

**WHAT  
INFLUENCES  
MATERNAL  
HEALTH  
PRACTICES  
IN FOUR  
COUNTRIES?**

## What influences maternal health practices?

To answer this question, BBC Media Action carried out research with women and their family members, such as husbands and mothers-in-law, through formative qualitative research in Bangladesh, Ethiopia, the Indian states of Madhya Pradesh and Odisha, and South Sudan. We also carried out quantitative surveys in all of those countries, although data from Bangladesh was not available at the time of writing. Results will help to inform and evaluate our media and communication projects.

Findings show that key knowledge gaps appeared to act as barriers to improving maternal health practices. For example, many people have a poor understanding of the recommended timing of antenatal care check-ups and adequate birth planning. Improving knowledge alone is not enough to improve practices, however. Unsupportive attitudes and norms were found in many communities, especially among key decision-makers, men and older women.

The strong preference for home deliveries, for instance, often meant that women chose not to give birth in health facilities, or were not given the resources they needed to do so. Many people also felt concerned about the cost and quality of care received at health facilities. Younger women's low social status also meant that they were not always able to make their own decisions or follow good practices around antenatal care and birth preparedness.

Women were more likely to follow the appropriate practices when their husbands supported them. Rollouts of government health initiatives also seemed to increase uptake of maternal health services.

This briefing summarises findings from a longer research report that drew on more than 64 focus group discussions, 139 in-depth interviews, and survey interviews with more than 9,687 women with an infant 0–9 months. It covered two research questions:

- What have we learned about current practices around key maternal health behaviours in the four countries?
- What have we learned about the potential drivers of and barriers to these health behaviours?

The drivers considered in the research are: knowledge, attitudes and beliefs; social norms; confidence, agency and self-efficacy (the belief in one's own ability to complete and reach goals) and interpersonal discussion.

## Media and communication can:

- Help to improve health by increasing knowledge, shifting attitudes and social norms, increasing confidence and action
- Enable and increase discussion, which can support healthier practices and transparency around health services and policy
- Help improve health workers' motivation and performance

## Why focus on maternal and child health?

Millennium Development Goals four and five call for a reduction in child mortality and improvement in maternal health in developing countries. Most maternal, newborn and child deaths can be prevented with available interventions, such as family planning, antenatal care, preventive treatment of malaria, neonatal tetanus protection, delivery with a skilled birth attendant, early initiation of breastfeeding and postnatal check-ups for new mothers.<sup>1</sup>

## Research findings: women have fewer antenatal check-ups than recommended

Attending antenatal care with a qualified provider and preparing adequately for birth are particularly important practices for improving maternal and newborn health. While most women in the four countries reported attending some antenatal care, the majority did not attend the recommended four check-ups and did not attend in the first trimester.

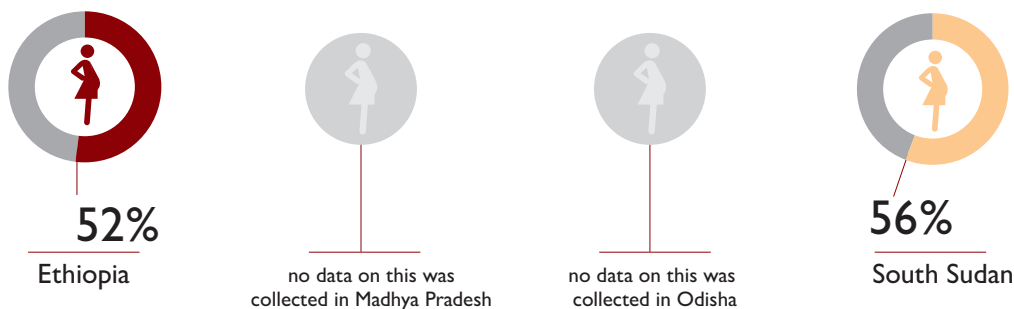
Our research suggests that many women in South Sudan, and to a lesser extent in Bangladesh, receive antenatal care from traditional birth attendants. Most women in the other countries receive their antenatal care from a qualified health worker.

### What is antenatal care?

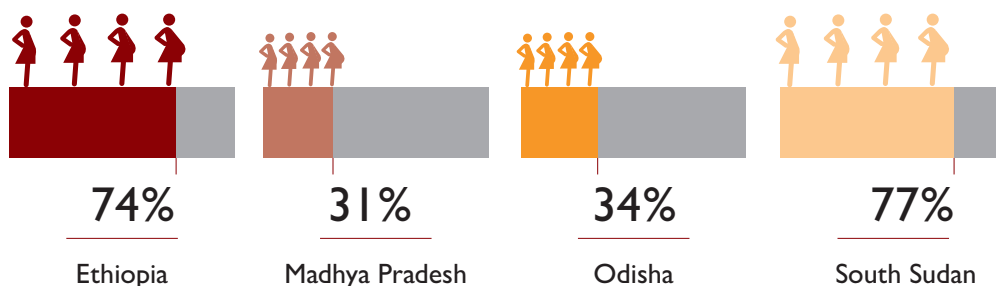
Appropriate antenatal should include:<sup>2</sup>

- Four or more check-ups with a qualified provider
- A check-up in the first trimester
- Interventions such as checking the mother's health and the baby's position, and providing iron and folic acid supplementation

### Knew to have first antenatal check-up in first trimester



### Knew at least four antenatal check-ups needed

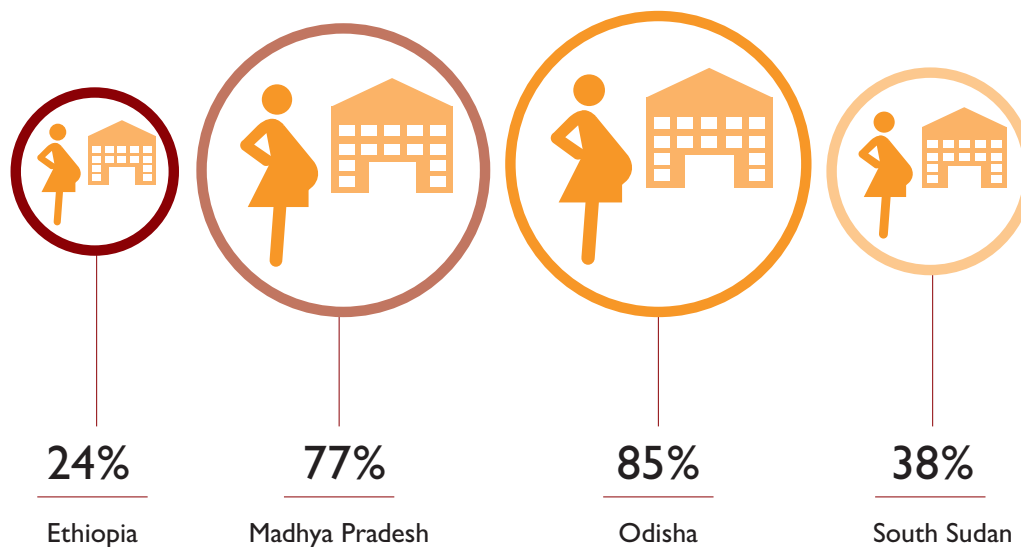


BASES: Know should go in first trimester: Ethiopia (1,899), South Sudan (1,194).

Know should have 4+ with qualified health worker: Ethiopia (1,855), MP (2,816), Odisha (2,707) South Sudan (1,293).

\*Bases include women with an infant 0–9 months who agreed that pregnant woman should attend some antenatal care.

## Delivered in a health facility



BASES: Ethiopia (2,044), South Sudan (1,639), Odisha (2,751), MP (2,977).

\*Bases include all women with an infant 0–9 months.

### Women could not afford to change their behaviour

In all four countries many women and their families could not afford for pregnant women to stop doing heavy labour, such as agricultural tasks, or to eat a more varied and nutritious diet when pregnant. In addition, some received limited support from relatives to do these things, often reflecting the relatives' unsupportive attitudes and beliefs. However, some women in Ethiopia were more likely to do so, as were some women living in non-traditional family structures in Bangladesh and India.

If our mother-in-law says that it is good to continue with daily work during pregnancy then we have to do it. What else can we do? We can't say no.

Woman, mainland village, Odisha, India

I would rather die than go to a hospital for delivery. A male doctor will take part in the delivery process. They will look at me and they will touch me.

Mother, rural Pirojpur, Bangladesh

## Women commonly deliver at home without medically trained birth attendants

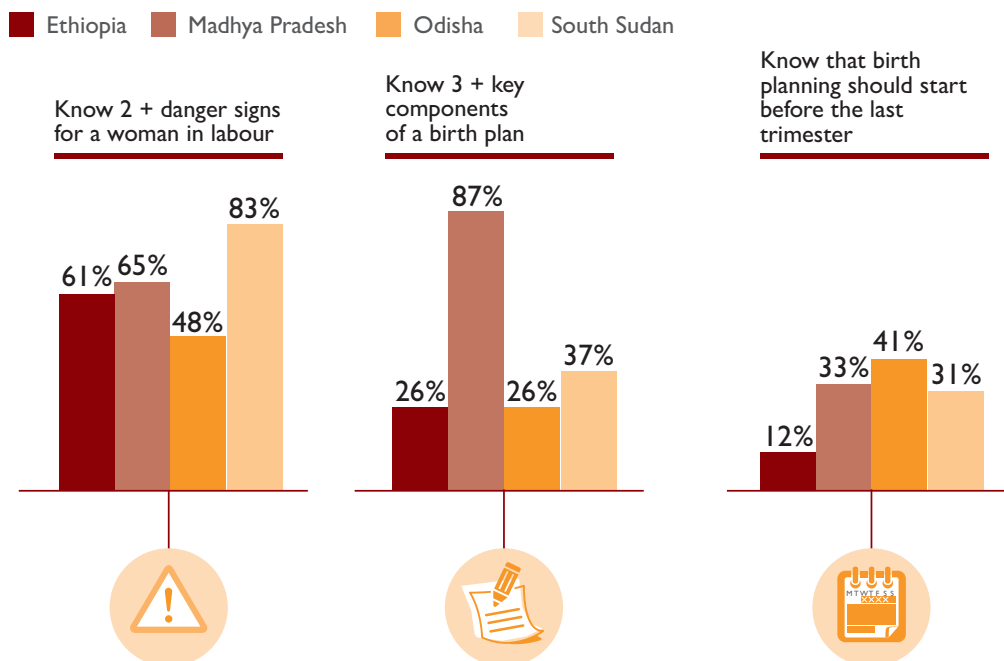
In all countries except India, most women deliver at home, assisted by relatives, neighbours and/or a traditional birth attendant. The most commonly made preparations are related to home deliveries and can include preparing clean cloths and a clean blade to cut the umbilical cord. While more families in Bangladesh and India reported making a greater number of the recommended preparations for delivery than in Ethiopia and South Sudan, preparations are often still inadequate. This can lead to a delay in taking pregnant women to the health facility, including when women delivering at home experience complications during labour.

Where preparations are made, they are often linked to the need to prepare the home for the baby and ensure the baby's comfort, rather than to ensure the safety of the pregnant woman during labour.

### Birth preparedness or birth planning includes:<sup>3</sup>

- Making arrangements for a skilled birth attendant to be present at a delivery, preferably in a healthcare facility
- Arranging transportation
- Saving money to pay for expenses including transportation and any costs around attending a health facility
- Planning for possible complications
- Assuring a clean, hygienic environment for the birth and the newborn

## Knowledge levels around birth preparedness



BASES: Know two or more danger signs: Ethiopia (2,044), South Sudan (1,638), Odisha (3,022), MP (2,977). Know two or more components of birth plan: Ethiopia (2,044), South Sudan (1,638), Odisha (3,022), MP (2,977). Know that birth planning should start before last trimester: Ethiopia (2,032), South Sudan (1,441), Odisha (2,594), MP (2,512).

\*Bases include women with an infant 0–9 months who agreed that pregnant women and their families should plan for birth.

## What influences women and their families?

**There are some key knowledge gaps around antenatal care.** While most people know that antenatal care is important, many do not understand the need for different interventions at different stages of pregnancy and the importance of early pregnancy care. A key driver of attending antenatal care in all countries is the perceived need to check the baby's health, rather than to safeguard the mother's health. People often do not understand that the baby's health, in fact, depends on the mother's health.

**Unsupportive attitudes and social norms can be barriers.** Some people believe that pregnancy is a "normal process" that requires no medical intervention, and that women should not disclose their pregnancy outside of their family until the fourth month. This can prevent attendance at antenatal care in the first trimester.

**Increased government services are linked to higher uptake of antenatal care.** For example, in Ethiopia increased uptake was associated with the rollout of the health extension worker (HEW) scheme. Distance to the health facility and the cost of getting there are key barriers for some women to attending early and regular antenatal care check-ups.

**There are knowledge gaps around birth planning.** In some places knowledge around the recommended components of a birth plan is low, while in others people know about planning but do not do it adequately or in advance of delivery. Some families may have a poor understanding of expected delivery dates or think that preparations for delivery can be made at the last minute.

**Social norms appear to influence the strong preference for home deliveries.** The vast majority of people understand that a facility delivery is safer for the mother and baby, yet many also believe that a "normal birth" takes place at home and women should be proud of it.

**Financial barriers influence decisions around pregnancy and childbirth.** The findings suggest that women often have low levels of self-efficacy in overcoming barriers to improved maternal health, particularly in relation to obtaining funds or household resources. Given their low status in many families and communities, women's health is often given low priority in the allocation of household resources. Women are much more likely to report that they have followed the desired practices when family members, especially husbands, have supportive attitudes.

**Barriers around health service provision, perceived or otherwise, have a large influence on people's behaviour.** While there is substantial scope to increase attendance of antenatal care check-ups and health facility deliveries across all countries, there are often specific reasons why women cannot use them. It may be that there are not enough facilities, they may not be close to where women live, women do not have the money to pay for transport or no transport is available. In Bangladesh and India in particular, many women and their families are concerned about being treated by a male health worker. Other key barriers include that people felt concerned about being treated poorly by health workers, or that health workers or drugs would not be available. Accountability around health services, therefore, is an important issue for many people.

**Husbands and older women are key influencers.** Some women reported the lack of their husbands' consent as a barrier to attending antenatal care check-ups, largely because the husband refuses to give his pregnant wife funds to get to the health facility for antenatal care.

# Implications



## Antenatal care communication programmes could:

- Address knowledge gaps around the timing of antenatal care check-ups, encourage women to confirm the pregnancy as soon as they suspect they are pregnant, and to start attending antenatal care immediately, highlighting the benefits of doing so.
- Aim to reach and engage with key decision-makers, for example husbands and mothers-in-law, among whom unsupportive attitudes around antenatal care are relatively common. Programme content should include their voices and perspectives.
- Emphasise that the baby's health depends on the mother's and promote the importance of women's health.
- Ensure that communication objectives and content reflect the changing service delivery environments.



## Birth preparedness communication programmes could:

- Address the particularly low levels of knowledge of the recommended components of a birth plan, particularly in Ethiopia and South Sudan.
- Focus on the poor understanding of birth planning timeframes across all countries and help families to find innovative ways to understand women's expected delivery dates better, such as following the phases of the moon.
- Create discussion around the belief or social norm that a "normal birth" takes place at home and recognise the existing perceptions of health centre deliveries.
- Recognise that, in some cases, families may not prepare adequately for birth, in part to ensure that a woman will deliver at home even if this is not her preference.
- Take into account financial barriers and the key role that money plays in decision-making around delivery, and that often men make decisions around the place of delivery as well as control the financial resources.
- Encourage men to allocate more resources to their wives' healthcare.
- Recognise that health facilities are not accessible in some areas, so it may be appropriate to increase their focus on hygienic home delivery, particularly in South Sudan.
- Focus on the acceptability of health services, which is a key barrier to improving maternal health behaviours.
- Consider how programmes can improve accountability around health services.

## Endnotes

1. [www.un.org/millenniumgoals/childhealth.shtml](http://www.un.org/millenniumgoals/childhealth.shtml).
2. The Partnership for Maternal, Newborn and Child Health (PMNCH) (2011), *A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH)*. Geneva: PMNCH.
3. Ibid.

## Contributing to the evidence base

BBC Media Action uses our Bridging Theory and Practice series to share our evidence and learning on what works in measuring and understanding media and development interventions. This series is designed for all policy-makers, practitioners and researchers with an interest in evidence-based decision-making.

## Media and audience research: a key part of BBC Media Action's work

BBC Media Action, the international development organisation of the BBC, uses the power of media and communication to support people to shape their own lives. Working with broadcasters, governments, other organisations and donors, we provide information and stimulate positive change in the areas of health, governance, resilience and humanitarian response. The UK Department for International Development (DFID) supports us to work with the media in 14 countries across Africa, the Middle East and Asia, and we have projects in more than 25 countries overall. This briefing was prepared thanks to DFID funding.

This project will contribute to family health and support people to make decisions based on recommended health practices and the resources available to them. Using research, evaluation and learning reviews, it also aims to contribute to the evidence base on the role of media and communication in development.

## Acknowledgements

This research briefing summarises a longer research report by Laura Smethurst, *What influences maternal health practices in four countries? Insights and lessons learned*. To read more visit [www.bbcmmediaaction.org](http://www.bbcmmediaaction.org).

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