportunity to inform pregnant women and help to plan for important components of birth preparedness. It is during these ANC visits where pregnant women are supposed to be assisted to plan and start preparing for delivery and safe motherhood. Because several topics need to be covered during these visits, it is clear that one should visit the health facility several times (at least four visits) to get most of the necessary information.

The Skilled Care Initiative (2015) and Hudson et al (2015) identified one of the key elements of birth preparedness as attending ANC at least four times during pregnancy. Participants in the study who attained at least four antenatal visits

account for 35%. This is an indication that more still needs to be done to attain satisfactory birth preparedness.

4.3.3 Choosing a safe place for delivery

All women who delivered in hospital were satisfied with the place of delivery. Gurmesa, Mesganew and Yalew (2014) maintain that the possible reason why birth preparedness was generally good among participants in their study was because of the provision of general knowledge and good counselling services on birth preparedness during the ANC services. The findings of this study are inconsistent with that of Markos and Bogale (2014), who claimed that many women in sub-Saharan Africa are often not adequately prepared for childbirth. As a result, the findings suggest the need for more educational and counselling support services for pregnant women during ANC to enable them appreciate the importance of birth preparedness and ways to effectively prepare for safe motherhood.

4.3.4 Transport preparation

A high proportion of participants reported that they had saved money as part of their birth preparedness plan. Participants further indicated that they had identified a skilled birth attendant or health facility and transport as part of their preparations. Only one participant who found out that her nearest site was being renovated returned home instead of going to another hospital and therefore ended up delivering at home. Another participant did not have enough money for transport and consequently also delivered at home. Similarly, Acharya et al (2015:130) found that nearly 48.9% women in their study had saved money and identified a mode of transportation for delivery.

Access to adequate ANC is critical in ensuring a good maternal health and preventing neonatal morbidity and mortality. According to Schoon (2013), maternal mortality in the Free State ranks among the highest in South Africa. The author adds that confidential inquiries into maternal deaths have identified transport as a factor relating to deaths. To address the problem, the Free State Department of Health prioritised staffed maternity inter-facility transport in 2011, and subsequently a sustained reduction in mortality was observed.

4.3.5 Saving for mother and baby

Most of the participants had saved some money for use during labour and delivery. One can deduce that financial preparation and the baby's clothes are what most pregnant women thought of as birth preparedness. From the responses, one noted that financial support was organised by the pregnant women themselves and their partners. Even the teenage mothers did not have problems with finances because the teens' mothers provided the finances. Teenage mothers face many challenges and need support and training constantly as they lack maternal skills (Mangeli, Rayyani, Cheraghi & Tirgadi 2017:165). Teenage mothers are often compelled to be financially dependent on their families or on public assistance. Consequently, the families of these teenagers were burdened with the additional responsibilities, supporting the teenager and her infant physically and financially. In families that are already struggling financially, providing for these teenagers becomes a major challenge. Teenage fathers are also at risk of dropping-out of school, which increases the risk of unemployment (Maholo, Maja, & Wright 2009:48).

4.3.6 Psychological preparation for labour

Pain associated with labour and the various procedures performed during labour and delivery require prior psychological preparation. However, not so many researchers and writers pinpoint the importance of psychological preparation of pregnant women for labour.

Some participants expressed that they discussed labour with their families and health care professionals who encouraged them to view labour as a natural process and not be anxious or fearful about it. This is similar to findings from Siabani, Jamshidi and Mohammadi (2019) who revealed that most women in their study had a positive attitude towards normal delivery, especially those who had normal deliveries in their previous child births. Few women mentioned that their mother-in-law decided how they should prepare for labour by using traditional methods of not reporting labour too early to show bravery. Such practices could result in delayed consultation if labour is prolonged and complicated. In some cultural settings, it is generally believed that eating vegetable soup especially the slippery soup or eating raw eggs will aid an expectant mother to deliver easily without any difficulty (Hadwiger & Hadwiger 2012). Similarly Roudsari, Zakerihamidi and Merghati (2015) found that cultural beliefs, values and traditions can significantly affect an individual's attitudes towards the mode of delivery.

4.3.7 Complication readiness

Pregnancy and labour complications are life threatening to expectant mothers and the unborn baby. Only a few participants were informed about complications that could arise from pregnancy and labour. They mentioned excessive bleeding, prolonged labour and problems with placenta. However, some of the participants stated that they were not aware of any pregnancy risks and labour complications and that childbirth is a normal process. Say et all (2014:332) report that the leading causes of maternal deaths in Africa were as a result of direct causes being haemorrhage or bleeding representing about 33.9% of the deaths.

Participants who had knowledge about complications of pregnancy and childbirth indicated that health facilities were the best option to deal with these dangers. They added that at the health facilities, the health care workers are able to give injections and infusions to mothers to avert these complications.

4.3.8 Knowledge regarding safe motherhood

Almost 15 participants needed clarity of the term safe motherhood before answering the question and the responses indicated having some knowledge

regarding the concept. Contraception and breastfeeding were expressed by some participants as good signs of safe motherhood. Few participants mentioned immunisation of babies to avoid diseases such as measles and tuberculosis.

In terms of principles of safe motherhood, family planning is a priority to ensure that couples plan and space their children. More importantly, ANC ensures that complications of pregnancy are detected as early as possible and clean safe delivery by skilled birth attendants and essential obstetrical care made available to all women in need of such care (Sandesh 2018; Stanton et al 2015).

4.4 CONCLUSION

Planning and preparing for labour and delivery in advance help to improve maternal health outcomes and complications are identified early so that proper action is taken. Safe motherhood entails initiatives to ensure that women receive high quality care in order to achieve the optimum level of care for mother and infant.

CHAPTER 5

JUSTIFICATION, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

This chapter addresses the justification, limitations, recommendations and conclusion of the study. The women who participated in the study were requested to describe how they prepared for delivery, complications and safe motherhood. This information could assist in improving the prenatal preparation package for delivery by midwives which can result in the reduction of high maternal and neonatal mortality in the country.

5.2 RESEARCH DESIGN AND METHODS

The research approach in this study was exploratory, descriptive and qualitative. A total number of 20 women, who had delivered within a space of one week, were interviewed using a structured interview guide. The main aim was to establish how they had prepared for labour, delivery, complication readiness, and safe motherhood. Such knowledge would assist in identification of strategies to improve maternal and neonatal health thereby reducing the high maternal and neonatal outcomes.

5.3 JUSTIFICATION OF THE STUDY

Previous studies on birth preparedness and safe motherhood emphasise the need for improvement in assisting pregnant women to prepare for labour, delivery and safe motherhood. The researcher also came to the conclusion that more still needs to be done to improve maternal and neonatal outcomes especially by ensuring that pregnant women develop plans for delivery and safe motherhood. Having met the study objectives, this study is justified.

5.4 LIMITATIONS OF THE STUDY

The following limitations are made.

- The study was conducted in a hospital at the hub of Swaziland. One cannot therefore generalise the findings for the whole Swati population. Even the places of residence of the participants covered two of the four regions in the country.

- Labour and delivery are painful and exhaustive experiences and therefore many eligible study participants declined to participate, especially those who had delivered in less than two days.

- The study required the respondents to recall health education they had learnt some months earlier. Some could not remember because they were not aware that they would be required to remember the information later on.

Despite having the mentioned limitations, the study findings and recommendations can still be used to improve ANC services, birth preparedness and safe motherhood. These are essential with the aim to reduce maternal and neonatal morbidity and mortality.

5.5 RECOMMENDATIONS

Research findings from the study resulted in recommendations for health care providers, nursing education, maternity hospitals and further research.

5.5.1 Health care providers

- Health care providers should motivate pregnant women to attend ANC soon after pregnancy is confirmed.

- ANC, labour and delivery health care providers should be professionals and support staff who are caring, approachable and understanding especially on SRH issues.

- Health education on SRH issues should be provided to individuals, couples and groups on regular basis. Topics can include, but not limited to safe

motherhood, danger signs during pregnancy, birth preparedness planning, labour, delivery and post-partum care.

- Health care providers should assist pregnant women to develop realistic plans on birth preparedness.

- Clients who are health workers should be provided with SRH information like all other clients, being health workers does not mean they know everything.

5.5.2 Nursing Education

- Health care professionals should be trained and groomed to respect and equip the recipients of the services they provide with necessary information.
- Continuing professional development for nurses and midwives should be promoted.

5.5.3 Maternity hospitals

- ANC and maternity staff should be carefully equipped and scheduled with the aim of reducing maternal / neonatal morbidity and mortality.

- Incentives for best customer-friendly and best performing department and staff should be considered. This could improve departmental performance and customer friendliness in the hospitals.

- Suggestions and feedback from the recipients of health care services should be promoted and actions taken to respond to the information gathered from such feedback.

- Alternative emergency health care settings nearby and transport should be made available in cases of renovations of critical areas like the maternity wing.

- Refresher or in-service courses on SRH issues should be made available for hospital staff.

5.5.4 Further Research

- Research on birth preparedness and safe motherhood involving all the regions in the country are recommended to compare results and get a clear picture of birth preparedness and safe motherhood in the kingdom.
- Research on why health worker clients / patients are neglected in terms of health education and information related to health services they seek.

5.6 CONCLUSION

The study revealed how pregnant women prepare for delivery, awareness about complications and safe motherhood. Knowledge about seeking ANC, labour and delivery preparations is presented and clarified. Contraception, family planning and other safe motherhood practices are traced. Evidence from the study pinpointed that as much as pregnant women prepare baby's clothes, transport and money for hospital fees, psychological preparation for labour seemed poor. Complication readiness was not known by most participants.

The study can be useful in improving the birth planning and safe motherhood package, including helping health care providers identify grey areas in the health education package from pre-natal to post-natal periods.

6. LIST OF REFERENCES

Acharya, AS, Kaur R, Prasuna, JG & Rasheed. 2015. Making pregnancy safer: Birth preparedness and complications readiness study among antenatal women attendees of a primary health centre, Delhi. *Indian Journal of Community Medicine,* 40(2):127-134.

Affipunguh, PK, & Laar, AS. 2016. Assessment of knowledge and practice towards birth preparedness and complication readiness among women in Northern Ghana; a cross-sectional study. *International Journal of Scientific Reports*, 2(6):121-129.

Berhan,Y & Berhan, A. 2014. ANC as a means of increasing birth in the health facility and reducing maternal mortality: A systematic review. *Ethiopian Journal of Health Sciences*. Special Issue: 93-102.

Bintara,D, Mohamed,A, Mghamba,J, Wasswa,P & Mpembeni RNM. 2015. Birth preparedness and complication readiness among recently delivered women in Chamwino District, Central Tanzania: A cross-sectional study. *Reproductive Health Journal*, 12 (4): 41-48.

Brink,H, van de Walt, C & van Rensburg, G.2018. *Fundamentals of Research Methodology for Health Care Professionals.* 4th edition. Cape Town: Juta & Company.

Burns, SK & Grove, N. 2009. *The Practice of Nursing Research.* Philadelphia: Saunders.

CIA World Factbook (last updated 8th October 2016). Swaziland maternal mortality rate. [online] Available at:

http://www.indexmundi.com/swaziland/maternal_mortality_rate.html
(Accessed 20 October 2016).

Ekabua, JE, Ekabua, KJ, Odusolu, P, Agan, TU, Iklaki, CU, Etokidem, AJ. 2011. Awareness of Birth Preparedness and Complication Readiness in south-eastern Nigeria. *Obstetrics and Gynaecology Journal,* 25:2011. https://doi.org/10.54002/2011/560641.

Fraser, DM & Cooper, AM. 2014. *Myles Textbook for Midwives*, 15th edition, London: Churchill Livingstone.

Grove, S.K., Burns, N. & Gray, J.R. 2013. *The practice of nursing research: appraisal, synthesis and generation of evidence.* 7th edition. Philadelphia: Saunders.

Gurmesa, T, Mesganew, FA, & Yalew, AW. 2014. The effect of Birth preparedness and complication readiness on skilled care use: A prospective follow-up study in south west Ethiopia. *Reproductive Health*, 11(60).

Hadwiger, MC & Hadwiger, SC.2012. Filipina mothers' perceptions about childbirth at home. *Nursing Review*, 59(1):125-131.

Holloway, I & Wheeler, S. 2013. *Qualitative research in Nursing and Healthcare*. United Kingdom: John Wiley & Sons.

Hudson, I, Gatongi, PM, Nyonga P, Makwali, J & Mudany, P. 2015. The Impact of Birth Preparedness on pregnancy Outcome: Findings from Lurambi, South County, Kakmega County, Kenya.

Idowu,A, Deji,SA, Aremu, OA, Bojuwoye, OM & Ofakunrin, AD. 2015. Birth preparedness and complication readiness among women attending antenatal clinics in Ogbomoso, South West, Nigeria. *International Journal of MCH & AIDS*, Volume 4(1): 47-51.

JHPIEGO. 2004. *Monitoring Birth Preparedness and Complication Readiness Tools and Indicators for Maternal and Newborn Health*. Maryland, USA: Maternal and Neonatal health program of JHPIEGO.

Kabakyenga, JK, Ostergren, PO, Turyakira, E & Petterson, KO. 2011. Knowledge of Obstetrical danger signs and birth preparedness practices among women in Ghana. *Reproductive Health*, 8(33).

Kakaire, O, Kaye, D & Osinde MO. 2011. Male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda. 2011. *Reproductive Health,* 8(12).

Kaur, A, Kaur, M & Kaur, R. 2015. Birth Preparedness among Antenatal mothers. *Nursing and Midwifery Journal, 1*1(4). Retrieved from http://medind.nic.nadt15/14p153,pdf.

Kuganab-Lem, RB, Dogudugu, R & Kanton, L. 2014. Birth preparedness and Complication readiness: A study of Postpartum women in a Rural district of Ghana. *Public Health Research*, 4(6):225-233.

Lobiondo-Wood & Haber 2014. Nursing Research: Methods and Critical appraisal for evidence. 8th edition: Mosby Elsvier.

Maholo, RB, Maja, TMM & Wright, SCD. 2009. Relationships, Perceptions and the Socio-cultural environment of pregnant teenagers in Soshanguve secondary schools. *African Journal of Nursing and Midwifery*, 11:46-58.

Mangeli, M, Rayyani, M, Cheraghi, M, Tirgadi, B. 2017. Exploring the challenges of adolescent mothers from their life experiences in the transition to motherhood: A qualitative study. *Journal of Family and Reproductive Health,* 11(3):165-173.

Markos, D & Bogale, D (2014). Birth preparedness and complication readiness among women of child bearing age group in Goba woreda, Oromia region, Ethiopia. *BMC Pregnancy and Childbirth*, *14*(1), 282. https://doi.org/10.1186/1471-2393-14-282.

Mgawadere, R, Unkels, R, Kazembe, R & van den Broek. 2017. Factors associated with maternal mortality in Malawi: Application of the three delays model. *BMC Pregnancy and Childbirth,* 17(219).

Neupane, S & Doku, D. 2013. Utilization of postnatal care among Nepalese women. *Maternal and Child Health Journal, 17*(10): 1922-1930.

Polit, DF & Beck, CT. 2012. *Nursing research*: *Generating and assessing evidence for nursing practice.* 9th edition. Lippincott Williams & Wilkins: Philadelphia (Chapter 9: Quantitative research design. Pages 201-234).

Polit, DF & Beck, CT. 2014. Essentials of Nursing Research: *Appraising evidencefor nursing practice.* 8th edition. Lippincott Williams & Wilkins: Philadelphia (Part 4: Qualitative research. Pages 265-321).

Roudsari, L, Zakerihamidi, M& Merghati, KE. 2015. Socio-cultural beliefs, values and traditions regarding women's preferred mode of birth in the North of Iran. *International Journal of Community based Nurse Midwifery,* 3 (3): 165-176.

Sandesh, A. 2018. Pillars of Safe Motherhood. *Reproductive Health, 15 (182).*

Say, L, Chou, D, Gemmil, A, Tuncalp, O, Moller, AB, et al 2014. Global causes of maternal death: A WHO system analysis. *The Lancet Global Health* 2(6): e 323-333

Schoon, D. 2013. Impact of inter-facility transport on maternal mortality in Free State province. *South African Medical Journal*, 103 (8): 534-537.

.

Siabani, S, Jamshidi, K & Mohamadi, MM. 2019. Attitudes of pregnant women towards normal delivery and factors driving use of caesarean section in Iran. 2019. *Biopsychosocial Medicine,* 13(8).

Seeiso, T & Maja, TMM. 2019.Quantifying Pregnant women's knowledge of Educational Components of Antenatal Care in Lesotho. *Africa Journal of Nursing and Midwifery*,21(1). http://doi.org/10.25159/2520-5293/4317.

Sellers, PM. 2012. *Seller's Midwifery*. 3rd edition. Claremont: Juta.

Smeele, P, Kalisa, R, van Elteren,M, van Roosman, J & van den Akker, T. 2018. Birth preparedness and complication readiness among pregnant women admitted in a rural hospital in Rwanda. *British Medical Journal of Pregnancy and Childbirth,* 18(1): 190.doi10.1186.

Stanton, ME, Kwast, BE, Shaver, TE, Callon, BM & Koblinsky, M. Beyond Safe Motherhood Initiative: Accelerated Preventable Maternal Mortality. *Global Health: Science and Practice*, 6(3): 408-412.

Swaziland Demographic and Health Survey, 2010. Preliminary report (online). Available at www.unicef.org/hiv-pmtctfactsheetswaziland, accessed 16 October 2018

Swaziland Ministry of Health, 2013. *Guidelines for Sexual Reproductive Health* 3rd edition. Swaziland Ministry of Health.

Swaziland National Policy on Sexual and Reproductive Health.2013. Swaziland Ministry of Health. Swaziland Service Availability Mapping. 2010. Swaziland Ministry of Health.

Tadesse, M, Boltena, AT & Assamoah, BO. 2017. Husbands' participation in birth preparation and complication readiness and associated factors in Wolaita Sodo town, Southern Ethiopia. *Africa Journal of Primary Health Care and Family Medicine*, 2071-2080.

The skilled Care Initiative. 2018. Birth Preparedness: An Essential Part of ANC Counselling. (online) http://www.familycareintl.org/issues/sm_skilled_care.php, accessed October 2018.

Tiku, S. 2015. Awareness of Birth Preparedness and Complication Readiness among Antenatal Care clients in Federal Police Referral Hospital. Addis Ababa, Ethiopia. *American Journal of Health Research,* 3(6): 362.

Tura, G, Afework, MF & Yalew, AW. 2014. The effect of birth preparedness and complication readiness on skilled care use: a prospective follow-up study in Southwest Ethiopia. *Reproductive Health*, 11(60).

Urassa, D, Pembe, AB & Mganga, F. 2012. Birth preparedness and complication readiness among women in Mpwapwa district, Tanzania. *Health Research* (14): 42-47. Doi:10.4314/thrb.v14:1.8.

World Health Organization. 2012. Progress Towards. MDG. Geneva, Switzerland: WHO

World Health Organization.2015. WHO recommendations on health promotion interventions for Maternal and Newborn health, Geneva. Retrieved from http://www.who.int/iris/handle/10665/172427.

WHO, UNICEF, UNFPA & World Bank. Trends in Maternal Mortality, 1990-2010,2012. Available at http://www.unfpa.org/publictions/trends-maternal-mortality 1990-2010.

ANNEXURES

ANNEXURE 1: UNISA ETHICAL CLEARANCE CERTIFICATE

UNISA RESEARCH ETHICS COMMITTEE:

DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

6 December 2017

HSHDC/797/2017
Khetsiwe Reginah Joyce Dlamini
Student No.:120617
Supervisor: Prof TMM Maja Qualification: PhD
Joint Supervisor:

Decision: Ethics Approval

Dear Khetsiwe Reginah Joyce Dlamini

Name: Khetsiwe Reginah Joyce Dlamjni

Proposal: Birth preparedness planning and safe motherhood among pregnant women at a hospital in Swaziland

Qualification: MPCHS094

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 6 December 2017 to 6 December 2019

The Research Ethics Committee reviewed the application in compliance with the Unisa Policy on Research Ethics: Department of Health Studies on. 6 December 2017

The proposed research may now commence with the proviso that:

1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.

2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as we// as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.

University of South Africa

Preller Street. Muckleneuk Ridge. City ofTshwane

PO Box 392 UNISA 0003 South Africa Telephone: +27 12 429 1

Facsimile: +27 12 429 4150 www.unisa.ac.za

Open Rubric

3) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.

4) [Stipulate any reporting requirements if applicable],

Note:

The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmai/, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof JE Maritz
CHAIRPERSON

maritje@unisa.ac.za

Prof MM Moleki
ACADEMIC
CHAIRPERSON

molekmm@unisa.ac.za

Prof A Phillips
DEAN COLLEGE OF HUMA

a

ANNEXURE 2: Permission letter from RFM Hospital

SWAZILAND NAZARENE HEALTH INSTITUTIONS (SNHI)
RALEIGH FITKIN MEMORIAL (RFM) HOSPITAL
COMMUNITY HEALTH CLINICS

At Junction of David Hynd Road & Ligusha Street

P.O. Box 14 Manzini 200 Swaziland

24th May 2018

Khetsiwe R.J. Dlamini
UNISA

Dear Madam

RE: AUTHORIZATION TO DO RESEARCH IN THE HOSPITAL

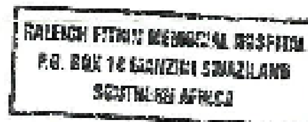
Your request on the fore mentioned endeavors has been dul considered and permission granted on the following condition please:-

a). That confidentiality is strictly observed
b). That the hospital receives a copy of the report on the proposed research.

Sincerely yours

Leonard S. Dlamini (Mr.)
HOSPITAL ADMINISTRATOR

CC: Matron 1
SMO



SWAZILAND NAZARENE HEALTH INSTITUTIONS (SNHI)
RALEIGH FITKIN MEMORIAL (RFM) HOSPITAL
COMMUNITY HEALTH CLINICS

At Junction of David Hynd Road & Ligusha Street

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24th May 2018

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UNISA

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b). That the hospital receives a copy of the report on the proposec research.

Sincerely yours

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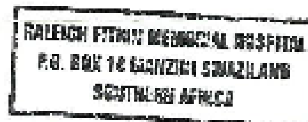
HOSPITAL ADMINISTRATOR

CC: Matron I
SMO



Annexure 3: Request Letter to SNHRU

P.O BOX 2031

MANZINI

11thJanuary2018

The Administrator
The Health Research Unit
P.O. Box
MBABANE

Dear Sir,

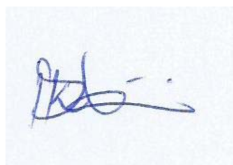
Request for Permission to Conduct a Research Study

I hereby request for permission to conduct a research study entitled: **Women's Birth Preparedness Planning and Safe Motherhood at a Hospital in Swaziland**. This study will be conducted in partial fulfilment of a Master's degree in Nursing Science with the University of South Africa (UNISA).

The purpose of the study is to establish women's preparedness for labour, delivery and safe motherhood in Swaziland. The study is aimed at improving maternal health and neonatal outcomes in the country.

Data will be collected at the Raleigh Fitkin Memorial Hospital from women who have given birth within a week for a period of three months from the date of approval of the request. Ethical considerations will be adhered to and disruption of services will be minimised during the process of data collection. Information gathered will be used for research purposes only and the research findings will be shared with UNISA, the Swaziland Health Research Unit and the Raleigh Fitkin Memorial Hospital.

Yours faithfully



Khetsiwe R. J. Dlamini

ANNEXURE 4

Research Protocol clearance certificate

Type of review	Expedited	X	Full Board	
Name of Organization	Student (Masters)			
Title of study	Woman's Birth Preparedness Planning and safe motherhood at a hospital in Swaziland			
Protocol version	1.0			
Nature of protocol	New	X	Amendment	Renewal
List of study sites	RFM Hospital, Manzini			
Name of Principal Investigator	Khetsiwe Regina Dlamini			
Names of Co- Investigators	N/A			
Names of steering committee members in the case of clinical trials	N/A			
Names of Data and Safety Committee members in the case of clinical trials	N/A			
Level of risk (Tick appropriate box)	Minimal X		High	
Clearance status (Tick appropriate box)	Approved	X	Disapproved	
Clearance validity period	Start date	10/08/2018	End date	10/08/2019
Signature of Chairperson				
Date of signing	10/08/2018			
Secretariat Contact Details	Name of contact officers	Ms Simangele Masilela		
	Email address	kaluamasi@gmail.com		
	Telephone no.	(00268) 24040865/24044905		

14 AUG 2018
HEALTH RESEARCH REVIEW BOARD

Page 1 of 2

APPROVAL CONDITIONS

Ref.	Conditions	Indication of conditions (tick appropriate box)				
1	Implementation of approved version of protocol	✓				
2	Reporting of adverse events within 5 days of occurrence	✓				
3	Submission of progress reporting for multi-year studies	**Yr 1**	**Yr 2**	**Yr 3**	**Yr 4**	**Yr 5**
		✓	**N/A**	**N/A**	**N/A**	**N/A**
4	Submission of end of project report (Hard copy)	✓				
5	Submission of end of project report (Soft copy)	✓				
6	Submission of data sets	✓				
7		✓				

List of reviewed documents

Ref.	Documents	Reviewed documents (tick appropriate box)
1	Completed application form	✓
2	Cover letter	✓
3	Evidence of administrative permission to conduct the research by involved institutions/sites (where applicable)	✓
4	Detailed current resume or curriculum vitae of Principal Investigator/s including Principal investigators declaration	✓
5	Summary resume or biography for other investigator(s)	✓
6	Evidence of approval/rejection by other Ethics Committees, including comments and requested alterations to the protocol, where appropriate.	
7	Research protocol (see outline in Annex 1)	✓
8	Questionnaires and interview guides (with back-translated versions where applicable)	✓
9	Case report forms (CRFs), abstraction forms and other data collection tools	✓
10	Participant/subjects Information Statement(s) (where applicable)	✓
11	Informed consent form(s) including photographic and electronic media consent statements.	✓
12	Advertisements relevant to the study (where applicable)	
13	Source of funding and detailed budget breakdown including material and incentives to participants if applicable	
14	Notification form for adverse effects/events.	
15	Proof of payment	✓
16	Proof of insurance cover for research subjects in clinical trials or where applicable	
17	Any other special requirements should be stated, if applicable	None

XZ

ANNEXURE 5: PARTICIPANT CONSENT FORM

CONSENT FORM FOR WOMEN'S BIRTH PREPAREDNESS AND SAFE MOTHERHOOD (ENGLISH VERSION)

I ________________ understand that I am being asked to participate in the research study entitled**: Women's birth Preparedness and Safe Motherhood in a Hospital** in the Kingdom of ESwatini. I understand that the purpose of this study is to explore women's preparedness for labour and safe motherhood with the overall aim of improving maternal health and neonatal outcomes as explained by the researcher, Ms Khetsiwe Dlamini.

I realise that participation in this study is voluntary and I may withdraw from the study

at any time. I am aware that withdrawal from participating will not endanger my right to health services. I therefore agree to respond to the questions that will be asked in this study.

I am aware that I may refuse to disclose information which I perceive to be confidential. I also understand that all research data from this study will be kept confidential. However, this information may be used in professional decision-making.

I have read and understood the information contained in this consent form and therefore, I agree to participate.

Participant's Signature____________________ Date____________________

ANNEXURE 6: RESEARCH SITE REQUEST LETTER

P.O BOX 2031
MANZINI

08th June 017

The Hospital Administrator
Raleigh Fitkin Memorial Hospital
P.O. Box 14
MANZINI

Dear Sir,

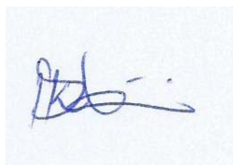
Request for Permission to Conduct a Research Study

I hereby request for permission to conduct a research study entitled: **Women's Birth Preparedness Planning and Safe Motherhood at a Hospital in Swaziland**. This study will be conducted in partial fulfilment of a Master's degree in Nursing Science with the University of South Africa (UNISA).

The purpose of the study is to establish women's preparedness for labour and safe motherhood in Swaziland. The study is aimed at improving maternal health and neonatal outcomes in the country.

Data will be collected from women who have given birth within a week for a period of three months from the date of approval of the request. Ethical considerations will be adhered to and disruption of services will be minimised during the process of data collection. Information gathered will be used for research purposes only and the research findings will be shared with UNISA and the Raleigh Fitkin Memorial Hospital and the Swaziland Health Research Unit.

Yours faithfully



Khetsiwe R. J. Dlamini

ANNEXURE 7: LANGUAGE EDITING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

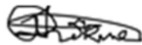
30 December 2019

TO WHOM IT MAY CONCERN

This certificate serves to confirm that I have edited and proofread KRJ Dlamini's dissertation entitled, "**WOMEN'S BIRTH PREPAREDNESS PLANNING AND SAFE MOTHERHOOD AT A HOSPITAL IN SWAZILAND.**"

I found the work easy and intriguing to read. Much of my editing basically dealt with obstructionist technical aspects of language, which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors' Guild.

Hereunder are my particulars:



Jack Chokwe (Mr)

Contact numbers: 072 214 5489

jackchokwe@gmail.com

ANNEXURE 8: INTERVIEW GUIDE

Women's birth preparedness planning and safe motherhood at a Hospital in Swaziland

Section A: Demographic Data

Age in years………………..
Marital Status: Married ( ) Divorce ( ) Co- habitation ( ) Single ( )
Employment: Employed ( ) Unemployed ( ) Self-employed ( )
Education: Primary ( ) Secondary ( ) Tertiary ( ) No schooling ( )
What is your usual place of residence?
Religion: What is your religious affiliation?

Section B: Birth preparedness

1. State if you have attended antenatal care during this pregnancy.
2. If yes to question 1:
   1.1 Where did you go for antenatal care?
   1.2 How many visits did you make?
3. Who attended you during the visit(s)? choose any mentioned
   a. Doctor
   b. Nurse
   c. Other….specify

4. Do you recall some of the messages you were given during the visits (probe)
   a. Method of contraception to be used after delivery
   b. HIV testing
   c. Partner testing for HIV
   d. Prevention of mother-to-child transmission of HIV
   e. Danger signs during pregnancy (may include any of the following),
      i. vaginal bleeding
      ii. rupture of membranes
      iii. fever
      iv. decreased/absent foetal movements
      v. anaemia
      vi. seizures
      vii. oedema of face and hands
   f. Early infant male circumcision
   g. Methods of contraception
   h. Infant feeding
   i. Signs of labour
   j. Sexually transmitted infections
   k. Birth preparedness plan (may include any of the following)
      i. Place of delivery
      ii. Mode of transport to be used when going to the delivery facility
      iii. When (time) will you go, eg, before/ during labour
      iv. Baby's layette
      v. Personal belongings (the mother)
      vi. Financial preparation- transport, food, hospital fees etc
      vii. Birth assistant
      viii. Birth companion

ix. Procedures- may include vaginal examination, episiotomy, suturing, caesarean section, resuscitation
x. Infant feeding option
xi. Other (name any other topic mentioned).

5. Where did you deliver the baby?
6. Who assisted you during delivery? (nurse, doctor, other health worker, student nurse or any other person)
7. How did you cope with labour?
8. How did you deliver the baby?
    a. Normal vaginal delivery
        i. Were you stitched after delivery Yes/No. If yes, how much did you cooperate with whoever was stitching you?
        ii. Do you feel you were prepared in advance (during pregnancy) for the stitching?
    b. Abnormal vaginal delivery (clarify the abnormality)
    c. Caesarean section
9. Describe your:
    a. Transport preparation
    b. Financial preparation
    c. Psychological preparation
10. What messages do you feel you should have been given in preparation for delivery?
11. How can you describe your preparedness for labour and delivery? (answers can include; was not prepared at all, was well prepared)
12. What do you think needed more clarity in preparing for delivery?
13. What was the delivery outcome? Answers can include; a live baby, macerated stillborn, fresh stillborn or any other outcome mentioned.
14. How can you explain your overall experience of the pregnancy and delivery with emphasis on the information you received from caregivers?

Section C: Safe Motherhood.

15. Were you informed about safe motherhood?
16. Explain what information was provided about safe motherhood. Responses may include
    a. Family planning
        i. method of contraception
        ii. child spacing
        iii. total number of children wished to have
    b. How to detect complications during pregnancy?
        i. What action to take in case of complications?
        ii. Were you informed about facilities to visit in case of complications
        iii. Caring for the baby
        iv. Baby feeding
        v. Napkin changing
        vi. Baby bathing
        vii. Observation and identification of abnormalities

17. Were you assisted to choose a safe environment for delivery?
18. Looking back now, do you think you made the right choice in choosing a place for delivery?
19. Who provided the information on safe motherhood?
20. What is your view regarding safe motherhood?

21. Suggest ways of improving birth preparedness and safe motherhood.

Thank you for your participation.