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Experiences in Care Given During Child Birth at a Referral Hospital in Kenya

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Abstract

The fifth Millennium development Goal (MDG) calls for a reduction in the maternal mortality ratio (MMR) by 75% between 1990 and 2015, with a key indicator being the proportion of births attended to by skilled health personnel, (United Nations, 2007). In Kenya the MMR is 400 and has made insufficient progress towards improving maternal health, (UNICEF, WHO, World Bank, 2013). According to KDHS (2014), the proportion of skilled birth attendance is 46.5%, while in Kenya it is 62% against an MDG target of 90%. According to Zaers S., et al., (2008), prior experience in delivery care by skilled attendants affects their subsequent use of these services. In Africa little research has been carried out on the experiences of mothers in facility-based delivery care. This study was therefore set to describe the experiences of women during labour and delivery at a referral hospital in Kenya

This was a cross sectional descriptive study that focused on experiences of delivery care by postnatal mothers at a referral hospital in Kenya. Systematic random sampling from a sampling frame of 327 was employed to recruit post-natal mothers who delivered in labour ward and four postnatal wards. A total of 109 participants were recruited into the study. Views and experiences of recently delivered women were elicited using a five-point Likert scale questionnaire focusing on four dimensions of participants' intrapartum experience. Data was analyzed using ANOVA. Research results were presented in frequency distribution tables, graphs and charts. P-values were used to determine the statistical significance of the results obtained.

Most participants (87.7%) agreed that they were treated with respect, accorded privacy and asked to consent, prior to the initiation of the procedures. A single aspect of communication, namely health provider explanation of health status with understandable terms was poorly rated (mean 1.8 to 2.2) as was the level of genuine interest in patient well-being (mean = 1.7 to 2.0) which was significant in the study. Most participant (n = 102(93.6%) said they would recommend delivery services at KNH to friends or family, although 6% of them said they would not recommend.

Majority of the participants had a positive experience of quality in delivery care. This was evidenced by the fact that majority of then stated that they would come to deliver in the same institution again or recommend a relative or friend. Aspects of care such as health providers communicating to clients in understandable terms and showing genuine interest in patients wellbeing was rated poorly.

Institutional factors such as inadequate space and shortage of staff were also noted to be significantly contributing to negative experience of delivery care in the study

Key words: *Experience, Delivery, Care, Mother, Quality*

1.0 Introduction

Pregnancy and childbirth have a profound effect on a woman's life and also affects her spouse, family and entire community to some extent. Giving birth is one of the most important events in life, which is a highly individual experience, (Bradley, *et al*., 2002). In poor communities the joy expected to accompany the birthing experience is many of the times eclipsed by obstetric complications, serious illness and disability and in some cases untimely maternal or perinatal death, (Zaers, *et al*., 2008). World Health Organization (WHO) estimated that over half a million women in developing countries die each year from causes related to pregnancy and childbirth, leaving at least one million children motherless (Bradley, *et al*., 2002). In developing countries the proportion that receive adequate healthcare during and soon after childbirth is less than half, despite the fact that most maternal deaths occur during these periods (Abouzahr, 2005).

The current emphasis on quality of care in maternal health, includes women's experience of care offered during delivery. According to WHO (2007), the required skills for skilled birth attendants include the ability "to cultivate effective interpersonal communication skills and an attitude of respect for the woman's right to be a full partner in the management of her pregnancy, childbirth, and postnatal period."

To ensure good experience in labor and delivery, the service delivery system must pay regard to clients' expectations and rights to access, safety, comfort, dignity, privacy and confidentiality and the right to express opinion about the services offered. Furthermore, women's reluctance to use obstetric care in developing countries stems from cultural inappropriateness of care, disrespectful and inhumane services, lack of emotional support, as well as high costs (Koblinsky, 2006).

Prior experience of quality in delivery care may hinder women from accessing delivery care or delay in reaching the care, Koblinsky, 2006). While many qualitative studies have been carried out on women's experiences in maternal health, few have focused on experiences of women during labor. The study aimed at assessing the experiences of women during delivery in the maternity unit at the Kenyatta National Hospital (K.N.H.).

2.0 Materials and Methods

A descriptive cross-sectional study was conducted on women aged 20-40 years seeking delivery services at KNH. The hospital was purposely selected because it attends to a diverse category of clients. A sample of 109 mothers were recruited from the postnatal wards. Systematic sampling was employed to recruit postnatal mothers within 48 hours of delivery into to the study where every third client was selected. The study utilized both quantitative and qualitative approach in data collection. A semi-structured questionnaire was administered to elicit information on socio-demographic characteristics and mothers' views on the care given during delivery. Three focus group discussions (FGD) comprising of postnatal mothers were conducted to explore on their experiences during delivery. Quantitative data were processed using Statistical Package for Social Sciences (SPSS) version 21. Qualitative data were analyzed using NVivo where themes were noted.

Approval to carry out the study was sought from Kenyatta National Hospital/University of Nairobi (KNH/UoN) research and ethics committee. The permission to access K.N.H maternity units was sought through the head of reproductive health division. Written consent was obtained from the study participants.

3.0 Results

3.1 Background characteristics of the mothers

From the study findings, close to a half (45.9%) of mothers were aged between 20 and 24 years. The average age of the study participants was 26±4.5 years. Parity among the participants ranged from 2 to 7. Over two thirds (71.6%) of the mothers were married. Nearly half of the mothers (48.6) had attained primary education and over a third (37.6%) attained secondary education. Nearly a half (45%) of participants were self-employed and slightly over a half (52%) earned between KES 5,000 and 9,999 per month (Table 1).

Table 1: Demographic characteristics of postnatal mothers at KNH

Characteristic	Frequency (n)	Percent (%)
Age in years		
20-24	50	45.9
25-29	35	32.1
30-34	19	17.4
35-40	5	4.6
Marital status		
Married	78	71.6
Single	15	13.8
Cohabiting	10	9.2
Divorced/Widowed	6	5.5
Educational level		
Primary	53	48.6
Secondary	41	37.6
College/University	15	13.8
Parity		
Para 2	37	33.9
Para 3	41	37.6
Para 4	17	15.6
Para 5 and above	14	12.8
Occupation		
Permanent	13	11.9
Casual worker	18	16.5
Self-employed	49	45.0
Housewife	29	26.6
Income		
KES 2000-4999	19	22.6
KES 5000-9999	44	52.4
KES 10000-14999	16	19.1
KES 15000 and above	5	6.0

*KES- Kenya shillings, Para- parity

3.2 Delivery care experience

Views and experiences of recently delivered women were elicited using a five-point Likert scale questionnaire focusing on four dimensions of participants' intrapartum experience. In general, participants rated experiences of quality of care based on perceived respect, dignity and equity by health workers highly. Most participants either strongly agreed or agreed that they were treated respectfully, accorded privacy and asked to consent to procedures, prior to the initiation of these procedures. Most patients felt that health workers accorded them adequate emotional support. Approximately three-quarters of patients disagreed that provider left them alone for most periods, 80.7% agreed and 8.3% strongly agreed that health workers offered compassionate care and similar proportions of participants felt health workers were genuinely interested in patient well-being. Approximately 91% of participants agreed that health providers explained what to expect during labor, listened to participants concerns and clearly explained to clients their condition.

Table 2: Mothers experience on quality of delivery care

Characteristic	SA	A	D	SD	DK
Respect, dignity & equity					
Respect	16(14.7)	88(80.7)	4(3.7)	0(0)	1(0.9)
Scolding	0(0)	1(0.9)	85(78.0)	22(20.2)	1(0.9)
Privacy	11(10.1)	73(67.0)	21(19.3)	1(0.9)	3(2.8)
Consent sought	12(11.0)	87(79.8)	8(7.3)	0(0)	2(1.8)
Emotional support					
Left alone	1(0.9)	12(11.0)	81(74.3)	14(12.8)	1(0.9)
Compassionate	9(8.3)	88(80.7)	11(10.1)	0(0)	1(0.9)
Genuine interest	10(9.2)	87(79.8)	10(9.2)	0(0)	1(0.9)
Effective communication					
Told what to expect	16(14.7)	84(77.1)	9(8.3)	0(0)	0(0)
Listened to	17(15.6)	85(78.0)	7(6.4)	0(0)	0(0)
Understood	14(12.8)	83(76.1)	10(9.2)	0(0)	2(1.8)

3.2.1 Findings from focus group discussions

Respect, dignity & equity

Regarding respect, dignity and equity, one respondent stated:

"They simply did not like me because a have delivered many times (six children) they kept telling me not to shout like a mother giving birth the first time because I have the experience."(R7)

Emotional support

Regarding emotional support, on respondent said:

"Sometimes due to shortage of staff and the overwhelming numbers of client especially now that maternity care is free, we are not able to monitor mothers in labour and some deliver alone on their labour beds."(R4)

Also one mother during an in-depth interview also said:

" The nurses were too busy and only came to my room once even when I continually called for help. The next time she came to my room the baby was already out."(R1)

Effective Communication

On effective communication, one respondent said:

''They never told me what was going on (referring to care givers). They came and did what they had to do but looked too busy to answer my questions. I only knew it was about time when one of them told me to push hard.'' (R3)

3. 3 Adequacy of space and equipments

Figure 1shows participant's response on the adequacy of space and resources for providing intrapartum maternity care. Over three quarters (79.8%) of the mothers reported that waiting rooms, examination rooms and delivery rooms were adequate while (16.5%) participants disagreed with this statement.

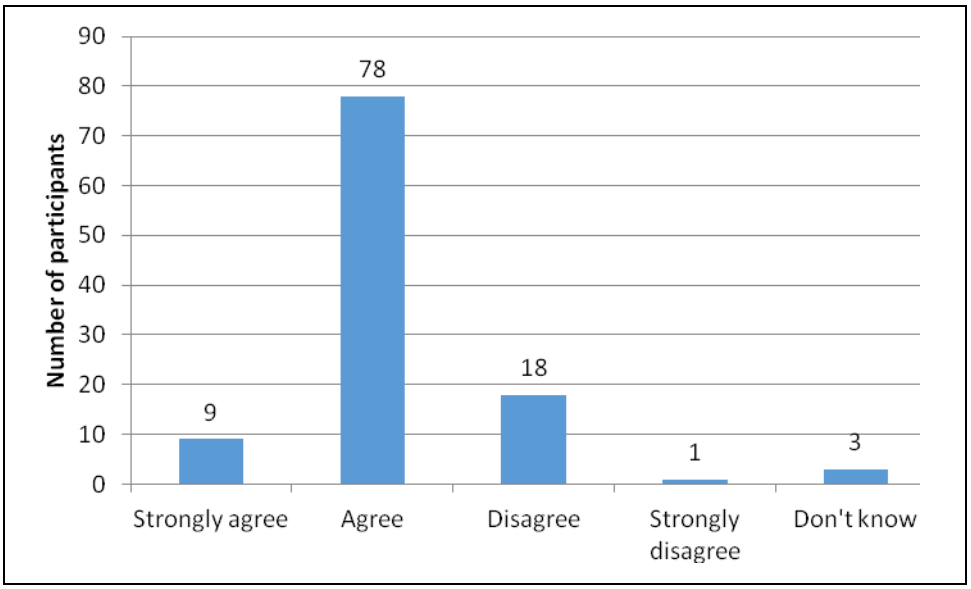

Figure 1: Participant rating of adequacy of space in delivery room and examination room

Finding from Focus Group Discussion

Regarding adequacy of space in the labour and delivery room, one respondent stated:

" I was made to stay on the corridor for one hour during labor as all labor rooms were occupied. Also after delivery I shared a bed with someone else together with our babies; things were really bad for me. (R6)

3.4 Client satisfaction level of quality of delivery care in KNH

One hundred and two participants (93.6%) said they would recommend delivery services at KNH to friends or family (Figure 2). A similar proportion was likely to deliver in KNH again.

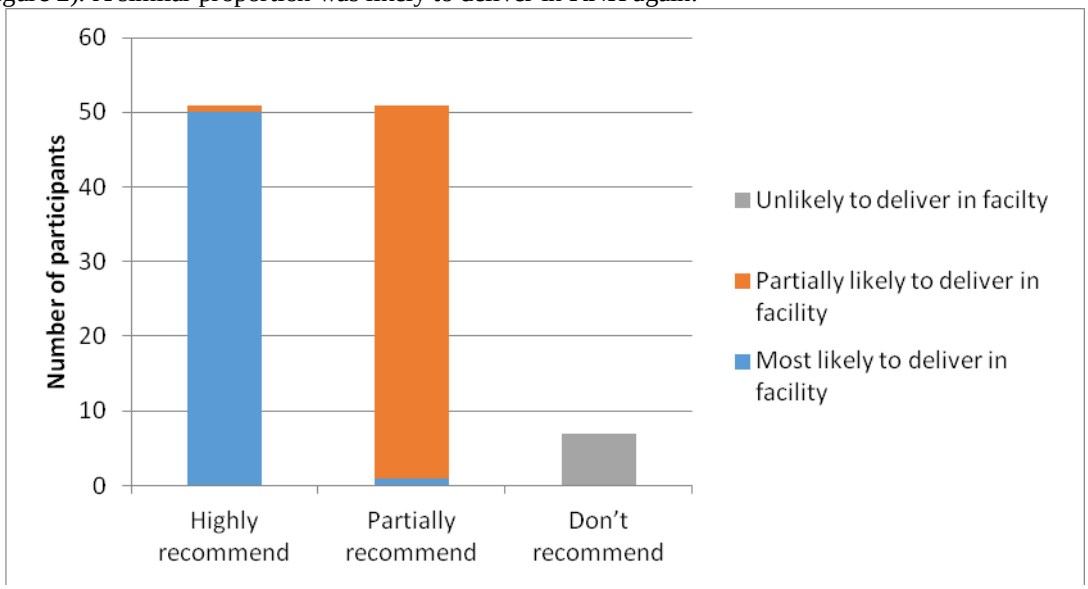

Figure 2: Participant recommendation of delivery services at KNH and future intention to deliver at KNH

4.0 Discussion

The average age of the participants was 26 years (SD 4.5); this differs slightly with average age of mothers giving birth in Kenya as indicated by Carroli, *et al.*, (2008) though on a different kind of study. The findings are however close to that of Bradley, *et al.*, (2002) which was 25.1 in America. Close to thirty eight percent (37.6%) of the participants had a parity of three, which indicates a figure below the approximate number of births per woman of 4.7 according to the World Bank (2011).Majority of the participants (71.6%) participants were married and (86.2%) of them had attained formal education. Forty five percent (45%) of participants reported that they were self-employed, and engaged in small-scale businesses or farming. House wives constituted 26.6% of the participants. The median income (inter quartile range) KSh 7,000 (KSh 5,250 to 9,750).

Of the 109 participants, 73(67%) had attended antenatal care and 107 (98.2%) reported that they preferred to have normal delivery. Most (95.4%) of the deliveries were uncomplicated and five (4.6%) participants had complicated births. Of the five participants with complicated births three stayed in hospital for over 72 hours postpartum, while the remaining two were in hospital for less than 48 hours. Labor most commonly (52.3%) lasted for durations of between 2 and 6 hours but there were seven (6.4%) participants reporting prolonged labor (over 12 hours). Forty-two (38.5%) participants had delivered in KNH previously.

In general, participants rated experiences of quality of care based on perceived respect, dignity and equity by health workers highly. Most participants (76%) agreed that they were treated respectfully, accorded privacy and asked to consent to procedures, prior to the initiation of these procedures. This differs with research carried out in the Dominican Republic, where women were not informed or asked to consent prior to providers' performing routine procedures (Miller, *et al.*, 2007). Also in studies of Sub-Saharan Africa and India, nurses scolded women for talking; moving too slowly; being viewed as "deviant" or dirty; and arriving late in labor. In delivery care, women were harassed, or insulted for not knowing what to do at various stages of delivery, (Mills and Bertrand, 2005). Verbal abuse, slaps and beatings to women during labor and delivery have been also been reported in studies, in Kenya (Behague, Victora and Barros 2006). In Sub-Saharan Africa, poor experience of quality in delivery care and the fear of being ridiculed have deterred women from delivering in government health facilities, as cited by Pearson, *et al.*, (2000).

Most patients felt that health workers accorded them adequate emotional support. Eighty seven percent of patients disagreed that the providers left them alone for most periods, 89% agreed that health workers offered compassionate care and similar proportion of participants felt health workers were genuinely interested in patient well-being. This however differs with Hodnett , *et al*., (2007), who cited that emotional support to the laboring woman, is often absent, although research has shown that it has health benefits. Also, Miller et al. (2006) reported that women were delivering unattended or being left alone for long periods of time.

Health worker and client communication appeared to be effective with 89.7% of participants agreeing that health providers explained what to expect during labor, listened to participants concerns and clearly explained to clients their condition. This however differs with studies done in Mexico and Uganda, which indicated that laboring women did not understand the medical terminology used by providers, did not have the opportunity to ask questions, or wanted more information about their condition (Weeks et al. 2005).

Most participants (81%) reported that waiting rooms, examination rooms and delivery rooms were adequate while 18 (16.5%) participants disagreed with this statement, which concurs with (Center for Reproductive Law and Policy, Latin American and Caribbean Committee for the Defense of Women's Rights (1999), which indicated that human and physical resources are often inadequate, resulting in neglect or lack of attention to women in Sub-Saharan Africa and Latin America. During an in-depth interview a participant revealed inadequacy of space,"

Most participant would either highly (n = 51, 46.8%) or partially (n = 51, 46.8%) recommend delivery services at KNH to friends or family. Of the 51 participant's highly recommending KNH 98% were highly likely to deliver in KNH again, while a similar percentage of participants partially recommending KNH were partially likely to deliver at the

facility again. Higher satisfaction with maternal health care may be related to women's future use of maternal health care, as well as women's sharing of information about their experience with other community members (Handler E. et al 2006). In a qualitative study in Ghana, women indicated they would return to deliver in a facility (a measure of satisfaction) where they had previously been treated well, (Bradley, *et al*., 2000)

However 7.4% of the participants were unlikely to deliver in the same institution again or recommend anyone therefore denoting dissatisfaction with care. Ronsmans, (2007) also cited that health services often fall short of acceptable standards according to clients and cannot be assumed to be satisfying.

5.0 Conclusion

From the study, it was clear that majority of the participants had a positive experience of quality in delivery care. This was evidenced by the fact that majority of then stated that they would come to deliver in the same institution again or recommend a relative or friend. Some aspects of care such as health providers communicating to clients in understandable terms and showing genuine interest in patients wellbeing was rated poorly. Institutional factors such as inadequate space and shortage of staff were also noted to be significantly contributing to negative experience of delivery care in the study.

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