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Exploring women's perspectives of access to care during pregnancy and childbirth: A qualitative study from rural Papua New Guinea

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ABSTRACT

Objectives: to explore women's perceptions and experiences of pregnancy and childbirth in a rural community in PNG.
Design: a qualitative, descriptive study comprising focus group discussions (FGDs) and in depth interviews.
Setting: this study took place in a rural community in Eastern Highlands Province, PNG.
Participants: 51 women participated in seven focus group discussions. In depth interviews were undertaken with 21 women, including women recruited at the antenatal clinic, women purposively selected in the community and three key informants in the community.
Findings: the majority of women mentioned the benefits of receiving antenatal care at the health facility and the importance of a supervised, facility birth. Women faced numerous challenges with regards to accessing these services, including geographical, financial and language barriers. Cultural and customary beliefs surrounding childbirth and lack of decision making powers also impacted on whether women had a supervised birth.
Key conclusions and implications for practice: distance, terrain and transport as well as decision making processes and customary beliefs influenced whether a woman did or did not reach a health facility to give birth. While the wider issue of availability and location of health services and health system strengthening is addressed shorter term, community based interventions could be of benefit. These interventions should include safe motherhood and birth preparedness messages disseminated to women, men and key family and community members.

Introduction

The majority of the 287,000 maternal deaths that take place every year occur in developing countries (WHO et al., 2012). Rural areas in the poorest and most remote locations bear the burden of these deaths (WHO, 2004). Lack of access to and low uptake of skilled attendance during childbirth is a major factor associated with maternal deaths (WHO, 2005). Globally, only 62% of women giving birth do so with a skilled attendant (UNICEF, 2008). In the least developed countries, the rate is as low as 39% (UNICEF, 2008).

Lack of skilled assistance during birth may not necessarily be a decision of choice but one of circumstances. Delay or an inability to access care is a major factor. In their conceptual framework, Thaddeus and Maine (Thaddeus and Maine, 1994) described three delays in women accessing maternity care: delay in the decision to seek care; delay in the arrival at a health facility and delay in the provision of adequate care. Within each of these delays many contributing factors further hinder access to skilled care, including lack of decision making powers, lack of transport and lack of supplies at the facility (Thaddeus and Maine, 1994).

In many developing countries, the decision to seek and access care frequently rests with family members, including the husband,

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mother, mother-in-law and grandmother and, in some situations, traditional birth attendants and village-based health-care workers (Beegle et al., 2001; Seljeskog et al., 2006; Allendorf, 2007; Mrisho et al., 2007; Danforth et al., 2009; Magoma et al., 2010; Sychareun et al., 2012). Other influencing factors include cultural and customary beliefs, geographical, structural and health facility barriers as well as economic and social constraints (Danforth et al., 2009).

Papua New Guinea (PNG), a developing country (IMF, 2012) within the Asia-Pacific region is rich in geography, social and cultural and linguistic diversity. The majority (87%) of the 6.5 million people in PNG reside in rural areas. Infrastructure in PNG is poor and the past several decades has seen a decline in health system performance, in terms of both coverage and quality and in many areas rural health services continue to weaken (NDoH, 2009).

The maternal mortality ratio (MMR) in PNG is the second highest in the Asia-Pacific Region and one of the highest in the world (NDoH, 2009) with an estimated 733 maternal deaths per 100,000 livebirths. Only37 to 53% of women receive skilled care during childbirth (NDoH-DHS, 2006; NDoH-NHIS, 2009). Women living in rural areas are more likely than their urban counterparts to give birth without skilled attendance. Despite this low uptake of supervised births, between 60% and 78% of women receive antenatal care from a health provider at least once during their pregnancy (NDoH-DHS, 2006; NDoH, 2009).

Reasons behind the data relating to lack of antenatal care and skilled birth attendance are not completely clear and the experiences and views of women who live in rural villages and remain at home to give birth without skilled attendance remain largely unknown. It is unusual for women's views in these settings to be explored in relation to the reasons for their decisions. Therefore we undertook a qualitative study to explore women's perceptions and experiences of pregnancy and childbirth in a rural community in PNG and to identify strategies to improve outcomes for women and their newborn infants. This paper reports one aspect of the study, that is, access to care during pregnancy and childbirth.

Methods

A qualitative, descriptive study (Sandelowski, 2000) comprising focus group discussions (FGDs) and in depth interviews was undertaken. This study took place following a community participatory workshop designed to engage the community in the research and facilitate the study.

Study site

Eastern Highlands Province (EHP) is the fourth most populous province in PNG with an estimated population of 538,227, predominately in rural areas. Maternal health indicators in the province are poor. Only 57% of women attend once for antenatal care and the supervised birth rate is 37% (NDoH-NHIS, 2009). The majority of maternal deaths in the province are due to postpartum haemorrhage and consequences of induced abortions (Sanga et al., 2010).

The study was undertaken in one of eight districts in the EHP. The rural area of Upper Bena in Unggai Bena district is an hour's drive from Goroka, the provincial capital. Access to the area is by an unsurfaced road frequently requiring grading due to heavy rain. Many villages are accessible only by bush tracks leading into mountains. Two government health facilities serve the area, Sigerehe Health Centre and Megabo day clinic. There are two village birth attendants (VBAs) practising in this area, each attended a two week training programme in 2004.

Community participatory workshop

Up to one hundred women participated in a community participatory workshop, undertaken prior to the commencement of data collection in order to facilitate the study. Experienced Papua New Guinean social science researchers trained in participatory activities facilitated the group work. Women were eligible to participate regardless of their own personal experience of pregnancy or childbirth. Thirty women joined a group of older women (> 35 years) and 60–70 women joined in the younger group (18–35 years). Women in the younger group were further split into seven groups of up to ten ensuring all participants had the opportunity to fully participate. Using spider diagrams (HIV/AIDS Alliance, 2006), women were asked to consider: '*What are the issues women face as a result of pregnancy and childbirth in your community*'(Fig. 1). This method of data collection obtained a free flow of responses from women, allowing a quick and easy means of collecting data from all participants, whether they were literate or illiterate. These responses enabled the research team to identify key themes and issues around pregnancy and childbirth and provided key terms and vocabulary for use in the FGDs and interviews (Fig. 2).

Focus group discussions

Women participating in the FGDs were grouped according to their age—older women (> 35 years) and younger women (18–35 years). Women unsure of their age were invited to participate in which ever group they felt most comfortable. Seven FGDs with a total of 51 women took place in three different locations in the Upper Bena area. There were three groups of older women, three groups of younger women and one group of village midwives, that is, untrained women who have assisted women to give birth in the village. Women participating in the FGDs were identified during the community participatory workshop or were recruited directly from the community.

In depth interviews

Women aged over 18 years were eligible to participate in the in depth interviews. In depth interviews were undertaken with 21 women. Eleven women were recruited at the antenatal clinic following a brief information session and seven were identified during the community participatory workshop and FGDs, thus were purposively selected. The remaining three women were key informants from the community. Two had experience of assisting mothers to give in the community and one was a village birth attendant (VBA).

Fig. 1. Community workshop group, older women.

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