ANTENATAL CARE IN ERBIL CITY-IRAQ: ASSESSMENT OF INFORMATION, EDUCATION AND COMMUNICATION STRATEGY

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ABSTRACT

Background and objectives Information education and communication strategy is included in the antenatal care to inform and educate pregnant women on topics related to pregnancy and care of newborn. The aim of this study was to assess women's awareness of danger signs of obstetric complications and their experiences at health care facilities.

Methods A sample of 1839 pregnant women attending primary health care centers from 1st of Jan through 30th of Apr 2009 was selected. At each primary health care center between 39 and 221 women were interviewed. Requested data included women's information on advice given on place of birth, family planning, benefit of birth in a health facility and other topics. Information on women's awareness of danger signs and their experiences at primary health care centers was also collected.

Results Family planning and nutrition were the most commonly discussed topics, 44.6% and 46.7%, respectively. Heavy bleeding, hypertension, anemia and bad obstetrical history were recognized by 67% 60%, 58% and 45% of clients as danger signs, respectively. Only 11% recognized prolonged labour as danger signs, with variations in the experiences of women at the primary health care centers; 61% reported spending three minutes and less with the health care provider, 53% were told about progress of pregnancy, 55% had the chance to ask questions and 65% were asked to return for another visit.

Conclusion Health education provided at antenatal clinic level in Erbil city seems to be relatively poor.

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Key words: Danger signs, Prolonged labour, Nutrition, Hypertension

Antenatal care is care routinely provided for all pregnant women at primary care level, or every aspect of care from screening to intensive life support provided to any women while pregnant and up to delivery.[1] Antenatal care provides an opportunity to inform and educate pregnant women on a variety of issues related to pregnancy, birth and parenthood.[2] Besides the benefits of identifying high-risk pregnancies and providing timely assessment and treatment, one of the expected utilities of antenatal care is the utilization of antenatal care services for gaining health knowledge and accessing other health services.[3]

Information, education and communication (IEC) can be defined as an approach which attempts to change or reinforce a set of behaviors in a "target audience" regarding a specific problem in a predefined period of time.[4] Both formal education and antenatal care had a significant impact on the results of child bearing.[5] Education provides women with accurate information about themselves, and about ways to prevent and treat illness. In addition, it brings desirable changes in reproductive patterns, in the status of women, and in living standards.[6]

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Coverage of antenatal care is relatively high in Erbil city with 84% of women receiving antenatal care at least once during the pregnancy. More than half the women had four or more visits and about 80% of them sought antenatal care for the first time during first and second trimester. Furthermore, three in four women sought antenatal care for the last time in the last trimester.[7] This high antenatal coverage and relatively high frequency of visits provides an excellent opportunity for education information and communication. The IEC strategy was included within antenatal care in early 1990s. The strategy is to inform and educate pregnant women on variety of topics including nutrition, awareness of danger signs of obstetrical complications, care of the newborn, and family planning.

Awareness of the danger signs of obstetric complications among pregnant women and in their communities is the first step to accepting appropriate and timely referral to essential obstetric and newborn care.[8] Late or failure of women with obstetrical complications to reach referral hospitals may be attributed to many reasons. One reason may be lack of awareness of significance of symptoms or obstetrical complications.

The aim of this study was to assess women's information on certain topics including awareness of danger signs of obstetric complications and their experiences at health care facilities. The data will be useful for reinforcing or modifying behavior change for pregnant women as part of overall strategy for achieving the country's Millennium Development Goal for Maternal Health.[7]

METHODS

This was a cross-sectional study carried out at primary health care centers (PHCCs) in Erbil city (Erbil district), from 1st of January through 30th of April 2009 after fulfilling the required permissions. Erbil city is one of seven districts of Erbil governorate. The estimated population of the governorate is 1,542,421. Erbil city has an estimated population of 808,600 with approximately 50% females.[9] The district has one maternity hospital, providing comprehensive emergency obstetric care and 36 PHCCs, only 14 of them provide maternal and child health services (MCH) and one center is provided with labour room.

Proper antenatal care is provided through public health care facilities only. Registration at a public antenatal clinic depends on place of residence. Public PHCCs provide services six days a week between 8:00 am and 1:00 pm. Pregnant women are usually given monthly appointments until 28 weeks of gestation, two weekly appointments until 36 weeks and then weekly appointment until birth. The programme of activities of each antenatal clinic session includes a health talk, assessment of pregnant women through history taking, examination and laboratory tests, provision of tetanus toxoid immunization and iron/folate supplementation. Health talks are intended to cover nutrition, danger signs of pregnancy and delivery, family planning, breast feeding and care of the newborn.[3]

PHCCs were categorized into two groups; Western and Eastern PHCCs based on geographical residential pattern of Erbil city according to Al-Mudaris and Al-Hajar.[10]

The crude birth rate in Erbil is approximately 30 per 1000 population[9] indicating that 2% of the total population of Erbil is expected to have been pregnant at any period (year).[11] Assuming that 26% of the women were aware of obstetric danger signs, according to Pembe et al study in rural Tanzania,[12] with a worst accepted deviation of 12%, 95% confidence interval, a design effect of two and a non-participation rate of 10%, the sample size required for antenatal client exit interview was calculated as 1670 by Epi-Info program. Anyhow a sample of 1839 was obtained. Since the study

intended to compare pregnant women at various primary health care centers, the sample size was determined separately for each primary health care center taking into consideration the monthly registration of new pregnant women at the center. At each PHCC between 39-221 women were interviewed. If there were more women than required at the clinic, a convenience sample was taken. If there were fewer women than required, all were selected and a second visit was done to the clinic to complete the required number. Individual women were approached, given information regarding the purpose of the study, invited to participate, assured of confidentiality before the interview, and an informed verbal consent was obtained.

Data were collected in especially designed questionnaire; requested data included socio-demographic characteristics of participants, number of pregnancies, number of visits made during the last pregnancy, gestational age at first visit and gestational age at time of interview. Other requested data included women's information on advice given on place of birth, family planning, benefit of birth in a health facility and other topics. Information on women's awareness of danger signs and their experiences at PHCCs were also collected. Women were asked to mention the danger signs. Based on Safe Motherhood Initiative the danger signs include vaginal bleeding during pregnancy and delivery, bleeding after delivery, anemia, headache, lack of or cessation of fetal movement, fits of pregnancy, high blood pressure and prolonged labor.[1]

Chi-square was used to test for association between proportions. Statistical significance was accepted at p-values ≤ 0.05.

RESULTS

The age of clients ranged between 15 and 49 with a mean ± SD of 25.4 ± 6.1 years. Nearly 11% of the clients were teenagers, 63% in the third decade, and 44% primigravida. The mean of antenatal care visits was 3.22 ± 1.48. Women visiting the health center for the first time constituted about 38% in the first trimester, and 61% in the second trimester. At the time of interview 64% of women were in the second trimester. Age distribution and obstetrical characteristics of the women are presented in Table 1.

Table 1. Age distribution and obstetrical characteristics of antenatal clients

Characteristic	No. (%)
Age distribution(years)	
<20	**201 (10.9)**
20-29	**1166 (63.4)**
30-39	**395 (21.5)**
40-49	**77 (4.2)**
Gravidity	
1	**812 (44.2)**
2	**155 (8.4)**
3	**344 (18.7)**
4	**241 (13.1)**
5	**134 (7.3)**
≥ 6	**153 (8.3)**
Gestational age at first visit	
First trimester (0-13 weeks)	**689 (37.5)**
Second trimester (14-27 weeks)	**1119 (60.8)**
Third trimester (28+ weeks)	**31 (1.6)**
Gestational age at time of interview	
First trimester (0-13 weeks)	**256 (13.9)**
Second trimester (14-27 weeks)	**1179 (64.1)**
Third trimester (28+ weeks)	**404 (21.9)**
Total	**1839 (100)**

Table 2 shows the proportion of antenatal clients who reported that they had received information on certain topics at any of their antenatal visits. Diet and nutrition was the most commonly discussed topic (47%). The second topic was child spacing and family planning; 45% of clients reported receiving information on this topic. Provision of IEC on how to get to the health facility in case

of an emergency was recalled by 12% of clients only.

Table 2. Women (n= 1839) provided with IEC on selected topics at any or all antenatal visits

Topic	No. (%)
Diet and nutrition	860 (46.7)
Family planning/child spacing	821 (44.6)
Place of birth	802 (43.6)
Benefit of birth in a health facility	794 (43.2)
What to do if there is a problem such as bleeding or convulsions/fits	674 (36.7)
Care of the baby and breast feeding	436 (23.7)
How to get to health facility if there is an emergency	220 (11.9)
Talk about sexually transmitted disease and HIV/AIDs	150 (8.2)

Heavy bleeding, hypertension, anemia and bad obstetrical history were the commonest signs recognized by the clients as danger signs; 67%, 60%, 58% and 45% respectively. Only 11% recognized prolonged labour as danger signs. There were statistically significant variations between educated and non-educated clients attending health centers in recalling heavy bleeding ($p < 0.001$), cessation of fetal movement, sepsis/bad obstetrical history and obstructed labour ($p < 0.001$) as danger signs. Educated clients were more likely to recall heavy bleeding, post partum abdominal pain and anemia as danger signs, than non- educated clients (Table 3).

Less than half of clients (48%) reported that they met the health care provider in private, 61% reported that they spent three minutes and less with health care provider. More than half (53%) of clients were told about the progress of pregnancy, 55% reported they had the chance to ask questions. About two third (64.7%) were asked to return for another visit. There were statistically significant variations between educated and non-educated clients attending the health centers in respect to meeting the health care provider in adequate privacy($p < 0.001$), time spent with the care provider ($p < 0.001$), having the chance to ask questions ($p < 0.001$) and asked to come back for another visit ($p < 0.001$). The odds of educated clients attending the primary health care centers were more than odds of non-educated clients attending the primary health care centers in respect to previously mentioned experiences (Table 4).

Table 3. Comparison of awareness of danger signs between educated and non-educated clients attending PHCCs in Erbil city

Danger signs	Total PHCCs (n= 1839) No. (%)	Educated (n=1144) No. (%)	Non-educated (n=695) No. (%)	Relative risk ratio (95% CI)*	P value
Heavy bleeding	1239 (67.37)	820 (66.18)	419 (60.28)	1.6 (1.3-2.04)	< 0.001
Hypertension	1110 (60.35)	689 (60.22)	421 (60.57)	0.9 (0.8-1.2)	0.88
Anemia	1063 (57.80)	834 (72.90)	229 (32.94)	5.4 (4.4-6.7)	< 0.001
Bad obstetrical history	829 (45.07)	432 (37.76)	397 (57.12)	0.4 (0.3-0.5)	< 0.001
Cessation of fetal movement	524 (28.49)	455 (39.77)	69 (9.92)	0.5 (0.4-0.7)	< 0.001
Sepsis/postpartum abdominal pain	357 (19.41)	280 (24.47)	77 (11.07)	2.6 (1.9-3.4)	< 0.001
Obstructed /prolonged labour	203 (11.03)	112 (9.79)	91(13.09)	0.7 (0.5-0.9)	0.028

**CI=confidence interval*

Table 4. Comparison of experiences between educated and non-educated clients attending PHCCs in Erbil city

Experiences	Total PHCCs (n= 1839) No. (%)	Educated clients (n=1144) No. (%)	Non-educated clients (n=695) No. (%)	Relative risk ratio (95% CI)	P value
Meeting health care provider in adequate privacy	884 (48.06)	644 (56.29)	240 (34.53)	2.4 (2-2.9)	< 0.001
She spent 3 min and less with health care provider	1121(60.95)	853 (74.56)	268 (38.56)	4.6 (3.7-5.7)	< 0.001
She was told of progress of pregnancy	981(53.34)	641 (56.03)	340 (48.92)	1.3 (1.1-1.6)	0.003
She was asking questions	1108 (60.25)	798 (69.75)	382 (54.96)	1.8 (1.5-2.3)	< 0.001
She was asked to return	1190 (64.71)	820 (71.67)	370 (53.23)	2.2 (1.8-2.7)	< 0.001

DISCUSSION

Antenatal care is an opportunity for health education and clarifying topics related to pregnancy and inform women about the danger signs and symptoms for which assistance should be sought from a health care provider without delay. This study is part of a comprehensive safe motherhood needs assessment[13] which has been conducted in Erbil city during the last two years.

Ideally the first visit should occur in the first trimester, around or preferably before week 12 of pregnancy.[14] The present study showed a pattern of late arrival; only 38% of interviewed women reported that they had obtained antenatal care during the first trimester of their pregnancy, while 61% in the second trimester. Al-Sherbini[15] in Egypt reported lower figure for first antenatal visit; 21% in the first trimester, and 35% in the second trimester. In Basrah 21% clients visited the health center in first trimester,[16] which reflects the lack of knowledge and information about the importance of this type of health care.

In this study, less than 50% of clients reported that they were provided with IEC on selected topics such as diet and nutrition, family planning/child spacing, benefit of birth in health facility, place of birth, indicating that provision of IEC is relatively poor. Nearly 47% of women were advised about diet and nutrition, which is higher than that reported in Gambia (35%),[17] 45% reported receiving information about family planning, a figure which is similar to that reported in India (42%).[18] However, breast feeding was reported to be covered in health education by only 24% of clients which is lower than that reported in India study (34%).[18]

The proportions of clients who recalled awareness of bleeding, hypertension and anemia as danger signs was relatively high ranging from 57% to 67%. However, awareness about other danger signs including bad obstetrical history, cessation of fetal movement, sepsis/postpartum abdominal pain, obstructed labour was reported by less than half of clients ranging between 11% and 45%. This could be attributed to variations in provision of health information; health care providers were concentrating on certain danger signs of certain topics. Only 11% of women were

aware of prolonged labour as an obstetric danger sign despite that it is associated with both maternal and fetal morbidity and mortality. In Pakistan 23% of women were aware of prolonged labour as a danger sign.[19] In Gambia, a study on urban and rural women attending antenatal care, prolonged labour was not recognized as a danger sign.[17]

A study in a rural district in Tanzania revealed that 52% of women were able to mention anemia as a danger sign,[12] while in a study among rural-to-urban migrant women in China, 50% of women have knowledge about anemia.[20] Both figures are lower than that revealed by this study (58%). China study revealed a higher figure for awareness of hypertension (70%) as danger sign than our figure (60%).[20]

In the current study, 48% of clients reported they met the health care provider in adequate privacy; a higher figure was reported in Gambia (72%).[17] More than 60% said they spent three minutes or less with the antenatal care provider, although the new antenatal care model recommends 30-40 minutes for the first visit and 20 minutes for subsequent visits to carry out all activities including individual education,[14] In Gambia study 70% reported spending three minutes or less,[17] while in Tanzania 30% reported spending less than 3 minutes on individual counseling.[21] Around 53% of clients were told of progress of pregnancy, 60% had the chance to ask question, and 63% were asked to come back for another visit. Figures reported in Gambia were 25%, 16% and 70%, respectively.[17]

Comparing recalling of warning signs and experiences of educated and non-educated clients revealed that generally educated clients attending primary health care centers were more likely to recall danger signs than non-educated clients attending primary health care centers. Staff shortage is a major constraint in the delivery of health services and may contribute to variation in provision of IEC; provision of health education may be given less priority.[22] Variations in perception of danger signs by clients in these catchments areas may be another contributing factor.

It seems that health education provided at antenatal clinic level in Erbil city was relatively poor. As there is a need for IEC to reach a wider audience, it may also be provided through mass media. A uniform message can be disseminated; it will reach non-pregnant women who will be better informed. These messages will also reach men to encourage positive participation as partners to make pregnancy safer.

In a developing country such as Iraq with persistent maternal and child health problems, there is an urgent need to increase both demand for and quality of reproductive health services. Provision of antenatal education alone is the answer but can provide partial solution. Pregnant women who don't have adequate and appropriate information about pregnancy and childbirth would be ill-equipped. On the other hand, pregnant women would be unable to make optimal use of the information they have been provided if services are not readily available and of high quality.

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پوختە

کلینیکەکانی پەیوەست بەچاودێری دایك ومندالّ لە شاری هەولێر – هەڵسەنگاندنی زانیاری کۆکردنەوە، هۆشیاری تەندروستی و پەیوەندی کردن

پێشەکی و ئارمانج: ستراتیژی زانیاری کۆکردنەوە لەسەر ڕۆشنبیری ئافرەت وپەیوەندی کردنی لە بنکەکانی چاودێری دایك ومندالّ بە مەبەستی فێرکردن وڕۆشنبیرکردنەوەی ئافرەتی دووگیان لەسەر کۆمەڵێك بابەت کە پەیوەستن بە سکپڕی وچاودێری منداڵی تازە لە دایکبوو. ئامانج لەو توێژینەوە هەڵسەنگاندنی پلەی هۆشیاری ئافرەت دەربارەی نیشانە ترسناکەکانی کێشەی منداڵبوون وڵێزانین وشارەزاییان لەسەر بوونی ئاسانکاری لە بنکە تەندروستیەکان.

ڕێکێن ڤەکولینێ: نموونەیەك لە ئافرەتان لە بنکە تەندروستیەکان چاو پێکەوتنیان لەگەڵ ئەنجامدرا بۆ ئەو توێژینەوە کە ژمارەیان (1839) ئافرەتی دووگیان بوو لە 1/ کانونی یەکەم تاوەکو 30/ نیسان لە ساڵی 2009. لە هەر یەکێك لە بنکە تەندروستیەکان 39– 221 ئافرەت چاوپێکەوتنی لەگەڵ کرا. زانیاریەکانی کۆکرانەوە بریتی بوون لەو زانیاریانەی ئافرەت هەیبوو لەسەر ئامۆژگاریە پێدراوەکان سەبارەت بە شوێنی لە دایکبوون وپلانی ژمارەی خێزانداری و سوودەکانی منداڵبوون لەو شوێنانەی کە ئاسانکاری تیایە وزۆر شتی تر. زانیاری وهۆشیاری ئافرەت دەربارەی ماکە خراپەکان وزیانە چاوەڕوانکراوەکان وشارەزاییان لەسەر بنکە تەندروستیەکان و ئاسانکاریەکانیان بۆ ئافرەت و کرداری منداڵبوون.

ئەنجام: پلانی ژمارەی خێزانداری/ نێوانی منداڵبوونەکان، خواردن/ خۆراکی وورده بریتی بوون لەو بابەتە سەرەکیانەی کە زۆر باسی لەسەر کرا، کە ڕێژەکانیان 45٪ و47٪ یەك لە دوای یەك. خوێن بەربوونەکی زۆر، بەرزبوونەوەی پەستانی خوێن، خوێن کەمی، هەروەها خراپی مێژووی سکپڕی زۆر بە زەقی دیار بوون وەك نیشانەی ترسناك کە ڕێژەکانیان 67٪، 60٪، 58٪، 45٪ بوو یەك لە دوای یەك. تەنها 11٪ درێژبوونەوەی کرداری منداڵبوونیان بە ماکی خراپ دانا، بیروڕایان جیاواز بوو دەربارەی ئاسانکاری لە بنکە تەندروستیەکان، 61٪ وایان ڕاپۆرت کرد کەوا تەنها 3 خولەك لەگەڵ دەستەی ئامۆژکاری تەندروستی گفتوگۆیان کردووە، 53٪ باسی چۆنیەتی بەرەوپێشەوەچوونی کرداری سکپڕیان بۆ کرابوو، تەنها 55٪ دەرفەتی ئەوەیان هەبووە کە پرسیار بکەن، تەنها 65٪ ئاگادار کرانەوە کەوا بۆ سەردانی دووەم بگەڕێنەوە.

دەرەنجام: هۆشیاری تەندروستی لە کلینیکەکانی پەیوەست بەچاودێری دایك ومندالّ لە بنکە تەندروستیەکانی شاری هەولێر کزو لاوازە.

الخلاصة

مراكز الرعاية للأمومة والطفولة في مدينة أربيل – جمع المعلومات، التثقيف الصحي وثقافة الاتصال

خلفية واهداف البحث: استراتيجية جمع المعلومات وثقافة الاتصال والمقابلة في مراكز الرعاية للأمومة والطفولة لغرض تعليم وتثقيف الحامل حول مجموعة من الموضوعات المتعلقة والمرتبطة بالحمل ورعاية المولود. كان الهدف من الرسالة تقييم وعي المرأة حول العلامات الخطرة لعملية الولادة وخبراتهم وتجاربهم حول نوعية التسهيلات التي تقدّم في المراكز الصحية.

طرق البحث: تم مقابلة 1839 حامل اللواتي زرن المراكز الصحية الأولية من 1 كانون الثاني إلى 30 نيسان سنة 2009. كان عدد المقابلات في كل مركز تتراوح بين 39–221.

كانت المعلومات المطلوبة شملت معرفة الحامل بنصائح والارشادات المقدمة لها حول مكان الولادة، تنظيم الأسرة، والتسهيلات الموجودة في المراكز والمؤسسات الصحية وموضوعات أخرى. وتم جمع المعلومات حول وعي المرأة بشكل عام حول معرفة العلامات الخطرة وخبراتهم وتجاربهم في المراكز الصحية الأولية.

النتائج: تنظيم الأسرة/ تباعد الولادات، الغذاء/ التغذية كانت من أهم الموضوعات التي تم مناقشتها، كانت النسبة 45%، 47% على التوالي. تم كشف العلامات الخطرة كالنزف الشديد، ارتفاع ضغط الدم، فقر الدم، سوء خلفية فترة الحمل، وكانت النسب كالآتي: 67%، 60%، 58%، 45% على التوالي. نسبة11% من النساء تعتبر اطالة فترة الحمل من العلامات الخطرة، وهناك مفارقات كبيرة بين وجهة نظرهن حول خبرتهن بالتسهيلات في المراكز الصحية الأولية، 61% منهن قد قضين 3 دقائق من الوقت مع المشرفات في الرعاية وقت الزيارة، 53% قد تلقين معلومات حول سير عملية الحمل، 55% منهن كانت لها فرصة المناقشة مع المشرفات، 65% قد أخذن موعد لزيارة لاحقة.

الاستنتاج: التثقيف الصحي في مراكز الرعاية في مدينة أربيل كانت غير جيدة وتحت المستوى المطلوب.