Barriers to utilization of preconception care services –A qualitative study

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Original Article

Abstract

Introduction: Preconception care, provides intervention for women in reproductive age, regardless of status or pregnancy, to improve health of women, newborns and children. Compared to developed countries, the preconception care coverage is lower in the developing world, and usually the first referral of women to health cares is after pregnancy. The purpose of this study was to explanation barriers to utilization of preconception care services.

Methods: This study is a qualitative study. The participants in the study were pregnant women, midwives, women's health care provider and members of the Maternal Health Committee. Data were collected by using semi-structured, face-to-face interviews and focus group. To analyze the data, conventional content analysis was used.

Results: The average age of pregnant women was 32.1, Most of them were housewives with high school education. Most of the providers were midwives and had associate degree. Data analysis led to find 95 Initial code and 40 final code, which were divided into 13 sub categories and 3 concept categories. Concept categories included "organizational barriers", “organizational outside barriers ", and" personal barriers. Organizational barriers were related to healthcare systems. Organizational outside barriers were related to out of healthcare systems and personal barriers were related to woman and family.

Conclusion: This study reveals barriers to utilization of preconception care services. It seems that eliminating the obstacles, can increase preconception care coverage in the country.

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Introduction:

Preconception care before pregnancy provided intervention for women in reproductive age, regardless of status or pregnancy, to improve health of women, newborns and children (1). The purposes of Preconception care are to improve maternal and child health, reduce of behavior, and personal and environmental factors which have a negative impact on maternal and child health outcomes. The ultimate goal is to improve maternal and child health in the short and long term (2,3) 33% of pregnant women in the United States, have at least one risk factors before pregnancy (4). In developing countries, many reasons and barriers were reported for low coverage of health services

which include political, financial, operational, and socio-cultural barriers (5,6). Access to health services means the timely use of personal health services to achieve the best health outcomes (7,8).

Low access may be due to lack of awareness, lack of information, lack of resources, lack of facilities, lack of health care providers, and cost of services (9,10). Costs can include the cost of supplies, medicines, and transportation. In many cases, the family will be poor because of the cost (11). The World Health Organization emphasized that preconception care in reaching the Millennium Development Goals (reduction of child mortality and maternal) has played an important role. Also, they said that all women should have access to proper care before pregnancy until 2015 (12).

According to some studies, preconception care index was reported 11% in Iran (2). The Hormozgan province is one of the regions with high maternal mortality in the country. In 2014, investigation on the causes of maternal mortality in Hormozgan province shows that pregnant women who die, didn't take care before pregnancy, and 86% of them had underlying disease (13).

Although, timely identification of women problems before pregnancy, appropriate care, and remedy the situation of mothers were helpful. Given the importance of preconception care, barriers to utilization of preconception care are unknown in Hormozgan province. Qualitative research is a suitable method to explore of individuals characteristics and experiences (14). This type of research seeks to human characterize and actions in real. Therefore, this qualitative study was designed to explanation barriers to utilization of preconception care services.

Methods:

This study is a qualitative study was carried out during in March 2014 to August 2015 in Bandar Abbas city. The study's participats were: 1. pregnant women who had not used preconception care and were referred to health centers for pregnancy care 2. Midwives and women's health care provider in the city 3. Members of the Maternal Health Committee. Inclusion criteria for midwives and women's health care provider were: interest for participation in the study, formal employment, having work experience of 5 at least years (for women's health service provider for at least 3 years). Data were collected by using semi-structured, face-to-face interviews and a focus group. For data gathering, depth interviews and focus group were used for pregnant women, and focus group was used for midwives, women's health care provider and members of the Maternal Health Committee. After obtaining the necessary permissions to carry out of the study, 15 depth interviews with 15 pregnant women were carried out by using guide questions and semi-structured interviews, and 1 focus group with 9 pregnant women, one focus group discussions with 14 midwives and women's health service provider, and one focus group discussions with 8 members of Maternal Health Committee was carried. Sufficiency sample size was according to data saturation. Interviews were recorded on the audio files and then they were transferred to paper. Interview and focus group discussion lasted from 30 minutes to 60 minutes. The informed consent was obtained from all participants and assured them that the information will remain completely confidential.

In this study, acceptability, transferability, consistency and verifiability were used for data qualitative assessment. To make sure of data accuracy, acceptability code reviewed were used by participants and other members of the research team. For acceptability, data sources integration was used. For this purpose, collection method combination (interviews and focus group), data source variation (mothers, Midwives and women's health service provider, members of the Maternal Health Committee), and reflexivity were used. To increase transferability, rich describtin of research detail and steps of the study, report of all decisions about theoretical, methodological and analytical choices, observing the interviews conditions and comparing these findings with other findings were used. To Increase consistency in data, external observer was used. In addition, data were analyzed using code-recode method. Part of coded data were recorded again after two weeks, and then the results of two coded were compared. For Increasing the verifiability, researcher tried registering all phases of qualitative research accurately, and other observers to audit procedures and codes. For

auditing, two reproductive health professors were used.

To analyze the data, conventional content analysis was used. In conventional content analysis, categories are extracted from the text data directly. In this method, researchers avoid the use of predetermined categories and allows categories and names emerge from the themes. At first level, it was performed initially by coding, then it was given a theme to basic concepts of sentences. In second level of coding, main themes and sub-themes will be reviewed and then basic concepts with the same meaning classified together and categories were formed. The interview was conducted repeatedly to get the result validated for the increase of reliability, coding categories and confirming sub-categories were used 3 external Observers.

Results:

The mean age of pregnant women was 32.1, Most of them were housewives and with high school education, and most of the health providers were midwives and has associate degree. Data analysis led to emergence initial code and 40 last code, which were divided into 13 sub and 3 concept categories. Concept categories included organizational barriers organizational outside barriers and personal barriers. Organizational barriers, related to healthcare systems. Organizational outside barriers related to out of healthcare systems and personal barriers related to woman and family.

Organizational barriers, including 5 subcategories: weaknesses in service providing, financial barriers, defects in preconception system, poor quality in service providing and lack of human resources.

Weaknesses in service providing: this subcategory includes: low sensitivity of staff towards the preconception care, fear of legal issues, no response to client questions, poor communication between client and staff, the negative experience of prior care and absence of staff. Midwife numbers 1 with 30 years' experience said:" the enough reason is not provided for women to do preconception care before pregnancy and is not suggested "Fear of legal issues related to maternal mortality in the health care system have caused the staff to be sensitive to prenatal care compare with preconception care. Midwife numbers 4 with 8 years' experience said: "we have gravid16 between pregnant women in our health center. These women needed careful care compare to women who referred to preconception care. High risk pregnant women are more important"

Financial barriers: this subcategory includes: high cost of preconception care and uncovered and poor coverage of preconception care by insurance. Most of participation said the high cost of preconception screening test is a barrier to use of this car. Midwife numbers 6 with 16 years' experience said "I think the greatest problem is the high cost of preconception care, certainly". Midwife numbers 6 with 8 years' experience said "Preconception care coverage is very low, even if the mother is high risk due to the high cost of care, does not refer."

Defect in preconception care system: this subcategory includes: lack of special clinics, physical space, special staff, care integration, appropriate definition of care, correct protocol, and low sensitivity of Ministry of Health and manager. Most of the participants said: appropriate protocol for preconception care program was not considered. Pregnant mother (28 y/o) said:" I went to the health center, and health workers referred me to midwives. Midwife referred me to a doctor, and doctor referred me to midwife". We have a health center in our village, why we cannot do preconception care in a health center, and we need to go to town.

Poor quality of health service: this subcategory includes: Busy health center, long wait to get health care and long distances to the health clinic. Between final cods, one of the preconception care barriers was busy clinic and lack of opportunities for women training by personnel due to high load clients. Participant number 2 (24-year) said: "I'm going to the clinic, and it is so busy, personnel, just focused on weight and blood pressure. Personnel had no time to explain.

Disproportion between human resources and health services: This subcategory includes: the high number of clients, lack of midwife compared to clients, high load of health service, and lack of provider. The disproportion between human resources and health services was one of

organizational barriers subcategories. Participants said: The number of preconception caring providers is low compared to clients, and the number of personnel needs to be added. Midwife numbers 6 with 10 years' experience said: a midwife need to do both reproductive health care and prenatal care in the health center, the load of health care in centers is high, and midwife can't be doing preconception caring.

This subcategory includes: private sector barriers, lack of transportation resources and participation barriers.

Private sector barriers: many participants were pointed that there is weakness in the private sector. Considering that, most of women using the private sector for health care, the role of this sector are important in increasing of preconception care coverage, and lack of awareness about this care to women in the private sector is one of preconception care barriers. Participant number 2 (24 years old) said: Because I had blood sugar, I was under the supervision of a specialist before pregnancy, but the doctor did not say anything about preconception care.

Lack of transportation resources: this subcategory includes: undesirable and lack of transport. Participants were expressed that a lack of transportation resources could be a barrier to preconception care utilization in women. Considering that preconception care provided by midwives, many women is coming from villages to cities for caring, and undesirable transport systems can be dissuade women to preconception cares. Participant number 15 (32 years old) said: "I have to go downtown for testing, and traveling is too expensive"

Participation barriers: this subcategory includes: lack of organizational participation, lack of awareness in target groups of religious leaders, less sensitive of religious leaders, lack of awareness of target groups by the public media. Given that marriage age is low in this province, educating of high school students about this care is important, and because many people use media such as television, TV and radio are effective to public awareness and preconception caring coverage. Midwife numbers 8with 22 years' experience said: "The marriage age very low in this province, should be written about this car in the high school books, we now have 17y/o girl who is pregnant ".

Midwife numbers 5 with 13 years' experience said: "religious leaders should advertise also, in Hormozgan province people are affected by their religious leaders.

This subcategory includes: Perceived susceptibility, beliefs and attitudes, social and economic barriers, mental concerns barriers and family barriers.

Perceived susceptibility: this subcategory includes: lack of awareness in women and low sensitivity in women with preconception care. Low sensitivity and awareness in women about preconception care noted in many interviews, participant number 13 (38 years old) said:" our mothers and sisters not taking preconception care and became pregnant and stay healthy, we don't take care too.

Belief and attitude barriers: this subcategory includes: believe and value barriers. Shame due to age and gravid is one of barriers that could be affected preconception care utilization. Participant number 3 (42 years old) said:" in this age, I'm ***ashamed to go to*** the clinic and said wanted to be pregnant"

Economic and social barriers: this subcategory includes: low economic and social level. With regard to preconception care that is costly, low economic level has reduced services access, and it will effect on unplanned pregnancy indirectly. Midwife numbers 9 with 7 years' experience said: "Rural women due to lack of money, cannot buy contraceptive. She became pregnant, and she cannot do the caring"

Mental concerns: this subcategory include: daily busy of mother and child care. The participants said that the daily concerns are effective in use of preconception care. Participant number 5 (42 years old) said: "I'm going to buy the contraception pill and come back quickly. I have no time. Housework is too much, and my child is alone in the house, how preconception care can be done.

Family barriers: this subcategory includes: husband opposition, lack of understanding and sensitivity to preconception care by husband, lake of family knowledge and masculism. Midwife numbers 8 with 16 years' experience said: "Family

pressure to women for childbearing is one barrier. Women' health is not important for families. They only want women to be pregnant; after pregnancy, they let women to do caring program.

Conclusion:

These study explained barriers to utilization of preconception care services in women for the first time and revealed important information about preconception care utilization barriers. According to this study, three classes of barriers were organizational, organizational outside and personal.

Participants' experiences indicated that the defect in preconception care system, lack of service quality, financial barriers and lack of human resources were the most important organizational barriers that limited preconception care utilization for women. Kovijo in 2008 Indicated, high costs of health service, inconsistent and unpredictable cost of the health service, low quality of health care , the lack of staff skills and staff respect to the client were emergency barriers in Sierra Leone (15).

These barriers are organizational barriers that confirm our study data. Reform and change the current system of preconception care may be needed for reducing these barriers. Participants were pointed, Ministry of Health and managers have low sensitivity to preconception care utilization and not given sensitization and training to staff in this field. It's necessary that intermediate and high level managers, are forming a team to evaluate the quality of this service by organizing and coordinating of programs among health care workers and by using staff capacity to provide the preconception care service for women (16). In any organization, effectiveness of the employee's activities depends on the monitoring (17,18).

Proper monitor and education promoted health care service, and will increase the quality and effectiveness of health care (19). Educational programs in the field of preconception care could help to promote awareness and sensitivity of staff (20). The high cost of health service is another effective and important factor for lack of preconception care coverage. Governmental and nongovernmental financial supports and reduced tariff rate are effective on women access to preconception care service. If they create public and private supports through insurance in the community, it will increase access to health services. In many federal and state, there are free health care services for eligible women (family income below the poverty line) (21).

Participants were pointed to weakness in the private sector, transportation systems and women's participation barriers. Ensure to locate a health clinic near to public transportation or clinic hours setting could reduce transport problems. The community health center model is one of the strategies to increase of care access. In a study of jamme with titles emergency services barriers in pregnancy long distances to the health center and inappropriate use of public transport has been shown barriers to emergency services in pregnancy (4) which confirms the results of this study.

According to participants, the lack of notification to target group by radio, television and other government agencies can be a barrier to preconceptions service. Considering that the people of this province using to media such as TV, notification of broadcasting is effective in increasing health care coverage (22). Use of educational resources such as magazines to promote health literacy in girl students about preconception care importance will help to increase of preconception care coverage (16,23). Information and advertising about preconception care is inadequate by religious leaders. Due to religious and cultural context in this province, religious leaders have a key role in the use of preconception care by women (24). It seems, there are many opportunities and challenges in engaging of some religious leaders about women's health needs before pregnancy, which it needs to deep study for exploring and interpret the matching religion and women's health before pregnancy (25).

The interaction between managers, religious leaders, and inviting of religious leaders in women's health meetings and committees at the provincial level could help to raise awareness of men and women in the field of preconception care (16).

Perceived susceptibility, beliefs and attitudes, social and economic level, mental concerns, and family barriers were personal barriers. Multi parity, permission to prenatal care, long distance to health centers, superstitious beliefs during pregnancy, and age showed as barriers to prenatal care other

research (26). Most of the women said they don't know about preconception care importance, and there was inadequate notification about this care through the health system, staff, mass media, religious leaders and educational system. Concern about disclosure of pregnancy in old age and multi gravid women with decision to pregnancy may cause embarrassment to the mother's preconception care (27,28). Midwives and health workers' reaction to old age and multi gravid women may be ashamed them from getting care (29,30).

Welcoming the clients, flexibility in service provision, focusing on communication, create relationships, develop confidence, and respect to peoples indigenous and their culture should be placed on service provider program (31,32). The community health center model is another proposed solution to the issue of access to prenatal care. This model allows women to have access to a local health center that adjusts its services to specific communities. Women would be able to seek treatment in their own neighborhoods and have access to staff members that understand their needs, such as language barriers and location issues. By using local and community-based health centers will be resolved child care problems and mental concerns (33). Low knowledge of the couple about preconception and pregnancy care, lack of couple participation in this care, lack of family support are important barriers (34). Promotion of participatory culture and women's health important before pregnancy for men and family need to remove culture and education barriers with the help of media, leaders, government and should male involvement design and implement from adolescence (16). This study reveals effecting barriers to utilization of preconception care services. It seems by removing them, can will be increased preconception care coverage in the country.

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موانع استفاده از مراقبت‌های پیش از بارداری – یک مطالعه کیفی

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مجله پزشکی هرمزگان سال بیستم شماره سوم ۹۵ صفحات ۱۹۳-۱۸۵

چکیده

مقدمه: *مراقبت‌های پیش از بارداری هر گونه مداخله مورد نیاز ارائه شده قبل از بارداری به زنان در سنین باروری، صرف نظر از وضعیت و یا تمایل به بارداری، به منظور افزایش بهبود سلامت زنان، نوزادان و کودکان است. در مقایسه با کشورهای توسعه یافته، پوشش مراقبت‌های قبل از بارداری در کشورهای در حال توسعه کمتر است و زنان بعد از بارداری به مراکز بهداشتی درمانی مراجعه می‌کنند. هدف از انجام این مطالعه، تبیین موانع استفاده از مراقبت‌های پیش از بارداری بود.*

روش کار: *این مطالعه یک مطالعه کیفی بود. شرکت‌کنندگان در این مطالعه زنان باردار، ماماها، ارائه‌دهندگان خدمات سلامت زنان و اعضای کمیته سلامت مادران بودند. داده‌ها با استفاده از مصاحبه نیمه ساختار یافته و چهره به چهره و روش گروه تمرکز جمع‌آوری شد. برای تجزیه و تحلیل داده‌ها از تحلیل محتوای قراردادی استفاده شد.*

نتایج: *متوسط سن زنان باردار ۳۲/۱ سال بود. بسیاری از آنها خانه‌دار و دیپلم بودند. بسیاری از ارائه‌دهندگان خدمت ماما و مقطع کاردانی بودند. تجزیه و تحلیل داده‌ها منجر به ظهور ۹۵ کد اولیه و ۴۰ کد نهایی شد. کدها در ۱۳ زیر طبقه و ۳ طبقه مفهومی تقسیم شدند. طبقات مفهومی شامل "موانع سازمانی"، "موانع خارج سازمانی" و "موانع شخصی "بود. موانع سازمانی به سیستم بهداشت و درمان مرتبط می‌شد. موانع خارج سازمانی به سازمان‌های خارج از سیستم بهداشت و درمان و موانع شخصی به زن و خانواده مربوط بود.*

نتیجه‌گیری: *این مطالعه موانع استفاده از مراقبت‌های پیش از بارداری را نشان داد. به نظر می‌رسد می‌توان با برطرف کردن این موانع، پوشش مراقبت‌های پیش از بارداری در کشور را افزایش داد.*

کلیدواژه‌ها: *مراقبت‌های بارداری، زنان باردار، بارداری*

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