International Journal of Africa Nursing Sciences 11 (2019) 100164

Contents lists available at ScienceDirect

International Journal of Africa Nursing Sciences

journal homepage: www.elsevier.com/locate/ijans

Sociodemographic factors associated with mothers' experiences of psychosocial care and communication by midwives during childbirth in Nairobi, Kenya

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ARTICLE INFO

Keywords:
Kenya
Mothers
Psychosocial communication
Midwives
Childbirth

ABSTRACT

Purpose: To clarify sociodemographic and socioeconomic factors associated with mothers' experiences of psychosocial care and communication by midwives during childbirth in Nairobi, Kenya.

Design: A descriptive cross-sectional study conducted in a government national referral hospital. Respondents were 109 systematically sampled mothers who delivered in the study hospital. Mothers' experiences of intrapartum care were assessed using three subscales from the Experience of Psychosocial Care and Communication during Childbirth Questionnaire (effective communication; emotional support; and respect, care and dignity). Simple and multivariable logistic regression analyses were used to assess associations between sociodemographic factors, socioeconomic factors and mothers' experiences of intrapartum care.

Findings: The majority of respondents were aged 20–24 years (45.9%), married (71.6%), had primary school education (48.6%) and were self-employed (45%). The majority reported positive experiences of communication, respect, dignity and emotional support from their midwives. Being an older mother was significantly associated with a positive experience of intrapartum care (adjusted odds ratio [AOR] 7.32; 95% Confidence Interval (CI): 1.17–45.9). The odds of having a positive intrapartum care experience was significantly lower among women with parity of four or more (AOR 0.09; 95% CI: 0.01–0.56) and tertiary education (AOR 0.11; 95% CI: 0.01–0.91).

Conclusion: Attention to the use of respectful language and adherence to clear communication must be an integral part of quality improvement for midwifery care in Kenya.

1. Introduction

Global efforts to improve the quality of maternal healthcare and women's experiences during childbirth have received increased attention in the past few years (World Health Organization and UNICEF, 2014). Improvement of women's experience of care has become a critical element in approaches to improve the quality of maternal healthcare (Tunçalp et al., 2015), especially the quality of childbirth (Baas et al., 2017; Bryanton, Gagnon, Johnston, & Hatem, 2008).

Some women experience disrespectful, abusive, and neglectful treatment during pregnancy and childbirth at health facilities (Baas et al., 2017). This treatment denies pregnant women their dignity, respect and autonomy and violates their human rights. It also discourages them from seeking and utilising maternal health care services and negatively affects their health and wellbeing (World Health Organization, 2015). However, to promote positive birth experience, the need to promote Human Rights in Childbirth according to the Hague Conference 2012 and the importance of dignity, respect and autonomy for pregnant women utilising health care facilities, are increasingly being recognised (Kinney, Boldosser-Boesch, & McCallon, 2016; Lokugamage & Pathberiya, 2017).

Quality of care involves both the delivery and experience of care (Baas et al., 2017). The experience of care, including respect, communication and emotional support, is particularly important to mothers

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https://doi.org/10.1016/j.ijans.2019.100164
Received 24 December 2018; Received in revised form 25 July 2019; Accepted 4 August 2019
Available online 05 August 2019

(Baas et al., 2017) because childbirth is a significant life experience with long-lasting effects on self-perception as a female and a mother. The experience of childbirth influences mothers' self-esteem, their feelings towards their new-born, adaptation to motherhood roles (Tunçalp et al., 2015) and future delivery experiences (Hallam, Howard, Locke, & Thomas, 2016; Tunçalp et al., 2015).

Birth experience is influenced by expectations of the forthcoming birth, information given by healthcare providers and interpersonal (midwife-client) communication (Henriksen, Grimsrud, Schei, & Lukasse, 2017). Positive experiences in labour and childbirth can be enhanced by addressing the mothers' expectations and rights to access, safety, comfort, dignity, privacy and confidentiality as well as the right to express their views about the services rendered (Bazant, 2008; Nystedt, Kristiansen, Ehrenstråle, & Hildingsson, 2014). Positive experiences can also be enhanced through 'strategic' communication between midwives and women, with a focus on tailored evidence-based interventions and health education (Hildingsson, Johansson, Karlström, & Fenwick, 2013; NICE, 2010). Historically, efforts to advance the quality of care have concentrated on improving the provision of care, with a little emphasis on underlying social determinants of communication interactions (Nystedt et al., 2014).

A positive birth experience also depends on receiving accurate and adequate information (Halldorsdottir & Karlsdottir, 2011). Positive experiences have been associated with age, parity, prenatal education, expectations, social status, being informed, experience of feeling in control, method of delivery, medications, experience of support from caregivers and partners, length of labour and the birth situation (Bryanton et al., 2008). Mothers whose positive birth expectations (safe labour, delivery and a live, healthy baby) were met reported a positive childbirth experience (Bryanton et al., 2008). According to Zamani, Ziaie, Lakeh, and Leili (2019), mothers who had a short labour and a normal vaginal delivery reported a positive childbirth experience compared to instrumental and caesarean delivery. Similarly, women who received continuous support by health care providers during childbirth were likely to report a positive childbirth experience (Bryanton et al., 2008). Women reported positive experience when they were given sufficient information regarding the care they received (Afulani, Kirumbi, & Lyndon, 2017). Putting the woman in a position of control over the process of birth was seen as key to a positive birth experience (Stankovic, 2017). Bryanton et al. (2008) showed that women of higher social economic status, who had given birth previously and were aged between 24 and 35 years, were likely to report a positive childbirth experience, as well as those that had received childbirth education classes.

An adverse birth experience can potentially be disempowering for women, lead to negative effects on mental health and cause anxiety about subsequent childbirth (Størksen, Garthus-Niegel, Vangen, & Eberhard-Gran, 2013). Childbirth services should therefore be receptive to women and the community (Koblinsky et al., 2006; Lerberg, Sundby, Jammeh, & Fretheim, 2014). Midwives should ensure they are not disrespectful or abusive, and do not impose unnecessary, uncomfortable and humiliating medical procedures on women (Hildingsson, 2015).

Effective midwifery engagement with women is needed in Africa (Nilsson, Thorsell, Hertfelt Wahn, & Ekström, 2013), especially as midwives and women could establish trusting relationships resulting in improved quality of care through good communication, connection, rapport and professional behaviours (Bohren et al., 2017; Chadwick, Cooper, & Harries, 2014). Midwives require highly developed interpersonal skills to provide individualised care and ensure the birthing woman's wishes are respected (Oikawa et al., 2014).

Women in low resource settings, including Kenya, continue to report disrespect and verbal abuse from midwives and other care providers, which deter them from giving birth in hospital (Lerberg et al., 2014). In addition, poor midwife-client rapport, relationships, and substandard midwifery care mean that women are further distressed (Abuya et al., 2015). Therefore, it is important to understand Kenyan women's experiences of childbirth care given by midwives in relation to the WHO recommendations for respectful maternity care and the Human Rights in Childbirth according to the Hague Conference 2012. The aim of the study was to identify the sociodemographic and socio-economic factors associated with their experiences.

2. Methods

2.1. Study design and setting

The present descriptive cross-sectional study was conducted in postnatal wards of an urban government referral hospital in Kenya between December 2013 and January 2014. The aim was to determine factors associated with the experience of care during the intrapartum period. An estimated 978 births are registered monthly at the study hospital, located in Nairobi city, Kenya.

2.2. Sample

A sample for a single proportion was calculated with a 5% margin of error and 95% confidence level, assuming an equal proportion of positive and negative experiences of intrapartum care among mothers. The sample was adjusted for infinite population (N = 978), and availability of time and resources. This indicated that 109 respondents were required for the sample. Systematic random sampling based on the hospital delivery register was used to identify respondents; every fourth mother that met the study eligibility criteria was sampled. Mothers who were admitted in the first stage of labour and had delivered vaginally without any complications were included in this study. Women admitted during the second stage of labour, delivered before arrival in the hospital, underwent a caesarean section, or had an assisted vaginal delivery or stillbirth delivery were excluded in the study.

2.3. Data collection

Data were collected with a researcher-administered questionnaire that covered demographic characteristics, birth information and experience of intrapartum care. The questionnaire was translated into Kiswahili. Women's experiences of intrapartum care were assessed on three subscales (effective communication; emotional support; and respect, care and dignity) from the validated Experience of Psychosocial Care and Communication during Childbirth Questionnaire (EPCCQ) (Bazant, 2008). Experience of intrapartum care was assessed with a 5-point Likert scale (5 = strongly agree; 1 = strongly disagree), with negative statements receiving an inverse score (5 = strongly disagree; 1 = strongly agree). The validity of the EPCCQ was previously confirmed in a face validity test by two experts and a reliability test (Cronbach's alpha of 0.86) (Bazant, 2008). The study tool was piloted for content validity among 10 consenting mothers in a different public hospital who met the study eligibility criteria.

2.4. Study variables

The main outcome variable for this study was women's experience of intrapartum care. Experience of intrapartum care was an index calculated using factor analysis based on the 10 parameters of effective communication (*explaining procedures before performing them, listening to the mother's questions with concern and explaining the mother's condition in terms she could understand*), emotional support (*left alone/unattended, shown compassion or genuine interest from nurses/midwives*) and respect, care and dignity (*treated with respect, offered privacy, not scolded/shouted at, and consent requested before procedures*). The variable was then categorised as a positive or negative experience based on positive and negative factor loadings.

Independent variables were age in years (*20–24, 25–29, 30+*), marital status (*in a union, not in a union*), parity (*2, 3, 4 and 5*),

education (*primary, secondary and tertiary*), occupation (*permanent, casual worker, self-employed and housewife*) and monthly income in USD (*< 100 and ≥100*).

2.5. Statistical analysis

All returned questionnaires were checked for completeness and the data were entered into SPSS version 21 for statistical analyses. Demographic characteristics were analysed using frequencies and percentages. Simple and multivariable logistic regression analyses were used to assess associations between sociodemographic and socioeconomic factors and experience of intrapartum care. Only complete cases were analysed, and a p-value of 0.05 was used to determine statistical significance. Income was excluded from the regression analyses because of a significant proportion of missing values (25/109; 23%).

2.6. Ethics

Ethical considerations included local ethical approvals of the study, departmental approval from the health facility and informed consent from the eligible women. Respondents were informed of the researcher's identity and assured of confidentiality and anonymity. They were also encouraged to answer questions truthfully without fear of being victimized.

3. Results

3.1. Respondents' characteristics

Of the 109 women who were sampled, the majority were aged 20–24 years (45.9%), married (71.6%), had a primary school education (48.6%), were self-employed (45%) and had between two and five children (Table 1).

3.2. Maternal experience of intrapartum care

Three-quarters of the respondents (n = 81) reported a positive experience of intrapartum care. However, one-quarter (n = 27) reported negative experiences of intrapartum care, mainly because of being scolded by their midwives during childbirth (97.2%) and being left alone/unattended for prolonged periods during labour (88.1%) (Table 2).

Table 1
Respondents' characteristics.

Characteristic	(n = 109)	%
Age, years		
20–24	50	45.9
25–29	35	32.1
30 and above	24	22.0
Marital status		
In a union	88	80.8
Not in a union	21	17.3
Educational level		
Primary	53	48.6
Secondary	41	37.6
Tertiary	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
Monthly income (USD)		
< 100	63	74.9
≥100	21	25.1

USD: United States dollars.

Table 2
Experiences of effective communication, emotional support, and respect, care and dignity.

Quality of care	Positive Experience		
	n	%	95% CI
Effective communication			
Explained procedures	100	91.7	84.9–96.2
Listened to	102	93.6	87.2–97.4
Health status explained	97	89.0	81.6–94.2
Respect, care and dignity			
Treated with respect	104	95.4	89.6–98.5
Scolded	3	2.8	0.6–7.6
Accorded privacy	84	77.1	68.0–84.6
Asked for consent	100	91.7	84.9–96.2
Emotional support			
Left alone	13	11.9	6.5–19.5
Shown compassion	97	89.0	81.6–94.2
Shown genuine interest	97	89.0	81.6–94.2

CI: Confidence interval.

3.3. Factors associated with experience of intrapartum care

The bivariate analysis showed no significant associations between the experience of intrapartum care and sociodemographic variables. However, the multivariable analysis found age, parity and education level were significantly associated with the type of experience with intrapartum care. Women aged 30 years or over had increased odds of having a positive experience of intrapartum care compared with those aged 20–24 years (adjusted odds ratio [AOR] 7.32; 95% confidence interval [CI]: 1.17–45.9). The odds of having a positive intrapartum care experience was lower among women with a tertiary education (AOR 0.11; 95% CI: 0.01–0.91), women in their fourth pregnancy (AOR 0.09; 95% CI: 0.01–0.56), and those in their fifth (or more) pregnancy (AOR 0.06; 95% CI: 0.01–0.60) (see Table 3).

There was no significant association between the specific components of experience i.e. effective communication; respect care and dignity; emotional support with the type of experience (Supplementary Table 1).

4. Discussion

The global standards for maternal health services in the world state that a woman has a right to dignity, privacy, and information, and that all women should have access to skilled attendance at childbirth (World Health Organization and UNICEF, 2014). These standards enhance the birthing experience by recognizing the basic human rights in childbirth and improve the quality of childbirth experience. Worldwide, midwifery practice is aiming at an improved way of maternal care through observing the human rights. This improved way is sustainable and has positive impact to both the mothers and midwives (Hazard, 2015; World Health Organization, 2015). However, this aspect of care is lacking in many regions worldwide.

In this study, we found that a majority of women had a positive intrapartum experience, mostly attributed to effective communication with midwives, respectful treatment, privacy, being involved (asked for consent), compassion and genuine interest from their midwives. This indicates that the maternity services at the study hospital to some extent adhered to the basic standards for maternal health services. Good interpersonal care and effective communication have been shown to

Table 3
Factors associated with maternal intrapartum care experience.

Variable	Bivariate	Multivariate
	OR (95% CI)	AOR (95% CI)
Age, years		
20–24	1.00	1.00
25–29	1.35 (0.50–3.68)	2.69 (0.63–11.4)
30+ years	1.52 (0.47–4.87)	7.32 (1.17–45.9)*
Marital status		
In a union	1.00	1.00
Not in a union	1.08 (0.36–3.30)	0.67 (0.16–2.89)
Parity		
Para 2	1.00	1.00
Para 3	0.36 (0.11–1.16)	0.28 (0.07–1.09)
Para 4	0.29 (0.07–1.13)	0.09 (0.01–0.56)*
Para 5	0.39 (0.09–1.74)	0.06 (0.01–0.60)*
Education		
Primary	1.00	1.00
Secondary	0.69 (0.26–1.80)	0.57 (0.18–1.78)
Tertiary	0.52 (0.15–1.85)	0.11 (0.01–0.91)*
Work Status		
Permanent	1.00	1.00
Casual	0.78 (0.15–4.07)	0.27 (0.03–2.58)
Self-employed	1.04 (0.24–4.44)	0.47 (0.07–3.30)
Housewife	0.75 (0.16–3.46)	0.24 (0.03–2.15)

OR: Odds ratio; AOR: Adjusted odds ratio; CI: Confidence interval; *p < 0.05.

empower mothers and increase the likelihood of a positive intrapartum experience (Bohren et al., 2017). The findings of this study differ from other African studies that documented negative experiences of intrapartum care following improper provider-client communication, including the use of rude and/or harsh language, unmindful staff and embarrassment (Atuyambe, Mirembe, Johansson, Kirumira, & Faxelid, 2005; Kujawski et al., 2015; McMahon et al., 2014). The present findings also differ from a study done in Tanzania regarding mothers' experiences of being treated with respect, afforded privacy and being asked for consent before performing procedures. Mothers in the Tanzanian study reported a lack of respect and dignity from their midwives (Kujawski et al., 2015). This study however interviewed the women who delivered in the preceding 14 months unlike the current study where women were interviewed within 48 h after giving birth. Negative experience during childbirth due to lack of respect was also revealed in the developed countries such as Norway (Henriksen et al., 2017). These observations indicate that respectful care is a critical component in improving maternal health irrespective of regions. Disrespectful and abusive treatment during childbirth has been shown to lower quality of care during childbirth leading to negative experience (McMahon et al., 2014).

In contrast to a study in Ghana where women reported lack of emotional support from their midwives during childbirth (Moyer, Adongo, Aborigo, Hodgson, & Engmann, 2014), most women in our study indicated they were 'shown compassion' during labour and childbirth and that the midwives showed a 'genuine interest' while administering care.

A finding of critical importance is that a small proportion of mothers had negative experiences of intrapartum care because of being 'scolded' and left alone during labour and childbirth. This experience could have been associated with the large numbers of mothers delivering in the referral hospital as the study was carried out few months after the government announced free maternity care in the country. This subsequently led to a large number of women giving birth in the hospital with limited staffing ratios. The finding of being scolded by midwives is consistent with other African studies that reported women felt ashamed when midwives made inappropriate remarks regarding their sexual activity, particularly unmarried women (Bohren et al., 2017; Kabo, Karani, Oyieke, Wakoli, & Cheruiyot, 2016; Kujawski et al., 2015; McMahon et al., 2014), and being left alone for prolonged periods during labour (Abuya et al., 2015; Bohren et al., 2017; Moyer et al., 2014).

Our findings also showed that age, parity and education were significantly associated with the experience of intrapartum care. Older women had significantly increased odds of a positive experience of intrapartum care, which is consistent with a Nigerian study where older mothers were more likely to report being involved in their care and treated with respect (Bohren et al., 2017). A Kenyan study also showed that younger mothers had a negative experiences of intrapartum care as a result of being shouted at and not being informed about labour expectations (Abuya et al., 2015). The findings of positive experience among older women may be as a result of prior experience and hence know what to expect during childbirth compared to younger women.

In the present study, higher parity and tertiary education were associated with lower odds of positive experiences of intrapartum care. A potential explanation is that women who have had previous births already know what to expect during childbirth from the care provider, and if this is not realised they are likely to experience poor locus control hence negative experience. Similarly women's level of education which is hypothetically higher at tertiary level shapes expectations (higher expectations), which if not met would translate to negative experience. The study's findings are consistent with other studies conducted in Africa, which showed that multiparty has been associated with negative experiences of midwifery care during childbirth (Kruger & Schoombee, 2010; Tunçalp et al., 2015). The findings however differ with findings highlighted by Henriksen et al. (2017) which indicated that women who were para two or more were less likely or report a negative childbirth experience. This study employed both quantitative and qualitative methods, compared to the current study, which was quantitative. Our findings also differ with earlier studies done in Ghana, Sierra Leone and Tanzania in which the results showed that high levels of education have been associated with positive intrapartum experiences (Atuyambe et al., 2005; Kruger & Schoombee, 2010; Moyer et al., 2014). The three studies employed quantitative and qualitative methods and the study population included health care providers, adolescent mothers and community members, which could explain the contrasting results. The studies suggest that the more educated the women are, the higher the level of understanding of what is expected during childbirth, making it easy for them to differentiate good from bad care and exercise their rights.

5. Strengths and limitations

This study addressed women's experience of care during childbirth, which is an important measure of quality of maternal health services in Kenya. It was conducted in the largest referral hospital in the country but as much as the results of the study are only generalizable to one large hospital, the facility, maternal care offered, and the clientele typically represent the maternal health care in public hospitals in Kenya. The study had some limitations. First, childbirth is an overwhelming experience and mothers are likely to understate or overstate their birthing experiences because of recall bias. In addition, being quantitative study using a questionnaire shortly after birth, may not reflect in-depth the experiences of women. Second, the study sample was small; therefore, the findings cannot be generalised to reflect the general experience of women's during intrapartum care. Finally, as much as the researcher disclosed her identity and assured confidentiality and anonymity, the women may not have been frank enough in their responses.

6. Conclusion

Women had both positive and negative experiences during childbirth according to the standards of respectful maternity care, and basic

human rights around childbirth. However, as much as they had positive experiences of intrapartum care, which was associated with age, parity and education level, some also experienced a violation of their childbirth rights through scolding by midwives. The Kenyan maternal healthcare providers and midwifery delivery services need to prioritise a psychosocial, patient-centred and healthcare equity approach within a respectful communication framework to enable positive birth experiences regardless of age, parity and education. Midwifery care in particular needs to protect women's human rights during childbirth observing and practicing what is stipulated by human rights in childbirth. Effective, respectful and dignified communication and treatment of pregnant women and mothers is central to a positive birth experience.

Declaration of Competing Interest

None.

Acknowledgements

The authors wish to acknowledge Mr Samwel Gatimu Faculty, School of Nursing and Midwifery Aga Khan University, for his immense contribution to the statistical analysis. Your input is highly appreciated.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijans.2019.100164.

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