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Improving Health Care among Postnatal Mothers: A Focus on Midwifery in Hospitals

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Abstract

The care provided by midwives to women, babies and their families is of utmost importance to society. In Africa generally, midwives are key professionals in ensuring that women have a safe and emotionally satisfying experience during their pregnancy, childbirth and the postnatal period. Patient satisfaction is a good measure that can assist midwives plan and execute midwifery care delivery properly (Jangsten, 2005). To improve health care, health workers need feedback from those they care for, so as to tailor their care based on the needs of their clients. Furthermore, quality can best be achieved through planned set of actions designed to provide the end-user with the product they expect. The best way to assure quality in midwifery care, is to hear from the recipients of that care; who are women in this case.

This study was aimed at assessing women's satisfaction or otherwise with midwifery care at Meru level 5 hospital. An exploratory descriptive design was employed during the study. Post natal women who had had normal delivery were selected purposively to participate. In total, 15 post natal women who met the inclusion criteria participated in the study. In-depth interviews were used to gather verbal information from the participants at their homes. Each interview was tape-recorded with consent from the participants. After the study, information or lack of it came out as a key determinant of satisfaction with midwifery care or otherwise. Also antenatal education on the women's rights and expectations during labour need to be strengthened to empower them to ask for services. Further, women in labour need to be admitted for close monitoring.

Keywords: Health Care, Postnatal Mothers, Midwives, Antenatal care.

Introduction

Midwives play a central role in ensuring that women have a safe and life-enhancing experience during their maternity care, and that their babies and families have the best possible start in life. The World Health Organization (WHO, 2006) recommends that; midwives should be friendly, respectful, use clear and simple language and encourage their patients to ask questions. The midwife should seek the woman's opinion and permission before carrying out any procedure on her (WHO, 2006). Factors in the delivery environment may make the labour experience negative. So, these factors should be identified and all those caring for women in labour notified so as to avoid or minimize them, (Borquez and Wiegers, 2009). The number of midwives caring for a woman in labour has been found to contribute to the description of labour as positive or negative. To make the experience of labour more positive, the number of midwives caring for a woman at any one time should be kept to the minimum (Fontein, 2010). Eventually, the classification of labour experience as either positive or negative will be influenced by the support a mother receives during labour (Sauls, 2004).

In Kenya, 56% of women still deliver at home or outside the hospital, and some of the reasons advanced for preferring to deliver at home is poor quality of services by hospital workers (Andolo, *et al,* 2010). Waweru (2011) says that pregnant women are shunning giving birth in hospitals owing to mistreatment by health workers. Further, it has been argued that the health system is failing women, because when a woman is in labour, she needs someone to listen to her and offer comfort but a midwife attending to many women at once cannot have time for all the women (Anyango, 2010). Women have complained that they are left alone during labour pain at the health facility but a TBA stays with them and helps them to deal with the pain (Cotter, *et al,* 2006). Patient satisfaction is a good measure that can assist midwives plan and execute midwifery care delivery properly (Jangsten, 2005). But the experience of mothers who deliver with a midwife is an area where little research has been done, especially in Africa in general and Kenya in particular (Du Plessis, 2005).

Only 26% of Kenyan women give birth in public health facilities (Chimaraoke, *et al.,* 2008) and poor quality of care has been identified as one reason for low rate of births in public health centers (Otis and Bret, 2008). The 2010 figures of 32% hospital deliveries (Andolo *et al.,* 2010) shows an improvement but the level is still low compared to the WHO recommendation of universal coverage (WHO, 2006).

Women are actually able and willing to travel to a health facility providing a good service but few are doing that (Tann, *et al.,* 2007). Bissalah and Karima (2010) say that one of the main reasons for not delivering in hospital among mothers who had attended ante-natal clinic is lack of privacy in public hospitals.

Midwives need to understand that labour and childbirth is not a one stop activity but a process that begins before conception and will continue after delivery (Gardener, 2006). Therefore the woman's birth environment should be made empowering, non stressful and communicate respect (Hodnett, *et al.,* 2007). Further, the philosophy underpinning midwifery-led care should be that of normality and being cared for by a known and trusted midwife during labour (Hatem, 2008). So, the goal of midwifery care should be that, all women have an opportunity to give birth on their own terms, in a calm and supportive environment ,and supported by people who can assist if need be (Edberg and Ingela, 2006). Women belief that birth is a journey, a rite of passage during which they need supportive birth companions working within a supportive birth environment (Edwards, 2008).

It is therefore important to understand what mothers perceive of their care because it is important in facilitating positive maternal and fetal outcomes (Igobeko Eustace, 2007).

Need for Feedback from Women

Women want to talk about their fear of labour, often associated with distrust in themselves and their capability to give birth (Berg, 2005) and for them, it is essential to put into words their own effort during labour which is mostly ignored by midwives (Berg, 2005). Women want opportunities to share and discuss their knowledge about themselves and their labour rather than have it be discounted or ignored (Lothian, 2008).

Masterson (2010) argues that there is need for research on outcome measures that stakeholders, particularly new mothers can identify with and value. It is important to engage the public in discussions about midwifery so that the public can conceptualize midwifery-led care and its benefits (Masterson, 2010). Also, Bailey (2008) opines that, it is important to encourage women to talk about their experiences; this helps them report any benefits and or problems encountered. Such reports would help midwives modify their approach to care for the benefit of the women.

Women want a caregiver who is there' emotionally and physically. Nurses/midwives are said to be rough and abusive to women in labour, in Kenyan public health facilities. It is important to encourage women to talk about their experience in labour so that they can verbalize their fears and what they think about their ability in childbearing. Finally, there is need for research on outcome measures on childbearing that women value.

Materials and methods

An exploratory/descriptive design and qualitative methodology using a phenomenological approach was used. Wood (1994) says that exploratory studies provide an in-depth exploration of a single process, variable or concept while descriptive studies examine one or more characteristics of a specific population. In this study, the author sought to explore women's experience during labour to enable midwives use the knowledge gained to improve their care giving tactics. The study was carried out at Meru Level five Hospital, post-natal ward where participants were selected and later interviewed at their homes. The hospital is a 600 bed occupancy district hospital, situated in Imenti North District in Meru County of Kenya. It acts as a referral for the upper Eastern Kenya region. The maternity unit is a 64 bed facility consisting of ante-natal, postnatal and a post Caesarian room. The delivery area consists of a six bed first stage room and a four delivery couch second stage room with a newborn baby unit adjacent to it. The study population consisted of Post-natal mothers at Meru Level five Hospital who had a Spontaneous Vertex Delivery (SVD).Purposive sampling was used to select respondents daily for one week after which interviews were conducted. A total 15 mothers were approached who accepted to participate. To identify the women to be approached, their files were used to confirm those who met the eligibility criteria. Once identified, the women were introduced to the study, the reasons for carrying it out and its importance to future midwifery care. After signing a consent, demographic data was taken and an agreement reached on a convenient day for the interview. Despite sample inclusions of spontaneous vertex delivery (SVD) women at Meru District Hospital, an exclusion criteria was also adopted that ensured women who; had undergone any complications post delivery like post- partum haemorrhage, had experienced still births or neonatal death, were in unstable mental post delivery status and living more than five kilometers from the hospital were excluded. Interview schedules and observations were used for data collection, an analysis of which was then done and consequent presentation.

Results and discussion

Participants except one who was given panadols were not given any medication for pain relief. Some of the respondents said they had no idea one can be given pain relief during labour. Other participants thought one should persevere during labour. These reports could have been due to lack of information on how to handle the situation, the fact that some respondents had no idea they could be given pain relievers at labour, is a clear indication that they were not informed of it.

Number of care givers

Participants talked of being cared for by many people; from 3 to 6. Change of shifts brought workers completely unknown to the participant. During a particular examination, (V E) a participant was examined by many people. While in the labour room, mothers require attention as they undergo the preparations to giving birth, it is however, evident that most women are attended to by various caregivers. The midwifery experience of these women at the hospital is not focused on one attendant but many as they work on shifts. This reduces the personal attention that mothers could receive if they had been attended to by only one care giver since at every shift they tended to meet completely new midwives.

Information to the mother

Communication and information is key in hospital attendance. Some participants were told the findings of their examination, while others were not told. At every step of their labour, women need be told of what they are undergoing and what to expect at what level of their labour. A participant was told she was 4 cm only to deliver within less than 10 minutes. Prior preparations need be done and the right information given to the labouring mothers at the right time while at the hospital.

Level of Midwife

Among the participants, 8 were delivered by student nurses while the other 7 were delivered by a qualified midwife. Qualification and experience is important when it comes to doing the right thing at the right time to the right person. Labouring mothers at different stages require varying attention. This can only be made possible if they are being attended to by the right people. It was however not satisfactory to most women as they were being attended to by students or trainers who were not properly knowledgeable or lacked much experience in midwifery.

All the participants were not assisted with pain relief during labour except one who was given panadols when she complained to a nurse. This appears to support the argument that pain relief plays a relatively minor role in women's satisfaction with childbirth compared to the quality of the relationship with her care giver (Leeman, 2003). Majority of the participants did not know one was entitled to pain relief during labour, so they did not seek that assistance. Others felt they were expected to persevere. This appears to suggest that ante-natal education for women at Meru which would include how to cope with pain during labour and the assistance available to them is not up to date. Vivilaki (2009) argues that women should be encouraged to have faith in their bodies during labour while Campbell (2009) says pain in labour is a purposeful, useful thing which has a number of benefits such as preparing a mother for the responsibility of nurturing a newborn. The findings of the study are that women experience a lot of pain but feel they need to persevere. This agrees with the feeling that labour pain is unique to individual women and that it is natural and bearable (Kgwiti, 2008). However, the same writer says that labour pain may be unbearable and the woman will need to be given medication for pain (Kgwiti, 2008). Therefore the midwife needs to listen to the woman in labour and intervene as appropriate.

Encouraging mobility during labour is good practice because it makes the contractions stronger. If contractions are stronger, the duration of labour will be shorter and there will be fewer interventions, which may be costly and may consume time while the maternal and foetal outcomes are being compromised (Lugina, 2004). Walking around is safe if the woman walks within the labour ward, otherwise if she goes outside, the midwife will lose control of her (Lugina,2004). However, the walking around appears to be uncontrolled as women in active labour are instructed to walk outside the ward and come after 4 hours. Only one participant said she was told to come back if the waters rupture. It is important to monitor women in labour (active) for any fetal and or maternal changes. It is also important to monitor the contractions and more important to perform a vaginal examination after rupture of membranes to rule out cord prolapse (Lawdermilk, 2006). Participants felt it would be better to be given a place to stay and allowed to walk around their bed. This will hopefully make it possible for the women to be monitored more closely for any complications that may arise.

Further, it is a fundamental human right to be cared for in privacy. Many women in labour tend to adopt any position and forget about their nudity. It is the duty of caregivers to ensure the woman's privacy.

Majority of the participants reported not being informed of what was happening to them. Rarely did the midwives inform them of their progress. Moore argues that client participation with care is an important element

of quality care often determining patient willingness to comply with treatment recommendations, thus influencing effectiveness of care (Moore, 2002). Further, Moore says that problems related to maternal care provider's behaviour and attitudes are a major barrier to utilization of skilled child care. Many participants did not seem to take the lack of information as being a bad experience, but evidence has shown the importance of information in making a woman feel in control of her body and the childbearing process. Furthermore, the constitution of Kenya in the chapter on the bill of rights (ch 4 sec. 19) clearly identifies consumer right to information as necessary to enable consumers gain full benefits from the services (Ag, 2008).

Finally a participant asserted that the older nurses are the ones treating women badly through physical abuse and verbal insults. Times have changed and considering that majority of the participants were below 30 years (80%) 12/15), old nurses may not have been their favorites. However from the information given by the participants, it is the physical or psychological abuse that made the experience of childbirth bad and not the age of the midwife.

Conclusion

Communication between midwives and the women they care for is quite limited. This further leads to lack of any meaningful relationship establishment between them. There appears to be no attempt made by the midwives, to make the woman in labour feel at ease. Although the lack of communication does not come out as affecting the experience of labour by the woman, good practice would demand that women in labour be made to feel as free and as comfortable as possible. Generally, pain relief for women in labour is not one of the aspects of care given to the women in labour. The women do not consider that one to be bad as they feel they need to persevere. This is an old fashioned way of thinking as modern obstetric approaches advocate a painless labour.

Recommendation

An analysis should be undertaken of the impact of an increasing trend towards part-time working among midwives including the impact on continuity of care, mentoring students, future recruitment, predicted absence and time required for continuing professional development. [p25]

All women in active labour need to be admitted for close monitoring and allowed to walk around their beds as opposed to being told to walk outside the bed.

Ante-natal education needs to be strengthened to empower pregnant women with knowledge on their rights during labour and the services available to make their childbirth experience better. Such education should be continued when the woman comes in labour. Communication between midwives and women in labour need to be enhanced. This will enable the women at least know the names of the people caring for them and their qualifications.

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