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CLINICAL ARTICLE

The impact of joint partner decision making on obstetric choices and outcomes among Malawian women

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ABSTRACT

Objective: To determine the effects of joint partner decision making on obstetric choices and outcomes in Malawi. **Methods:** Between July 15, 2014 and February 25, 2015, interviews were performed with women who reported at least one lifetime pregnancy in Lilongwe District, Malawi as part of a cross-sectional study of reproductive decision making. Logistic regression models were applied to examine associations of joint decision making with delivery location and obstetric complications. **Results:** The study population included 860 women. Women who engaged in joint decision making with partners (adjusted odds ratio [aOR] 4.9; 95% confidence interval [CI] 3.3–7.2) and women whose partners made obstetric-care decisions alone (aOR 3.2; 95% CI 2.4–4.4) were more likely to undergo delivery at a healthcare facility compared with women who made obstetric-care decisions individually. In comparison with women who made obstetric decisions individually, no difference in the likelihood of experiencing obstetric complications was observed for women who engaged in joint decision making (aOR 1.1; 95% CI 0.7–1.7) or for women whose partners made decisions individually (aOR 0.8; 95% CI 0.5–1.3). **Conclusion:** In rural Malawi, partner involvement in obstetric decision making was associated with improved obstetric choices.

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1. Introduction

Sub-Saharan Africa has the highest maternal mortality ratio in the world [1]. Maternal mortality arises from both inadequate maternal health services and inadequate uptake of existing services [2]. Many women do not attend the recommended number of prenatal care visits or undergo delivery without skilled attendants present; those who receive inappropriate obstetric care often include unmarried women, those with lower household incomes, those who have less education or less educated partners, and those who have more children and have not experienced complications during previous pregnancies [3,4].

Decision-making autonomy is another important determinant in the uptake of maternal health services. Women in low-income countries are often precluded from household decision making, and this exclusion can also extend to reproductive health; power imbalances within relationships can interfere with women's ability to access reproductive

health services [5]. Women, especially poor women with little or no education, are more likely to be in unequal relationships and to have limited autonomy in accessing obstetric care [5,6]. In the context of limited autonomy and high maternal risk, facilitating joint decision making in obstetric care choices could improve obstetric outcomes. Involving male partners in maternal health education has been demonstrated to improve obstetric outcomes in India and Nepal [7,8].

In the present study, data were collected as part of the baseline survey of a cohort study of sexual and reproductive health in rural Lilongwe District, Malawi. Questions regarding maternal health and access to health services are especially prominent in Malawi, where maternal mortality has remained high over the past decade despite a temporary government ban on traditional birth attendants, as well as ongoing efforts to encourage facility deliveries and skilled assistance at delivery [1,9,10]. The present analysis included an overview of reported obstetric care, examining delivery locations, assistance during delivery, delivery complications, and neonatal birthweight. The aim of the present study was to examine relationships between who made obstetric decisions (a woman individually, her partner individually, or a woman and her partner jointly) and two outcomes (delivery location and complications) to determine if facilitating joint decision making could be a useful reproductive-health intervention in the region.

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2. Materials and methods

In the present study, data from a baseline questionnaire administered as part of the “Umoyo wa Thanzi” (“Health for Life”) research project were analyzed; this is an ongoing prospective cohort study of sexual and reproductive health decision making in Lilongwe District, Malawi. Villages in the catchment area of a rural health facility—an area approximately 40 km² in size including 68 villages and 20 000 inhabitants—were selected via stratified, cluster sampling method that allowed for the enrollment of approximately 1000 women of reproductive age. In selected villages, all women aged 15–39 years and their partners, were eligible to participate. Between July 15, 2014 and February 25, 2015, 1034 women and 441 men completed the baseline questionnaire. Only female participants who had been pregnant at least once were included in the present analysis. The study was approved by the Ohio State University institutional review board and the University of Malawi College of Medicine research and ethics committee prior to participant enrollment. All participants provided written informed consent before being included in the study.

In each selected village, trained research assistants conducted face-to-face interviews in Chichewa with all consenting participants. Data were recorded on tablet computers using the Magpi electronic data capture system (Magpi, Washington, DC, USA) and were uploaded daily to an internet-based storage system.

The primary exposure was decision making in the context of obstetric care; each participant was asked who made the decision regarding where to deliver during their most-recent pregnancy. Participants could answer as follows: self (coded “independent”), partner (coded “partner”), self and partner together (coded “joint”), or someone else. The exposure was coded as an ordinal categorical variable and “independent” was used as the referent category.

Outcomes included measures related to each participant’s most recent delivery. Specifically, participants were asked to report the location of delivery (home, traditional birth attendant’s home, on the road, at a clinic/hospital/health facility), assistance present during delivery (nobody, relative, traditional birth attendant, doctor/nurse), any complications (none, excessive bleeding, infection, prolonged labor, obstructed labor, high blood pressure, convulsions, obstetric fistula), and neonatal birthweight (very large [>4 kg], large [2.5–4 kg], small [1.5–2.4 kg], or very small [<1.5 kg]). For multivariable analyses, the variables capturing location of delivery and complications were dichotomized. Location of delivery was coded as “health facility” (including delivery at a clinic, hospital, or health facility) and “outside health facility” (including home, traditional birth attendant’s home, and on the road). All complications were aggregated into a single outcome category, and women who had experienced complications were compared to women who had not experienced any complications.

Descriptive statistics were used to characterize demographics, delivery practices, and obstetric outcomes of study participants. Village-level clustering was taken into account and separate unadjusted logistic regression models were constructed to examine associations between joint decision making and the two outcomes of interest (delivery location and complications). Models were then adjusted for relevant socioeconomic and demographic factors. Based on prior literature [4], age, education, and marital status were retained in all models. The number of living children, whether a participant’s partner was also a study participant, and household wealth were evaluated as confounders and were retained if their removal resulted in a change in any association of interest by more than 10%. Goodness of fit was assessed using the Hosmer–Lemeshow test. All analyses were conducted using R version 3.2.2 (The R Foundation for Statistical Computing, Vienna, Austria).

3. Results

In the parent cohort study, 860 women had been pregnant at least once and were included in the present analysis population. The median

age of participants was 27 years (interquartile range 22–32). Approximately half of participants ($n = 418$ [48.6%]) had completed 4–8 years of education, and nearly a third ($n = 249$ [29.0%]) had completed just 1–3 years of schooling. More women reported a monthly income below 5000 Malawian Kwacha (MK) (~US\$13 at the time of data collection) than reported a monthly income above MK20 000 (~US\$52) ($n = 298$ [34.7%] vs $n = 212$ [24.7%]). Most participants ($n = 794$ [92.3%]) were married and the median number of living children was 3 (interquartile range 2–4) (Table 1).

When asked about their most recent pregnancy, most participants ($n = 649$ [75.5%]) specified that they had delivered at a health facility, whereas fewer women delivered at home ($n = 90$ [10.5%]) or at a traditional birth attendant’s home ($n = 81$ [9.4%]) (Table 2). The most commonly cited reasons for delivering outside a health facility were a lack of transportation ($n = 71$ [8.3%]), that labor occurred late at night ($n = 56$ [6.5%]), and that the nearest health facility was too far away ($n = 54$ [6.3%]). A majority of participants ($n = 591$ [68.7%]) reported skilled assistance from a doctor or nurse during delivery, and a minority ($n = 114$ [13.3%]) reported assistance from a traditional birth attendant during delivery. Although none of the women who delivered at home had skilled assistance during delivery, among the 649 women who had delivered at a healthcare facility, some women ($n = 59$ [9.1%]) reported not having skilled assistance during delivery.

Most women ($n = 670$ [77.9%]) reported experiencing uncomplicated deliveries. Obstructed labor was the most commonly cited complication ($n = 62$ [7.2%]). Some participants also reported excessive bleeding ($n = 52$ [6.0%]) and/or prolonged labor ($n = 25$ [2.9%]). Most participants ($n = 472$ [54.9%]) reported that their most recently delivered neonate was large (2.5–4 kg) at delivery and a sizable group of women ($n = 177$ [20.6%]) reported their child being very large (>4 kg) (Table 2).

Approximately one-third of women ($n = 287$ [33.4%]) stated that they had made a joint decision with their partner regarding where to undergo delivery, with smaller numbers of participants reporting that they decided independently ($n = 223$ [25.9%]), that their partner had made the decision individually ($n = 193$ [22.4%]), or that someone else had made the decision ($n = 73$ [8.5%]).

Both the unadjusted and adjusted logistic regression analyses found that women who reported joint decision making were significantly more likely to undergo delivery at a healthcare facility than women who reported making the decision independently (adjusted odds ratio [aOR] 4.9; 95% confidence interval [CI] 3.3–7.2) (Table 3). Additionally, women who reported that their partner made the decision regarding delivery location were more likely to deliver at a healthcare facility in comparison with women who reported making the decision independently, both in unadjusted and adjusted analyses (aOR 3.2; 95% CI 2.4–4.4). No differences were observed in the odds of obstetric complications between women reporting joint decision making and women who engaged in independent decision making, both in unadjusted and adjusted analyses (aOR 1.1; 95% CI 0.7–1.7) (Table 3). Similarly, no differences were observed in the odds of obstetric complications between women who reported partner decision making and women who engaged in independent decision making, both in unadjusted and adjusted analyses (aOR 0.8; 95% CI 0.5–1.3). According to the results of Hosmer–Lemeshow testing, all models demonstrated close fits with the empirical data.

4. Discussion

A significant minority of woman in rural Lilongwe District, Malawi, reported delivering outside a health facility ($n = 185$ [21.5%]) or without the presence of skilled assistance ($n = 203$ [23.7%]) during their most recent childbirth. Additionally, in comparison with women who made obstetric decisions independently, those who made decisions jointly with their partner and those whose partners made decisions independently were more likely to deliver at a healthcare facility.

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