Enhancing Changes in Undesirable Practices and Health Sector Response Related to Maternal, Newborn and Child Health in Paletwa Township: A Qualitative Approach

Yadanar Aung[1], Kyaw Thu Soe[1] & Kyaw Oo[2]*

[1]Department of Medical Research (Pyin Oo Lwin Branch)
[2]Department of Human Resources for Health

The project on strengthening local capacities to improve Maternal, Newborn and Child Health (MNCH) interventions has been launched in 100 villages of Paletwa Township, Chin State since 2010,. This cross-sectional study using qualitative methods aimed to assess the knowledge, perceptions, and practices related to MNCH and health sector response in rural setting. The research team used a multistage sampling procedure to select 9 villages from December 2015 to February 2016. In each selected village, the eligible women with under 2 years old children (n=72) were purposively selected to join 9 focus group discussions and 9 mothers participated in in-depth interviews. Moreover, the team recruited 9 midwives and 9 auxiliary midwives for key informant interviews using pre-tested guidelines. All sessions were audio-recorded and supplemented by manual note-taking. Village women revealed good knowledge of care during pregnancy, delivery, post-natal and newborn care. However, some risky traditional practices for both mothers and newborns remained such as food taboos and cord care. Focus group discussants reported home deliveries either on their own or assisted by untrained traditional birth attendants (TBA) rather than choosing skilled birth attendants or hospital delivery due to spreading myths and misconceptions. Health care providers reached a consensus for improving awareness of the consequences of home deliveries assisted by unskilled TBAs/none, not using contraception and improper newborn/ infant feeding practices. Developing information, education and communication materials in a simple language inclusive of the needs to change undesirable practices and to promote the use of quality services is critical in a remote setting.

Keywords: MNCH, Rural setting, Traditional practice, Cultural barriers

INTRODUCTION

Myanmar has made significant progress in improving maternal, newborn and child health (MNCH), but in remote areas still remarkable gap between health sector response and strongly needed to enhance changes of undesirable practices among Chin ethnic minority women. Although Myanmar's overall maternal mortality rate is 282 per thousand live births, Chin State figured out that ethnic minority people have higher maternal mortality (MMR : 357 per thousand live births), infant and under five mortality rates in 2014.[1] The project on strengthening local capacities to improve MNCH interventions has been launched since 2010 in 100 villages of Paletwa Township, Chin State. The International Rescue Committee (IRC) has worked with local Non-Govern-

*To whom correspondence should be addressed.
Tel: + 95-92216777
E-mail: dryadanaraung@gmail.com,
DOI: https://doi.org/10.34299/mhsrj.00977

mental Organizations (NGOs) in Paletwa Township, Chin State in past 6 years to implement the project interventions.[2]

The project trained community health workers (CHW), auxiliary midwives (AMW), and Village Health Committees (VHC) to implement community health prevention and behaviour change communication (BCC) activities in collaboration with Basic Health Staff (BHS) including midwives (MW). Baseline and midterm surveys on Knowledge, Practice and Coverage (KPC) concerning reproductive health interventions were completed.[3] More mothers in project villages were aimed to be able to identify warning signs of childhood diseases and to seek timely care from trained health care providers mainly CHWs. During the years of intervention, the project led to more positive deviants than negative in terms of knowledge, practices and coverage of MNCH services.[3] However, sustainability issues should be put forward for changes in breast feeding, postpartum care, child care, immunization and sanitation practices that require more external resources. To evaluate the impact of previous project implementation and to address the gaps in health sector response, this research aimed to identify the knowledge, perceptions, and practices related to MNCH and health sector response in rural setting in Paletwa Township, Southern Chin State.

MATERIALS AND METHODS

A cross-sectional study using a qualitative approach was conducted in Paletwa township from December 2015 to February 2016. Among those areas which had granted to secure, good communication skills, and responsiveness of village women, nine clusters with similar travel route were included. After assembling the village based on transportation ability, village (easy to reach and not easy to reach) was selected by random. The research team used a multistage sampling procedure to select 9 villages in Paletwa township. In each selected village, the eligible women with under 2 years old children (n=72) were purposively selected to join 9 focus group discussions and 9 mothers participated in-depth interviews. Each FGD lasted one and a half hour conducted by one trained moderator/ facilitator and two note-takers. At each and every village, focus groups were scheduled to encompass all work shifts. One trained local interpreter attended the FGDs to minimize the language barrier. Moreover, the team recruited 9 midwives and 9 auxiliary midwives for key informant interviews using pre-tested guidelines which lasted 45 minutes to one hour. Guidelines covered knowledge, perception and practices related to MNCH care. Participants were assured anonymity and confidentiality of their responses. All sessions were audio-recorded supplemented by manual note-taking. After transcribing, coding was done by using ATLAS.Ti software. Two researchers reviewed the transcripts and identified themes and subthemes. Triangulation was done for meaningful interpretations of findings from FGDs and KIIs.

Ethical consideration

The Ethics Review Committee of Department of Medical Research approved this study. All interviews were done following the written and informed consent.

RESULTS

Theme - 1: Knowledge of abnormal pregnancy, newborn care and source of information

The knowledge of mother on pregnancy, delivery and newborn care impacted on their choices of delivery places. Pregnant women in selected villages worried about congenital anomalies and complications from hospital deliveries spread by word-of-mouth. On the other hand, they had trust and confidence in MW, AMW, and TBA. But most of the pregnant women gave birth at home and some delivered by themselves and cut the umbilical cords with available local materials. They admitted that if they have enough money to travel, they

might deliver with the MW. Even though they had sought antenatal (AN) care and planned to give birth with a MW, at the time of labour pain, MW was away from village for other activities such as meetings, mopping up immunizations etc. For pregnancy and delivery process, they felt that this is normal part of every woman's life and thought that did not require any special medical knowledge.

"I had experienced of prolonged labour. At that time, the TBA refereed me to Paletwa hospital. But because of a long distance, I gave birth on the boat. I have followed the advice from my elder family members rather than Sayarma (MW) because they had rich experiences throughout their lives"

(a 28- year-old mother)

The participants could identify the complications in pregnancy and delivery such as premature labour, bleeding, hypertension, edema, headache, vomiting, loss of appetite, fever, breech delivery, hemorrhage, cord around the neck, early rupture of membrane and child death. Health staff and CHWs informed them about healthy diet and good nutrition in pregnancy, not to avoid foods as suggested by elders, not to give birth to newborn babies, to keep babies warm, and not to apply anything on cord except methylated spirit. However, women stated that they were unable to read the posters displayed at the RHCs and could not grasp the facts during health talks. They still have limited knowledge on caring newborn babies.

"Although MWs said not to take bath a newborn baby, my mother did and feed rice and salt when my baby was four months old. The umbilical cord dryness in newborns was also important. So applied the bamboo ashes after falling off the cord stump."

(a 32- year-old mother)

During key-informant interviews, BHS and volunteers recited that knowledge of mothers on newborn care, feeding practices and immunization were acceptable. Most of the pregnant women had AN care at late pregnancy and a minimal visit of three times. They usually gave birth at home with skilled birth attendants and MWs or by themselves. After delivery, they preferred to eat rice and salts with hot water. For family planning, the women felt uneasy to ask for three monthly Depo injections available at RHCs and sub-centers.

"They thought a big family was stronger than the small size and had at least 3-4 babies in one household. I can't speak Chin language. So, I can't communicate with pregnant women and mothers who can't speak Myanmar language"

(a midwife)

Key informants noted that if the mothers sought for AN care, postnatal care and newborn care with TBA or SBA, they followed the rules related to cord care. They started breast-feeding soon after delivery but some were reluctant to practice exclusive breast feeding due to work. They continued their usual feeding practices: rice, milk and milk powder before one month of babies' age. For immunization, all mothers in selected villages accepted full doses.

Theme - 2: <u>Current practices of delivery, postnatal care and newborn care</u>

Most of the discussants preferred home delivery due to: convenience, no problem encountered with home delivery, had a chance to enjoy with family members around, and availability of SBA or AMW or TBA with very little financial constraint. Nevertheless, they accepted hospital delivery as a better and safer place but they would choose only if they have encountered problems or being referred by their birth attendants.

"Even though I preferred hospital delivery, I gave birth at home because of financial and geographical barriers."

(a 42-year-old mother with four kids)

Since they had experienced deliveries at home/village without facing any problems previously, they did not have serious concerns about untoward consequences related to home

delivery. However, the utilization of skilled birth attendants such as MWs for home deliveries was also apparent. They decided to deliver at homes depending on the condition of pregnancy and delivery. Some mothers trusted midwives and followed their instructions. Nearly all of the discussants had only salt and rice with hot water for gaining strength during postpartum period (*meedwin*) for 7-10 days and then joined their routines for cultivation.

"I started to work after delivery within a week or not more than 10 days. That's why I breastfeed my baby early morning and in the afternoon, I can't as I was in the forest for cultivation."

(a 38-year-old mother with three kids)

"Me and my mother climbed the mountain to cut the wood. Impossible to give exclusive breast feeding because I left my baby every day when I went to work. I can't stay at home without working for six months."

(a 27-year-old mother)

Several discussants reported that they had never seen or heard about newborn deaths in this study area. Some villages had volunteer health workers assigned for newborn care who were young and inexperienced unlike TBAs. But they had attended the training at Plaetwa hospital. Mothers still gave a hot water bath to a newborn baby in some villages expecting for better health. During FGDs, all mothers reported that they kept their newborn babies warm. In some village, they stilled practiced the application of ash from brunt bamboo mat to dry the cord or application of mother's saliva for healing of cord wound.

Theme - 3 : Service availability and challenges in utilization

Village women received AN care, PN care, immunization and family planning services at the MCH center and at Paletwa hospital. Moreover, RHCs and sub-RHCs provided immunization, treatment for common minor illness and the initial treatment for emergency conditions. Most of the village women received AN care in late pregnancy and stilled preferred home delivery. However, women at remote sites did not use delivery services.

"Sometimes, a medical doctor was not available at the hospital for obstetric emergencies as he had to attend the meeting at Hakha. Also, there are no well-trained AMWs in my village. The strong reason for me not going to health facilities was my reluctance to show my private part. Moreover, I can't afford to travel to the hospital"

(a 32-year-old mother with two kids)

For minor illness during pregnancy, self-medication was common. They used hospitals only for emergency conditions such as retained placenta, prolonged labour and twin pregnancy. They sought treatment for their sick children from MWs. Some women preferred hospital delivery if they could afford travelling costs. Other challenges to seek healthcare from doctors, and MWs included the irregular availability of health staff and the travelling distance of over one-hour to the nearest health center.

Theme - 4: Health sector response to MNCH issues, priority actions and community participation

At RHCs, BHS could provide full package of maternal care services to AN clinic' attendees such as measurements of blood pressure and body weight and supplying multivitamins and anti-helminths. The MWs did timely referral of emergency cases to Paletwa hospital and provided health education in remote areas about nutrition, arranged provision of medicinal supplies and delivery kits to pregnant women, a recruitment and training of AMWs and TBAs. Key informants addressed human resources development as their priority action by increasing the number of skilled providers and to improve the skills of existing workers including AMWs and community volunteers. For efficient and effective performance of BHS and volunteers, an adequate medicinal supply was critical. Health information and behaviour change communication (BCC) initiatives were

(essential. For further improvement of MNCH) services, key informants suggested free health care services, improved information for health care delivery, establishment of family planning clinics, promoting skilled delivery and clean home delivery, supporting timely referral system and finally to negotiate with VHWs in referral trans portation system.

"We, healthcare providers, take care everyone. If behaviour change communication program interventions focus on better-off in implementing optimal institutional delivery and timely referral system, there could be further obstacles in newborn care and postpartum care."

(a midwife)

The key informants acknowledged BHS and health centers as major sources of health information and behaviour change communication (BCC) for clients. Because of poor literacy, poster displays/pictorial cards were the main media for BCC interventions in relaying health messages. Since some of the behaviours were evident as preventing actions for improving MNCH, those were prioritized as a principle target. According to key stakeholders, there were priority actions for BCC such as self-delivery at home, newborn care especially feeding practices, family planning services and contraceptive practices.

"I am working as a AMW responsible to look at socio-economic disparity in promoting the early initiation of breastfeeding. Poverty and illiteracy are beyond my capacity, and the existing language barrier in ethnic groups prevents us to systematically prioritize actions as required."

(an axillary midwife)

"To my opinion, further investigation is necessary why most deprived group of mothers from the implemented communication actions. A multi-sectorial approach addressing various dimensions of maternal and child health care, particularly cord care practices, hygiene practices and postpartum nutrition habits might bring about positive impact leading to the effectiveness of BCC and MNCH interventions."

(a midwife)

The lack of pooling fund in some villages was the major obstacle for community participation in implementation and funding for BCC and MNCH interventions. Most of the villages formed village health committees and collected funds monthly from every household. All villagers are willing to participate in different interventions for MNCH activities.

DISCUSSION

The study highlighted the traditional practices related to MNCH in a remote rural setting that required intensive BCC and other support for BHS and volunteers amidst of project interventions that aimed to promote an access to health information and quality care.

Improved vs. unimproved practices and associated factors

After project interventions over a six-year period, PN care practices including proper cord care, and early breast feeding were improved. But some traditional behaviours remained like nutrition for pregnant mothers and cord care that were risky for both women and newborn. There were some barriers such as lack of local adaptability of IEC materials and health information given by health staff. Nonetheless, findings indicated good knowledge of mothers, satisfaction of services provided by BHS, and compliance to referral due to good system support. However, they still practiced home delivery and use of TBA due to some limitations related to choose SBA and hospital delivery.[4] In most of the RHCs, BHS were not available because they had to attend training and/or meeting at Paletwa township hospital. Accessibility/ availability of skilled providers and lack of consciousness on risk during delivery were main factors that influenced utilization of skilled birth attendants which was consistent to other studies.[5, 6]

The number of healthcare providers and midwives required strengthening in the study sites according to the geographical landscape and population expansion. Major constraints in access to the health center for delivery in this study encompassed socio-economic hardship, and cultural barriers. Better knowledge and good education were main factors influencing the utilization of quality services.[7] Pictorial cards have been used in resource-poor settings in rural Nepal to educate women on pregnancy danger signs, birth-preparedness, and maternal nutrition.[8]

Focused BCC using pictorial cards during AN visit in study sites or similar remote rural areas might improve knowledge regarding five danger sings in pregnancy with clear implications for improving institutional delivery rates. Moreover, educational campaigns and behaviour change activities should modify both modern and traditional beliefs and practices to help women be better able to access safe motherhood, delivery and child cares.[3] Maternal nutritional practices need to be changed and educated well not to follow traditional eating habits during post-partum period (42 days after delivery). Like previous study[9], continuation of exclusive breast feeding practices should be encouraged.

Health sector response, challenges encountered and potential solutions

In this study, production of adequate numbers of AMWs, capacity building of local volunteers and village health committee members, and existing fund-pooling mechanisms were noted as good opportunities for sustainable BCC interventions.[7, 8] Furthermore, motivation and incentives for local volunteers to prevent attrition is essential for the community on the changes they want to get while making significant behavioural changes. Increasing coverage of local volunteers and their capacity is the most possible, practical and effective implementation. There is a need to promote community awareness in existence of fund-pooling mechanisms and support functions of VHCs. The training for VHWs should include how to provide effective health education messages for clients especially about danger signs in pregnancy, life-threatening complications in delivery as well as danger signs of newborn/childhood illnesses and untoward consequences related to lack of childhood immunization. The formal and sustained IEC channels should be considered. Developing information education, and communication materials in a sample language inclusive of the needs to change undesirable practices and to promote the use of quality services is critical in a remote setting.

Competing interests

The authors declare that they have no competing interests.

ACKNOWLEDGEMENTS

We would like to extend our words of thanks to the International Rescue Committee (IRC) for financial support to conduct this study. Our heartfelt gratitude goes to Township Medical Officer, local authorities and administers of Paletwa Township for their contributions in conducting research and security concerns. Last but not the least, we owe our gratitude to research assistants from DMR (POLB) for their kind assistance and our deep respect to Dr. Kyaw Oo for overall technical guidance during this study.

REFERENCES

1. Department of Population. *The 2014 Myanmar Population and Housing Census.* Naypyitaw, Ministry of Immigration and Population, 2015.
2. 3MDG Fund. *Supporting Implementing Maternal Newborn and Child Health Services (MNCH) in Chin State.* [Internet]. 2013. Available from [https:// www. 3mdg. org/ en/ what-we-do/ maternal-newborn-and-child-health/ partners-projects/ item/ 438-save-the-children-township-health-plan-chin-state]
3. International Rescue Committee. *Report of Knowledge, Practice and Coverage (KPC) Survey for Maternal and Child Health, Paletwa Township, Southern Chin State. IRC, Myanmar, 2012.*

4. Ministry of Health and Sports & ICF. *Myanmar Demographic and Health Survey 2015-16.* Naypyiptaw, MoHS and ICF, 2017.

5. Sollom R, Richards AK, Parmar P, Mullany LC, Lian SB, Iacopino V, *et al*. Health and human rights in Chin State, Western Burma: A population-based assessment using multistaged household cluster sampling. *PLoS Medicine* 2011; 8(2): e1001007.

6. Diamond-Smith N, Thet MM, Khaing EE & Sudhinaraset MJC. Delivery and postpartum practices among new mothers in Laputta, Myanmar: Intersecting traditional and modern practices and beliefs. *Culture, Health & Sexuality* 2016;18(9): 1054-1066.

7. Wanjira C, Mwangi M, Mathenge E & Mbugua G. Delivery practices and associated factors among mothers seeking child welfare services in selected health facilities in Nyandarua South District, Kenya. *BMC Public Health* 2011; 11(1): 360.

8. McPherson RA, Tamang J, Hodgins S, Pathak LR, Silwal RC, Baqui AH, *et al*. Process evaluation of a community-based intervention promoting multiple maternal and neonatal care practices in rural Nepal. *BMC Pregnancy Childbirth* 2010; 10(1): 31.

9. Hmone MP, Dibley MJ, Li M & Alam A. A formative study to inform Health-based randomized controlled trial intervention to promote exclusive breast-feeding practices in Myanmar: Incorporating qualitative study findings. *BMC Medical Informatics and Decision Making* 2016; 60(16): 1-10.