THE UNIVERSITY OF ZAMBIA, SCHOOL OF MEDICINE, DEPARTMENT OF POST-BASIC NURSING

A STUDY OF THE PRE-OPERATIVE INFORMATION GIVEN TO PREGNANT MOTHERS WHO UNDERGO EMERGENCY CEASAREAN SECTION AT U.T.H.

A RESEARCH STUDY SUBMITTED TO THE DEPARTMENT OF THE POST-BASIC NURSING SCHOOL OF MEDICINE IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE BACHELOR OF SCIENCE DEGREE IN NURSING.

COURSE: NURSING RESEARCH, NR 420

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Declaration of Submission

I hereby declare that the work presented in this study for the degree of Bachelor of Science in Nursing has not been submitted either wholly or in part for any other Degree and is not being currently presented for any other Degree.

Signed: .....
CANDIDATE

STUDY APPROVED BY: .....
SUPERVISING LECTURER

STATEMENT OF ORIGINALITY

I hereby certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly indicated in the text and in the references.

Signed: .....
CANDIDATE

DEDICATION

To my Dear Parents, husband and children.

ABSTRACT

The study was conducted at the University Teaching Hospital in the Department of Obstetrics and Gynaecology. The purpose of this study was to find out pre-operative information give to pregnant mothers who undergo emergency ceasarean section, with the view of using the findings to provide evidence of inadequate psychological preparation of the pregnant mothers before operation.

Another research question associated with the study was whether the operation influenced the feelings ofthe the mothers towards future pregnancies.

A purposive sample consisting of thirty-five (35) mothers was selected and interviewed around the third day post-operatively when the mother was in less pain.

The findings of the study revealed that patients were not informed of the reasons why procedures are carried out on admission to labour ward (80%), and also pre-operatively (71%). The findings also revealed that a substantial number of the patients reported that they were not given chance to ask any questions)93%).

Finally, almost over half of the mothers (54%) reported negative feelings about future pregnancy because they feared having another operation.

The findings are of particular interest to the midwife as they will enable her to review her role in the care of a labouring woman. The findings should also give the midwife an insight into her psychological care and preparation of a woman in labour for surgery who is already under stress.

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My gratitude are also extended to my sister Rose, for willingly looking after my youngest daughter during the period of my studies. I am greatly indebted to my husband, Lazarus and my children for patiently enduring my absence from home. I extend my gratitude to Mrs Ruth Michelo for being a friend in need and finally but not the least to Mrs Theresa Nyuma Ngulube who patiently typed this paper.

CHAPTER ONE

INTRODUCTION, OPERATIONAL DEFINITIONS, STATEMENT OF THE PROBLEM, HYPOTHESES, PURPOSE OF THE STUDY, SIGNIFICANCE OF THE STUDY.

1. INTRODUCTION

Information given during the period of hospitalization should provide the patient with knowledge of his illness, its investigation and treatment, and also provide knowledge suitable for the period after operation. While working in the antenatal clinics and the labour wards of various Hospitals in Zambia, participating in the nursing care and observing the care rendered by other health care providers, I observed that there was need to give more information to the pregnant mothers to enable them understand reasons why certain procedures, treatments, nursing activities were carried out.

I also discovered that there were large gaps between the information held by medical personnel and information given to the pregnant mothers who undergo caesarean section in relation to the indications for operation and procedures carried out pre-operatively.

According to Jean and Edeani, communication with patients is important in helping the doctor make a diagnosis and for effective treatment and nursing care. They further state that:

> "During the hospital stay and after discharge, the patient must understand what is being asked and what is being stated in order to co-operate fully with health care personnel."[1]

Many times, however, health personnel tend to look at the patient as a passive recipient of instructions and orders, one who does not need to know the reasons for treatment and certain procedures performed on him. Patients who do not know of their behaviour and how they should react to the information given, leave it all to the medical personnel to do whatever seems right for them; after all, "they know it all". As a result of such a situation, the medical personnel capitalise on this ignorance and deny the patient the right to know the necessary information. Chisengantambu in her study on patient's awareness of their rights in relation to health care, found that most patients were not aware of their rights and that communication between staff and patients was very poor. This created feelings of insecurity in patients and also it made it difficult for them to ask any questions about their care.[2]

2. OPERATIONAL DEFINITIONS

For the purpose of this study, the following definitions of terms were used:

INFORMATION: Knowledge of the indications for performing the emergency caesarean section and procedures performed on the patient before operation.

INDICATIONS: Reasons for performing the operation.

EMERGENCY CAESAREAN SECTION

An unplanned operation performed on the pregnant mother to deliver the baby due to unforeseen complications that arise during labour.

LABOUR:

The process of giving birth.

PRE-OPERATIVE PERIOD

The period between the time the decision is made to perform the operation on the pregnant mother and when the mother is taken to theatre.

COMMUNICATION

sharing of information by medical personnel with a patient in relation to the problem or disease.

MIDWIFE

A Nurse who has successfully completed the prescribed course of studies in Midwifery in a recognised Midwifery School and is currently practising in a labour ward of an obstetric unit.

MEDICAL PERSONNEL

All Midwives and doctors who come in contact with the woman during the time she is in labour, up to the time of delivery.

EPISIOTOMY

An incision made into the perineum to enlarge the vaginal orifice.

3. STATEMENT OF THE PROBLEM

Many studies have been carried out to find out common indications of caesarean section and also to find out pre-operative information given to patients undergoing general surgery. Some studies have focused on effects of pre-operative information given to patients on the coping behaviour after surgery.

In a study done by Kinney, the results indicated that there was continued need to identify the psychological needs of patients in their pre-operative preparation and which of these needs they could use. It was also discovered that patients responded to pre-operative teaching by showing decreased anxiety levels regardless of coping styles.[3]

This points to the fact that a surgical operation is usually viewed with fear, anxiety and worry by

every patient. These fears need to be dealt with by the medical personnel attending to the patient pre-operatively by giving the patient as much information as possible.

Raphael conducted a study on patients' views of life in general Hospitals and found that most of the patients reported that they were not informed of either their illness or their treatments. Raphael states further that perhaps explanation of tests and treatment was more needed than knowledge of diagnosis and prognosis.[4]

Information must be given in such a way that the patient is able to understand the terms used and the meaning of the message.

However, very few studies have been done to try and find out what pre-operative information is given to pregnant mothers who undergo emergency caesarean section. In a society where so many beliefs are attached to child birth, the woman who is faced with a situation to undergo a ceasarean section is torn between different kinds of feelings towards the operation. These feelings of fear, inadequacy coupled with ignorance, may affect the pregnant mother's out look and expectations in future pregnancies.

Wassner states that expectations of patients regarding surgery and anaesthesia reflect the beliefs of that society and is also related to individual experiences. She continues to say however, that:

> These beliefs frequently cannot be correlated any longer with the hospital staff who through acquired knowledge and specialised experiences have modified for themselves the society's shared beliefs. This creates a gap between their patient and the hospital staff. As a result of this, the safety of the patient is not only dependent on physical measures but is equally dependent on an understanding of their beliefs, expressed emotions regarding their illness and pending surgery and dealing with these beliefs.[5]

It is therefore important to really understand a woman's cultural beliefs in order to give her adequate information about her condition and the necessity for any treatment that may be prescribed for her in order to gain her confidence and co-operation.

In some cultures, if a woman fails to deliver naturally the failure is atrributed to the husband's unfaithfulness during pregnancy. These beliefs may disrupt the relationship between husband and wife, and also create feelings of fear of death and helplessness in the patient and family members.

Adeleye, in his study about primary elective caesarean section in Ibadan, Nigeria, reports that Nigerian women have a general fear of the operation

because of its association with maternal and fetal hazards and also because of the general belief among the women that to deliver abdominally constitutes failure on their part.[6]

Many times, mothers in the antenatals clinic have expressed ignorance about the indications of a previous caesarean section. Some of them do not even know the difference between a ceasarean section and an episiotomy. These experiences give rise to doubts as to whether these preganant women are informed about indications for ceasarean section or about procedures performed on them especially if the operation is an emergency one.

This study was focused on the questions:

1. What is the pre-operative information given to pregnant mothers who undergo emergency ceasarean section?
2. What do the mothers feel about the information given? Another research question associated with the study was:
3. do the mothers think that the operation performed influenced their feelings about future pregnancies?

4. HYPOTHESES

i. there is a relationship between lack of pre-operative information given to the pregnant

mothers undergoing emergency ceasarean section and their knowledge about the indications for the surgery.

ii. there is a relationship between lack of pre-operative information given to the mothers undergoing emergency ceasarean section and their knowledge about pre-operative procedures performed on them.

iii, there is reluctance expressed by the mothers to have any more preganancies in future in those who receive inadequate pre-operative information before undergoing an emergency ceasarean section.

5. PURPOSE OF THE STUDY

The purpose of this study was to try and assess the pre-operative information given to the pregnant mothers who undergo emergency ceasarean section in relation to the indications and procedures carried out on them. The study also sought to find out from the mothers whether the information given to them influenced their feelings towards future pregnancies.

6. SIGNIFICANCE OF THE STUDY

The study was done to assess how much pre-operative information is given to the mothers before they undergo

emergency ceasarean section with the view of using the findings to provide evidence of inadequate psychological preparation of the pregnant mother before operation. The findings will help Midwives and Doctors to improve the care of such women during the most stressful moments in the delivery process. It is also hoped that if the inadequacies in giving information are corrected it would help patients understand procedures and indications for the operation and hence develop positive attitude towards future pregnancies and labour.

Knoweledge about indications for the operation will help the mother give comprehensive history of the previous pregnancy. This would assist the obstertric team in diagnosing, management and nursing care of the patient.

CHAPTER II

REVIEW OF THE LITERATURE

The importance of information giving to patients before operation and before any procedure has been shown by the many articles written about it. It is even much more important when it concerns giving information to a patient who is scheduled for an emergency operation. Few people look forward even to minor operations without doubts and fears. The pregnant mother who has already been burdened by labour pains often reacts to the recommendation for surgical intervention with apprehension and anxiety.

Field states that unfortunately, many times the patient is frequently excluded from any participation in arriving at a decision which vitally concerns him and which may affect his entire life.[7] Often, after the doctor has made the decision, he just directs the patient to sign the consent for operation, as it is the only best method of treatment.

Although there is no best method of communicating effectively with patients, it is very important to ensure that good communication exists between health care providers and patients. According to Kolle, the main duty of a midwife in an obstetric department

is and will always be to help the woman in labour, where ever she may be operating from. It is very important that the midwife explains all aspects of pregnancy and labour to the pregnant woman. These aspects should include the physiological, sociological and psychological changes that may occur as a result of pregnancy and labour.

The pregnant woman and her husband should know what is to be expected during pregnancy and labour to allay anxieties. Kolle, further states that: "It is the midwives'duty to give the women confidence in themselves, their environment and the birth process after which they are able to co-operate with her actively."[8] This means that the midwife must be an active participant in the dissemination of information and advice to the pregnant women in the process of caring for them.

According to Reeder, et al., child-birth classes are now including information about the reasons for performing a ceasarean section and what it involves so that the pregnant women and their families are aware of the type of delivery.[9] They further state that "Psychological sequela of ceasarean section are first being investigated. It is now known that the woman

who undergoes a ceasarean section especially when it is not a planned one will often have feelings of failure and guilt about not having a 'normal' or natural child-birth experience."[10]

According to Wassner, in order for the midwife to give safe pre-operative care she has to look at the patient as a whole person. The mind and body should never be treated as separate entities. The physical and Psychological preparation of the patient for operation should go hand in hand because the trauma of surgery is reduced and recovery is quicker if applied together.[11] Osborne and Barnnet State that it is very apparent to many that patients need to be told about their conditions, their treatment and recovery.[12] Unfortunately this need for information is never satisfied and that they remain ignorant, anxious and not sure about what to do next.

Pregnant mothers need the information so that they are able to anticipate any complication that may arise and they also need time to get used to ideas and facts which make it easier for them to deal with their anxieties and fears.

According to Wassner, "The skill of a nurse lies in the adptation of the quantity and depth of

information given to the capacity of the individual person as each will vary as to the amount of information he can tolerate at any one time."[13]

Bebb states that speaking to patients is part of the nurses' responsibility in order to give information, answer questions, educate, advise and allay their anxieties. She continues to state that: "if a patient is worried about his condition and his physical condition is cared for but his emotional needs are neglected, he will recover much more slowly as he is unable to air his fears."[14]

From the moment a patient is admitted, his privacy is interfered with, his sense of security is threatened and sometimes questions of the utmost intimacy are asked and answers are expected.

On the part of the medical personnel, explanations are seldom volunteered and the patient's questions are answered superficially or in a jargon he does not understand. And yet these are questions which involve his well-being, perhaps his survival.

Minna states that apart from interupting the ordinary pattern of living, illness also affects the person's feelings about himself.[15] Minnar describes

how the patient comes in with a lack of understanding of hospital procedures and states that "the patient is subjected to examinations and tests, the purpose of which he does not understand, and the results of which are not explained to him".[16] He also describes a typical scene where:

> A nurse comes in and sticks him with a needle, another puts a thermometer in his mouth; a strange-looking machine is wheeled to his bedside and connected with his arms and legs, heis put on a stretcher and wheeled through long corridors and passage ways.[17]

A pregnant woman is also subjected to the above treatment and these would even increase her anxiety if none of the procedures are explained. Already she is experiencing labour pains which in themselves cause enough anxiety and fear in the woman, for she does not know the outcome of that labour. The anxiety is even more if the woman is a primigravida who does not know what labour is all about.

Fairweather, writing about progress and problems in the care of the Mother and baby, states that communication has been one of the greatest constraints in the relationship between doctors, midwives and other health professionals with the patient. He makes it clear in his article that "It is absolutely

necessary that health personnel confirm whether their patients have understood and are aware of what they are trying to communicate, do and the reasons for doing what ever isdone. Patients should feel that they are involved, are a part of the team and not playing a passive role. He further states that a good midwife should be one to whom needy pregnant mothers can refer their problems.[18]

According to William, many patients view a surgical operation as a threat to normal routines and therefore fear and worry are at the maximal at the time of operation.[19]

To achieve an equivalent level of safety for the psychological component of the trauma Wassner states that the staff should "provide appropriate factual information and communication of concern, at the same time both the patient and the staff must adapt to each other's needs and capacity."[20]

For this reason, therefore, the midwife should be involved in giving meaningful information to the woman in labour especially one who is to undergo an emergency ceasarean section. It is the midwife who cares for the labouring woman from the time of her admission to the labour ward to the completion of

the birth process. Kölle states that "the midwife creates the atmosphere in the labour ward and stays with the woman through the delivery so that she is never left alone with the apparatus, her anxieties and loneliness." [21]

Oyeguule, writing about the role of the anaesthetist in the prevention of Maternal Deaths in ceasarean section states that "awoman in labour is an example of a patient who is not or is inadequately prepared for surgery because she is anxious and afraid both for herself and for her infant.[22] In such a woman information about progress of labour and any procedures performed and decisions made is vital in allaying anxiety and fears. Her concern is about her safety and that of her infant. The midwife should therefore be sensitive to these anxieties and worries so that she can deal with them.

Caplan, while studying the crisis of premature birth found it healthy for the future mother-child relationship if the parents obtained as much information as possible about the baby's situation, if she frequently questioned the nurse and doctor, requested specifics on the causes, prognosis, treatment plan and any any other information that she found valuable to know.[23]

From the review of the literature one could conclude that there is a felt need among patients for information in relation to their diseases and procedures carried out during their hospitalization. Nurses and Doctors must realize that communication between the patient and medical personnel is very important because it is part of emotional support which constitutes one of the important components of medical treatment.

A woman in labour has the greatest need of emotional support, for she is not only worried about her condition but is also worried about the baby. Therefore continuous information about the progress of labour, condition of the baby and explanation of procedures done makes the woman confident and less anxious. At least she knows that someone cares about her and everything is being done to help her and her baby. When things are done without her knowledge and understanding, it makes her more apprehensive and she is left in suspense, not knowing what to do and how to conduct herself during the time she is going through the labouring process.

CHAPTER THREE

1. METHODOLOGY

Records and observations have shown that there is need for medical personnel to give information to patients about their condition and procedures performed on these patients in order to gain their confidence and allay anxiety. Rabkin and Mitchel state that patients often judge their experiences in the hospital more from the fulfilment of their needs for reassurance, confort, personal dignity and awareness of whatever is happening rather than from the technical quality of diagnosis and treatment given.[24]

the patients are more concerned with the right to know about their illness and diagnostic procedures and other routines and behaviour patterns expected of them in hospital. Many times patients are not able to comprehend these activities and nobody bothers to tell them the meaning.

This study was carried out to determine pre-operative information given to pregnant mothers who undergo emergency ceasarean section, in relation to indications, procedures and psychological support.

1. THE RESEARCH DESIGN

The approach adopted in carrying out the study was the descriptive survey design. according to Seaman and Verhonick, a survey research is that method of research which relies heavily on the validity of verbal reports.[25] Sweeny and Olivieri, state that this type of research allows the investigators to gather current information about whatever it is that they wish to study.[26]

Data gathering using the descriptive research design is done in a natural setting, therefore the subjects are approached in their natural setting and are not subjected to unnecessary incoviniences. This enables them to co-operate readily.

The design was chosen because it enables the researcher to obtain a measure of attitudes, beliefs and practices. It also allows the investigator to explore particular areas of knowledge in order to identify morespecific research questions. TReece and Treece state that "A survey can provide insight into a situation, suggest kinds of questions to ask and suggest the direction the research should take."[27] Another reason for chosing the survey design is that it is easy to carry out. Another advantage of the survey is the

ease with which the researcher obtains the subjects and collects data.[28]

Considering the limited time in which to submit the study this research design was considered most suitable.

2. THE RESEARCH SETTING

The study was conducted at the University Teaching Hospital in Lusaka, the capital city of Zambia. It is the biggest hospital in the country and offers curative, preventive and rehabilitative services. The Hospital also serves as a referral hospital for patients from all parts of the country.

The University Teaching Hospital has a bed capacity of about one thousand and seven hundred (1,700), distributed among six (6) speciality departments. These include, Peadiatrics, Medicine, Surgery, Neonatal-Surgical, Obstetrics and Gynaecology and Admission Wards.

Apart from the preventive, curative and rehabilitative services, the hospital offers different areas for clinical experiences for students from several institutions of higher learning such as the University of Zambia, Schools of Nursing, Midwifery and Theatre based at the

hospital, Chainama College of Health Sciences and Evelyne Hone College.

This study was carried out in three Post-natal wards of the department of Obstetrics and Gynaecology. There are generally three (3) wards which carter for both ante-natal and post-natal patients, and include Wards B03, B11 and B13. Ward Bo1 is another post-natal ward which only carters for those patients who have had a normal delivery. Therefore the study was concerned with the three wards which receive patients from the labour ward and theatre on alternate days.

3. DESCRIPTION OF METHOD OF SELECTION OF SAMPLE

Since the focus of the study was on the pre-operative information given to mothers who undergo emergency ceasarean section, a purposive sample of 35 mothers was selected from the three (3) post-natal wards. A purposive or judgemental sample "is based on the judgement of one carrying out the research, regarding the characteristics of a representative sample."[29] The aim is to select subjects that are judged to be typical of the population under study. This type of sampling involves the selection of a

particular group because of some desired characteristic.

The criteria for being included in the sample were as follows:

1. the subject should have had an emergency ceasarean section
2. The ceasarean section should be the first one.
3. The day of interview should be any day after the 3rd day when the mother is in less pain from the operation.

4. INSTRUMENT FOR DATA COLLECTION

Sweeney and Olivieri define an instrument as the device or tool used by researchers to collect and record the data that is obtained from the respondents.[30] there are several ways in which a researcher can collect data. The instrument is an important component of the research study and therefore should be used with care.

For the purpose of this study a structured interview schedule was administered to the subjects, after which a review of the patients' record was done to verify and compare information given by the patients (see appendix C).

Treece and Treece state that the structured interview allows the interviewer freedom to probe

relevant topics in depths. The method was especially chosen because it can be used to collect data from a broader group of individuals than can the questionnaire since the respondents do not have to know how to read and write.[31]

Polit and Hungler give the following advantages of interviews:-

1. The response rate tends to be very high in a face to face interview.
2. Interviews can be used with virtually all types of subjects.
3. The method offers a protection against ambiguous or confusing questions since the interviewer can clarify those which have not been understood.
4. Information obtained is much detailed because the interviewer can probe issues.
5. There is a strict control of the order of questions.
6. Interviews allow greater control over the sample in the sense that the interview is carried out on the intended subjects, while as in the questionnaire it may be passed on to somebody who does not qualify to answer it.

7. The interviewer can gather more data through observations.[32]

However, despite the many advantages there are also several disadvantages of the interview schedule. Treece and Treece list the following disadvantages of the interview schedule:

1. It is time consuming.
2. It may be difficult to compare data collected by one interviwer with another unless a strict procedure is adhered to.
3. It is costly in terms of transportation to reach the respondents or hiring of interview assistant.
4. The interviewee has no choice in the date or place of interview.[33]

Polit and Hungler add on and state that the interview method does not offer anonymity therefore the respondent is made unconfortable with socially unacceptable responses. They also state that interviewer and interviewee interact as human beings therefore there is always an element of biasness in the process.[34]

In order to overcome the several disadvantages the interviews were conducted personally by the researcher herself. The instrument was checked and corrected by the

supervising lecturer before administering it. The patients were only interviewed after getting their concent.

5. QUESTION SEQUENCE OF THE INTERVIEW SCHEDULE

In question one (1) to eight (8) the mother was asked to give her age, marital status, number of children, how many pregnancies she has had, academic qu alification, how many days she had been in hospital and who had brought her to the hospital. In questions nine (9) to twelve (12) the mother was asked to indicate whether she was referred from the clinic or not, and whether she was told the reason for referral, to state who examined her first when she was admitted to labour ward, what she was told after examination and who gave the information. In questions fourteen (14) to sixteen (16) the mother was requested to state what examinations were done on her at time of admission and if she was told the reasons for those examinations. She was also asked to state the information given if at all it was given.

Questions seventeen (17) to twenty-two (22) asked the mother the duration of the labour before a decision was made to take her for operation, whether she was told

thenature of operation, who told her the information and to state whether she understood the information very well and also give reasons why she thought she had understood the information.

Numbers twenty three (23) to twenty seven (27) requested the mother to state the procedures and investigations done before she was taken to theatre, to say whether reasons were explained as to why the procedures had to be done, the feelings the mother had about the explanations and whether she was given any chance to ask questions relating to procedures and investigations. The mother was also asked to state her feelings if nothing was explained to her.

In questions twenty-eight (28) to thirty-seven (37) the mother was requested to state whether anyone told her anything about the baby while she was in the labour ward, and how she felt about the information given or when nothing was told to her. She was also asked to indicate whether the information given before operation was useful. In ast two questions, thirty-eight (38) and thirty-nine (39) the mother was asked whether the operation had influenced her feelings towards future pregnancies and whether she had any other comments.

6. PROCEDURE OF DATA COLLECTION

Written permission was obtained from the Acting Director of the University Teaching Hospital Management Board through the head of the department of Post-Basic Nursing. See Appendixes A and B. The research proposal was also presented to head of the department of Obstertrics and Gynaecology after which it was presented and approved by the research committee for the department.

An informed consent was obtained from each subject during the time of interview. Polit and Hungler define an informed consent as "an ethical principle that requires researchers to obtain the voluntary participation of subject, after informing them of possible risks and benefits."[35] Interviews were usually carried out in the evenings between 18.00 hours and 21.00 hours, from the 6th May, 1988 to 15th June, 1988. The time of interview was chosen because it was not possible for the researcher to interview during the day as she had to attend to other commitments. Interviews were carried out at the bed side with the patient resting in bed. Confidentially was maintained by drawing the curtains around the bed.

7. DATA ANALYSIS

Data was categorised and analysed by hand. Presentation was done in the form of tables using numbers and percentages. Polit and Hungler state that the data collected in a research project do not answer the research questions or test the hypothesis unless processed and analysed in some systematic way so that relationships between variables can be identified and assessed.[36] Qualitative and descriptive analysis was used and, data was presented in form of tables.

CHAPTER 4

DATA ANALYSIS AND PRESENTATION OF FINDINGS

Thirty-five (35) respondents were interviewed for the purpose of collecting data pertaining to pre-operative information given to mothers undergoing emergency ceasarean section at the U.T.H. Data collected is worthless for any comparison or demonstration of relationships unless data are combined so that averages and categories can be identified and presented in table form.[37]

The tables presented are arranged according to question sequence. Questions one to question three requested the respondents to state their ages, marital status, number of children and their parity.

TABLE 1

AGE DISTRIBUTION OF RESPONDENTS

AGE	NUMBER OF RESPONDENTS	PERCENTAGE
Under 20 Years	7	20
20 - 25 years	13	37
26 - 30 years	8	23
31 - 40 years	5	14
Do not know	2	6
TOTAL	35	100

Most of the respondents were between 20-25 years (37%). Another substantial number (7) of the respondents were below 20 years of age. This constituted 20% of the total number of respondents. The mean age was 16 years. Table one (1).

Table two (2) shows the marital status of the respondents.

TABLE 2

MARITAL STATUS OF RESPONDENTS

MARITAL STATUS	NUMBER OF RESPONDENTS	PERCENTAGE
Single	3	9
Married	32	91
Total	35	100

Ninty-one (91) per cent of the respondents said they were married and only (9) per cent were single. None of the respondents were single. None of the respondents were divorced or widowed.

TABLE 3

NUMBER OF CHILDREN RESPONDENTS HAD

NUMBER OF CHILDREN	NUMBER OF RESPONDENTS	PERCENTAGE
0-2	22	62
3-4	7	20
5-6	3	9
7-8	3	9
Total	35	100

Table three shows twenty-two (22) of the total number of respondents had children between 0 and two. This represented sixty-two (62) per cent of the total sample. Seven (7) of the respondents which was twenty per cent, had three (3) to four (4) children. Six (6) of the respondents had five (5) to eight (8) children, which was eighteen (18) per cent of the total sample.

TABLE 4

PARITY OF THE MOTHERS

PARITY	NUMBER OF RESPONDENTS	PERCENTAGE
Primipara	15	43.0
2-5	13	37
6-10	07	20
Total	35	100

Fifteen (15) respondents, which composed of fourty-three (43) per cent of the total number, were primipara. Thirteen (13), (37%), of the respondents were between parity two to five. A small number 7 (20%) were between parity 6 to 10.

TABLE 5

PLACE OF DELIVERY OF PREVIOUS BABIES

PLACE OF DELIVERY	NUMBER OF RESPONDENTS	PERCENTAGE
Hospital	15	43
Clinic	2	6
Home	1	2
Both Hospital and Clinic	2	6
Having first baby	15	43
Total	35	100

Table 5 shows that fifteen (43%) of the respondents delivered in hospital, two (6%) at the clinic and one (2%) of the respondents had delivered at home. Another two (6%) of the respondents said they had delivered both in the hospital and at the clinic. Fifteen (43%) of the respondents were having their first babies.

TABLE 6

RESPONDENTS' NUMBER OF DAYS IN HOSPITAL

NUMBER OF DAYS	NUMBER OF RESPONDENTS	PERCENTAGE
0-5	17	48
6-10	14	40
11-15	2	6
16-20	1	3
21-25	0	-
26-30	1	3
Total	35	100

When respondents were asked to state the number of days they had been in Hospital, seventeen (48%) reported that they had been in hospital for less than 5 days. Forteen (40%) said they had been in hospital for six to ten days, and four (12%) said they were there for over 10 days. The mean days of stay in hospital was 7 days.

TABLE 7

PERSON WHO BROUGHT RESPONDENT TO HOSPITAL

RESPONSES	NUMBER OF RESPONDENTS	PERCENTAGE
Husband	7	20
Mother	1	3
Other	27	77
Total	35	100

Table 7 shows that only seven (20%) of the respondents were brought to hospital by their husbands. One (3%) was brought by the mother and twenty-seven (77%) were brought by others other than the husband or mother. Of the twenty-seven respondents brought by others, eighteen (67%) said they were brought by the nurse-midwife from the clinic. The remaining 9 (33%) said they were brought by any other relatives.

TABLE 8

RESPONDENTS' HIGHEST GRADES COMPLETED

GRADE	NUMBER OF RESPONDENTS	PERCENTAGE
Never been to school	5	14
1-4	4	11
5-7	10	29
8-12	13	39
Post-secondary	3	9
Total	35	100

Only five (14%) of the respondents reported that they had never been to school. Four (11%) of the respondents had done Lower Primary school grades and 10 (29%) had been to upper primary school. Thirteen (37%) of the respondents had been to secondary school and only 3)9%) of the sample had been to post-secondary colleges.

TABLE 9

STATEMENT OF WHETHER RESPONDENTS WERE REFERRED FROM CLINIC OR NOT

RESPONSE	NUMBER OF RESPONDENTS	PERCENTAGE
Yes	22	63
No	13	37
Total	35	100

Twenty-two (63%) the respondents stated that they had been referred from the clinic and thirteen (37%) said they had come from home.

TABLE 10

REASONS FOR REFERRAL TO HOSPITAL

REASON FOR REFERRAL	NUMBER OF RESPONDENTS	PERCENTAGE
Face presentation	1	4
Prolonged labour	4	16
Draining	2	8
Breech	3	13
Big Baby	3	13
Raised B/P and Oedema	6	25
Elderly primigravida	1	4
Bleeding	1	4
Hand andCord Prolapse	3	13
Total	24	100

When respondents were asked the reasons for being referred to the hospital, they gave various reasons as tabulated in table 10. The majority six (25%) said they were referred to hospital because the blood pressure was high and they had oedema of

the legs. Four (16%) respondents said they were referred for prolonged labour, two (8%) were referred for draining and 9 (39%) of the respondents were equally distributed between breech, big baby and hand andcordprolapse. The last 3 (12%) were again equa equally distributed between elderly primigravida, bleeding and face presentation.

TABLE 11

MEDICAL PERSONNEL WHO FIRST EXAMINED RESPONDENTS IN LABOUR WARD		
EXAMINER	NUMBER OF RESPONDENTS	PERCENTAGE
Midwife	28	80
Doctor	6	17
None	1	3
Total	35	100

Table 11 shows responses about who examined the respondents on admission to labour ward. Twenty-eight (80%) said the midwife examined them, while six (17%) said it was the doctor. Only 1 (3%) respondent said she was not examined by any of the two.

TABLE 12

INFORMATION GIVEN TO RESPONDENTS AT THE TIME OF ADMISSION		
INFORMATION GIVEN	NUMBER OF RESPONDENTS	PERCENTAGE
To sign consent because was going to theatre	3	9
was about to deliver	2	6
cervical dilatation and stte of membranes but did not understand	4	11
various presentations of thebaby	5	14
induced - not in labour so no information given	4	11
admitted to prevent complications	1	3
in labour, but no information given	13	37
to wait for the doctor	3	9
Totals		

When respondents were asked to state the information given to them at the time of admission several answers were given. Three (9%) said they were told to sign the consent because they were going to theatre. Two (6%)

said they were told that they were about to deliver and four (11%) were told the dilatation of the cervix and state of membranes which they said they did not understand what it meant. Five (14%) respondents said they were told the presentation of the baby and four (11%) said they did not come in labour at time of admission so no information was given to them. Only 1 (3%) of the respondents stated that she was told that she was admitted to prevent complications as the baby was breech presentation. No information was given to 13 (37%) of the respondents and 3 (9%) were told to wait for the doctor. One of these three had reported that she sat for six hours before she was seen by the doctor.

TABLE 13

MEDICAL PERSONNEL WHO GAVE INFORMATION AT TIME OF ADMISSION

MEDICAL PERSONNEL	NUMBER OF RESPONDENTS	PERCENTAGE
Nurse	17	49
Doctor	6	17
None	12	34
Total	35	100

Table 13 shows medical personnel who gave the information to the respondents at the time of admission. Seventeen (48%) of therespondents said they were given the information by the nurse, six (17%) sait it was the doctor and 12 (34%) said none of the two gave them the information.

TABLE 14

EXAMINATION DONE AT TIME OF ADMISSION

	RESPONSES					
Examination	Yes	%	No	%	Total	%
Temperature	19	54	16	46	35	100
Blood Pressure	24	68	11	32	35	100
Urine	13	37	22	63	35	100
Abdominal palpation	31	89	4	11	35	100
Vaginal	32	91	3	9	35	100

When respondents were asked to comment on the examinations done on admission, 19 (54%) agreed that temperature was taken, and 16 (46%) disagreed. Twenty four (69%) respondents said blood pressure was measured and 11 (31%) said it was not done. Only thirteen (37%) respondents reported that urine was examined, but twenty-two (63%) said it was not. Thirty-one (89%) respondents

said abdominal palpation was done and four (11%) of the respondents said it was not done. Almost all respondents reported that vaginal examination was done at a time of admission. Thirty two (91%) respondents said it was done and only 3 (9%) said that it was not done.

TABLE 15

RESPONSES AS TO WHETHER RESPONDENTS WERE TOLD REASONS FOR CARRYING OUT EXAMINATIONS

RESPONSES	NUMBER OF RESPONDENTS	PERCENTAGE
Yes	7	20
No	28	80
Total	35	100

Table 15 shows responses as to whether respondents were told the reasons for carrying out the examinations on admission. Only seven (20%) said that they were informed about the reasons why the examinations were done, and twenty-eight (80%) of the respondents said they were not informed.

TABLE 16

RATIONALE FOR CARRYING OUT PROCEDURE/EXAMINATION

RATIONALE	NUMBER OF RESPONDENTS	PERCENTAGE
To check if blood-pressure is normal	1	14.3
To assess progress of labour	1	14.3
To check condition of the baby	4	57.1
To supply more oxygen to baby	1	14.3
Total	7	100

Table 16 shows the reasons given to the respondents for carrying out the procedure or examination. Out of the seven respondents who said they were told reasons for carrying out the procedure, four (57%) said they were told that they were being examined to check the condition of the baby. Three (42.9%) of the respondents gave different reasons each and these included, checking if the blood pressure is normal, assessing the progress of labour and supplying more oxygen to the baby.

TABLE 17

TIME RESPONDENTS WERE IN LABOUR BEFORE DECISION WAS MADE TO CARRY OUT OPERATION

No. of Hours	Number of Respondents	Percentage
1-5	7	20
6-10	6	17
11-15	6	17
16-20	4	11
21-24	0	0
Over 24	1	3
Taken to theatre immediately	11	32
Total	35	100

When the respondents were asked to state how long they had been in labour before the decision was made to take them to theatre, eleven (32%) of the respondents said they were taken to theatre immediately they arrived. Twenty-three (65%) of the respondents reported that they had been in labour for less than 12 hours, and only one (3%) respondent reported having been in labour for more than 24 hours.

TABLE 18

RESPONSES AS TO WHETHER RESPONDENTS INFORMED ABOUT NATURE OF OPERATION

RESPONSES	NUMBER OF RESPONDENTS	PERCENTAGE
Yes	28	80
No	7	20
Total	35	100

In table 18, twenty-eight (80%) respondents agreed that they were informed about the nature of the operation and seven (20%) respondents said that they were not informed.

TABLE 19

INFORMATION GIVEN ABOUT THE NATURE OF OPERATION

INFORMATION	NUMBER OF RESPONDENTS	PERCENTAGE
To deliver baby and remove ruptured uterus	1	4
To deliver baby dueto to various indications	26	92
Caesarean section due to cord prolapse	1	4
	28	100

When the respondents who had received information about the nature of the operation were requested to state the information received, twenty-six (92%) said they were told that an operation to deliver the baby for various indications was to be done. Only one (4%) respondent said she was told that she would have a ceasarean section for cord prolapse and another one said an operation to deliver the baby and removal of uterus was going to be done because the uterus had ruptured.

TABLE 20

MEDICAL PERSONNEL WHO EXPLAINED NATURE OF OPERATION TO RESPONDENT

PERSONNEL	NUMBER OF RESPONDENTS	PERCENTAGE
Midwife	8	29
Doctor	14	50
Both	6	21
Total	28	100

Fourteen (50%) of those who reported having received information about the nature of operation said they were informed by the doctor, only eight (29%)

said they were informed by the midwife and six (21%) reported that both themidwife and the doctor informed them.

TABLE 21

RESPONSES ABOUT WHETHER RESPONDENT THOUGHT SHE UNDERSTOOD THE INFORMATION GIVEN PRE-OPERATIVELY

RESPONSE	NUMBER OF RESPONDENTS	PERCENTAGE
Yes	24	69
No	11	31
Total	35	100

Table 21 shows that twenty four (69%) of the respondents thought they had understood the information given and eleven (31%) of therespondent said they did not understand the information given.

TABLE 22

COMMENTS AS TO WHY RESPONDENTS FELT THEY DID NOT UNDERSTAND THE INFORMATION

COMMENTS	NUMBER	PERCENTAGE
Was confused because at first was told baby was cephalic then breech	1	9
Did not understand what 3cm dilation meant	1	9

TABLE 22 (Continued)

no information was given	6	55
was sedated	1	9
was not told where they were taking her, only saw people wearing masks	1	9
no information was given but only saw vacuum being applied.	1	9
Total	11	100

Table 22 shows comments about why respondents felt they had not understood the information given. Five (45%) of they gave various reasons and six (55%) said they did not get any information at all.

TABLE 23

PRE-OPERATIVE PROCEDURESAND INVESTIGATIONS DONE

	RESPONSES					
PROCEDURE/INVESTI-GATION	YES	%	NO	%	TOTAL	%
Shaving	26	74	9	26	35	100
Intraveneous infusion	31	89	4	11	35	100
Catheterization	21	60	14	40	35	100
Signing of consent	32	91	3	9	35	100
Taking blood	8	23	27	71	35	100

TABLE 24

RESPONSES AS TO WHETHER RESPONDENTS WERE TOLD WHY PRE-OPERATIVE PROCEDURES WERE DONE

RESPONSE	NUMBER	PERCENTAGE
Yes	10	29
No	25	71
Total	35	100

In table 24, 10 (29%) respondents agreed that they were told the reasons why pre-operative procedures and investigations were done and 25 (71%) reported that they were not told the reasons for procedures and investigations.

TABLE 25

FEELINGS ABOUT EXPLANATIONS GIVEN TO RESPONDENTS

RESPONSES	NUMBER	PERCENTAGE
satisfied with explanations	10	28
worried and afraid about pending operation	1	3
no explanations given and thought the medical personnel know best	24	69
total	35	100

When the respondents were asked how they felt about the explanations given to them, ten (28%) said they were satisfied with the explanations, one (3%) said she felt worried and afraid about the pending operation and twenty-four (69%) said that no explanation were given and they felt that the medical personnel knew what was best for the respondents.

TABLE 26

RESPONSES AS TO WHETHER RESPONDENTS WERE GIVEN CHANCE TO ASK QUESTIONS

RESPONSES	NUMBER	PERCENTAGE
Yes	2	6
No	33	94
Total	35	100

Table 26 shows that only two (6%) of the respondents agreed to having been given chance to ask questions while 33 (94%) said they were denied the chance.

TABLE 27

FEELINGS ABOUT NOT HAVING BEEN GIVEN CHANCE TO ASK QUESTIONS

FEELINGS	NUMBER	PERCENTAGE
No feelings because nurses and doctors know what is best	22	67

TABLE 27 (Continued)

Did not find it necessary to ask because did not know anything	10	30
Very anxious to know what was happening	1	3
Total	33	100

In table 27, the respondents were requested to state their feelings about not having been given the chance to ask questions. Twenty-two (67%) reported to have no feelings about it because they thought nurses and doctors knew what was best for them. Ten (30%) of the respondents said they did not find it necessary to ask any questions because they did not know anything. Only one (3%) respondent reported that she was very anxious to know what was happening.

TABLE 28

RESPONSES TO WHETHER RESPONDENT WAS TOLD ANY INFORMATION ABOUT THE BABY

RESPONSES	NUMBER	PERCENTAGE
Yes	21	60
No	14	40
Total	35	100

Table 28 shows that twenty-one (60%) said they were given information about the baby and fourteen (40%) said they were not given any information about the baby.

TABLE 29

INFORMATION GIVEN ABOUT THE BABY

INFORMATION GIVEN	NUMBER	PERCENTAGE
Fetal heart alright	10	48
Baby's position	3	14
Fetal heart not satis-factory	5	24
Baby already dead	3	14
Total	21	100

When respondents were requested to state the information given about the baby, various responses were elicited. Ten (48%) of the srespondents said they were told that the fetal heart was good. Three (14%) said they were told the position of the baby. Five (24%) were told that the fetal heart was not satisfactory, and three (14%) were told that the baby had already died in utero.

TABLE 30

FEELINGS OF RESPONDENTS WHO WERE NOT INFORMED ABOUT THE BABY

RESPONSES	NUMBER	PERCENTAGE
was afraid the baby may die due to compli-cation	8	67
Felt nothing because were more concerned about own life	3	25
Annoyed and frustrated	1	8
Totals	12	100

Table 30 shows the feelings of those respondents who were not informed about the baby. Eight (67%) of the respondents said they were afraid the baby may die due to thecomplication. Three (25%) said they felt nothing about it because they were more concerned about their own lives, and only one (8%) said she felt annoyed and frustrated.

TABLE 31

RESPONSES TO WHETHER RESPONDENTS FOUND THE PRE-OPERATIVE INFORMATION USEFULL

RESPONSES	NUMBER	PERCENTAGE
Yes	24	69
No	11	31
Total	35	100

Twenty-four (69%) respondents said that they found the pre-operative information useful while 11 (31%) said they did not find the information of any use. When these were asked why they said they had found the information useful they all said that it enabled them to understand what was happening and they understood reasons for the operation. See Table 32.

TABLE 32

REASONS FOR FINDING THE PRE-OPERATIVE INFORMATION USEFUL

RESPONSES	NUMBER	PERCENTAGE
Enabled respondents to understand what was going on and also the reasons for operation.	24	100
Total	24	100

TABLE 33

REASONS FOR NOT FINDING THE PRE-OPERATIVE INFORMATION USEFUL

RESPONSES	NUMBER	PERCENTAGE
was not told truth about condition of the baby	1	9
was not told anything apart from condition of baby	2	18
no reason because was not told any information	8	73
Total	11	100

Those respondents who did not find the information useful gave various reasons for saying so. One (9%) gave the reason that she was not told the truth about the condition of the baby. Two (18%) said they were not told anything apart from the condition of the baby. Eight (73%) said they had no reason to find the information useful because they were not told anything.

TABLE 34

RESPONSES ABOUT WHETHER RESPONDENTS WANTED TO KNOW ANYTHING ELSE APART FROM WHAT THEY WERE TOLD.

RESPONSES	NUMBER	PERCENTAGE
Yes	13	37
No	22	63
Total	35	100

Thirteen (37%) of the respondents said they had wanted to know something else apart from the information that had been given. Twenty-two (63%) refused.

When the respondents were asked to state the type of information that they would have liked to know apart from the one given, they gave several responses. See Table 35.

TABLE 35

RESPONSES ABOUT INFORMATION WANTED	NUMBER	PERCENTAGE
How doctors and nurses would help her since baby had arm prolapse	1	8
indication for operation	4	30
whether will have another operation next pregnancy	1	8
how to care for the wound	2	15
condition of baby	2	15
how inside sutures would be removed	1	8
how long will stay in hospital	1	8
why i.v. drip was commenced	1	8
Total	13	100

TABLE 36

RESPONSES ABOUT WHETHER RESPONDENTS HAD ANY COMMENTS ABOUT PRE-OPERATIVE EXPERIENCES

RESPONSES	NUMBER	PERCENTAGE
Yes	13	37
No	22	63
Total	35	100

Table 36 shows the responses to about whether the respondents had any comments about the pre-operative experience. Thirteen (37%) respondents said they had comments to make, while twenty-two (63%) said they had no comments.

TABLE 37

COMMENTS GIVEN BY RESPONDENTS ABOUT PRE-OPERATIVE EXPERIENCE

COMMENTS ABOUT PRE-OPERATIVE CARE	NUMBER	PERCENT
Thankful that both baby and myself are alive	3	23
Was satisfied with the care given. The nurse was always near by to help	8	61
It took a long time for me to be taken to theatre after the hand of baby prolapsed I was very anxious	1	8
The decision was made too quickly. I could have been given more time.	1	8
Total	13	100

The respondents gave various comments about the pre-operative experience. (See Table 37).

TABLE 38

COMMENTS ON WHETHER OPERATION HAD INFLUENCED FEELINGS ABOUT FUTURE PREGNANCY

COMMENTS	NUMBER	PERCENTAGE
Have no plans now for any more pregnancies. Afraid same thing may happen again.	19	54
Operation has not influenced feelings because had planned to stop after present pregnancy.	5	14
Operation has not influenced feelings because still wants more children	10	29
Do not know what to say because was not told what to expect next pregnancy.	1	3
Total	35	100

Table 38 shows comments on whether the operation had influenced the feelings of the respondents about future pregnancies. Several responses were given as indicated in Table 38.

TABLE 39

RESPONSES TO ANY OTHER COMMENTS

COMMENTS	NUMBER	PERCENTAGE
Wants to know more about family planning and child spacing	4	11

TABLE 39 (Continued)

COMMENTS	NUMBER	PERCENTAGE
Wants a letter to her husband so she can rest for reasonable period	1	3
Wants to thank doctors and nurses for help rendered	2	6
Want to know when can resume sexual relationship with husband	1	3
It would be better if one is told what is going on during labour	2	6
Wanted to know whether wound would heal because she has burst abdomen	1	3
No comments	24	68
Total	35	100

In table 39, patients were requested to give any other comments. Twenty-four (68%) said they had no comments. Eleven (32%) gave various comments about information which they still wanted to know about.

CHAPTER FIVE

DISCUSSION OF FINDINGS NURSING IMPLICATIONS AND RECOMMENDATIONS, SUMMARY, CONCLUSION AND LIMITATIONS TO THE STUDY.

1. DISCUSSION OF FINDINGS

The findings of this study are based on the analysis of data collected from thirty-five (35) women who had undergone emergency ceasarean section at the University Teaching Hospital in Lusaka. The aim of the study was to find out pre-operative information given to pregnant mothers who undergo emergency ceasarean section and also to find out whether having an operation performed in such circumstances influenced their feelings towards future pregnancies.

Table one (1) shows the age distribution of the respondents. The results showed that 7 (20%) of the mothers were teenage mothers. It appears that with the high dropout rate in the Zambian schools, more and more teenage girls find themselves in early marriages. Table 8 reflects the fact that most of the respondents had only done grade 7 and below. Arkutu also found that the youngest patient was 11 years old and the mean age for the group was 14.5 years.[38]

This implies that more and more teenage mothers will continue to form a significant proportion of the obstetric population in Zambia.

The findings also revealed that 32 (91%) of the respondents were married and only 3)9%) were single. This could again be attributed to the high drop out rate at grades 7 and 10 levels which forces the girls into early marriages. Arkutu found that only 5.3% were not married and 83% of the patients were married. He attributed the high rate of married patients to the traditional practices of the Wazaramo tribe which was the ethnic group in and around Dar-es-Salaam.[39] This fact applies to most traditional practices existing in Zambia. It is regarded as shameful for a particular family if a girl got pregnant outside marriage. The parents would rather send the girl to the man responsible for the pregnancy than keep her in their home. Therefore it follows that the high rate of married patient could be a reflexion of these traditional practices.

On parity of the mothers, the study revealed that 15 (43%) of the mothers were primigravidae, 13 (37%) were of parity 2-5 and 7 (20%) were of parity 6-10. Since in Zambia there is much importance attached to

child bearing, this could have been the reason for the 10 (29%) of the mothers who felt that the operation had not influenced their feelings about future pregnancies because they still wanted more children.

Table 5 shows that despite the fact that delivery services have been decentralised to urban clinics most of the patients 94% reported that they had delivered in at the hospital. Two patients (4%) reported that they delivered at the clinic and home respectively, and only one (2%) said she had delivered at both the hospital and clinic. These results indicate that urban clinics were under utilized.

It was however surprising to note from Table 9 that twenty-two (63%) of the patients were referred from the clinic. This contradicts the above data and can be attributed to thetime elapse between the period when most of the respondents had their last baby and the present, which could have been one or two years ago. It therefore appears that there has been an improvement in the utilization of the urban clinics for deliveries by the mothers.

Twenty-two (63%) of the mothers were referred from the clinic and 18 (81%) of these were brought to the hospital by the midwife. This reflects efficient

observations by the midwives in clinics where complications of pregnancy and labour werepro promptly identified and referral to the hospital made. The high rate of mothers referred from the clinic could also be attributed to the fact that U.T.H. is the only referral hospital in the province, therefore all complicated cases come to U.T.H.

All mothers referred from the clinic reported that they were informed of the reason for referral to the hospital. On record review, the reasons given by the mothers corresponded with those given by the mothers. These findings susggested the fact that the mothers were given information by the midwives attending to them in the clinics.

Table 11 shows that twenty eight (80%) of the mothers were examined by the midwife at time of a admission. Only 6 (17%) said they were examined by the Doctor. One (3%) respondent said none of them examined her because she was not in labour. The results show that it was almost always the midwife who was at hand when the women came to the labour ward. In developing countries like Zambia, doctors are not so readily available to attend to every patient who comes for treatment. A major

problem facing the world today is the inadequate provision of doctors, trained midwives and other health personnel to large sectors of the population.[40] Most of the times the doctors are just called upon to review complicated cases. Those patients in normal labour are attended to by the midwive. This therefore, requires the midwife to be very competent, efficient and should have a high degree of critical judgement in order to be able to identify the abnormal from the normal, for the safety of the patient and her baby.

On whether the mothers were given information at time of admission, fifteen (43%), said they were given information and indicated various information as shown in Table 12. Twenty (57%) of the mothers said they were not told anything. Most of the information given by the mothers suggested that although some information was given, it was not understood by the mothers. These findings contradict the ones found by Eastwood where she found that both student nurses and qualified nurses viewed communication skills valuable in influencing and effecting patients' response to treatment and also in establishing a real person to person relationship. [41]

The essential value of communication is in the understanding given to patients' needs and ability developed in giving guidance, counsel and support when necessary. It appears that midwives in the labour ward at U.T.H. did not realise the importance of effective communication with the patient.

Seventeen (49%) of the patients who reported to have been given information at time of admission said they got the information from the midwife, six (17%) from the doctor and 12 (34%) reported that they were not given any information. Kölle states that the midwife is responsible for the mother's proper preparation for delivery including instructions about relaxation and information about the course of pregnancy and labour.[42] The findings could be due to the fact that the midwife is always available and sees the patient first before the doctor is called to see complicated cases.

Another interesting finding was in relation to the examinations done at the time of admission. The results are summarised in table 14. All the mothers seemed to remember the examinations that were done. The majority said vaginal and abdominal examinations were done. The results show that the midwives examined

the mothers on admission. Urine examination was reported by only 13 (37%) of the mothers to have been done. This could have been due to the fact that reagents might have been out of stock. On the other hand it could have been that the midwives viewed it a less important examination to do.

On whether mothers were informed of the reasons for carrying out the examinations, twenty-eight (80%) reported that they were not told, 7 (20%) said they were told, (see table 15). The above results again show how little importance was attached to information giving by the midwives. Information giving helps to alleviate anxieties by reducing the area of unknown experiences, fears and fantacies are corrected through providing a realistic account of what will happen.[43]

The study also revealed that twenty-eight (80%) of the mothers said that they were told the nature and indication of the operation. The indications included compound presentation antepactum haemorrhage, cord and hand prolapse pre-eclampsia and fetal distress. On record review these indications corresponded with those in the patients' records.

The above findings suggested that the mothers were given information about indications for operation, but reasons for carrying out the procedure were not explained to the mothers. Hypothesis number 1 which states that there is a relationship between lack of pre-operative information given to the pregnant mothers undergoing emergency ceasarean section and their knowledge about the indications was, therefore, not supported.

Table 17 shows the length of time the mothers was in labour before the decision was made to take her for operation. The responses varied from one hour to over twenty four hours. Eleven (32%) of the mothers, however, reported that they were taken immediately they were admitted. These responsescould have come from those who presented with a complication on admission. The rest of the patients were taken to theatre after a complication arose while in labour. The modern obstetrician resorts to ceasarean section either as a planned procedure or as an urgent measure when vaginal delivery is considered hazadous or practically impossible. Going into labour is like going into the world of the unknown. There is always the risk

of new obstetrical problems arising in otherwise normal pregnancy and more often than not, a delay of action and mortality are linked.[44]

Tables 20, 21 and 22 show responses to who gave the information about the operation to the mothers, whether the mothers understood the information and why those who did not understand the information said so. Fourteen (50%) of the mothers said they were told by the Doctor; eight (29%) were told by the midwife and six (21%) said both the doctor and the nurse gave them the information. The results show that it is probable, now, that there are Zambian Doctors working in hospitals, that these are able to communicate with the patients directly rather than through the nurse. The results are further supported by Fairweather who states that more attention must be given to the informational and educational aspects of the physician's activities, as far as the patients are concerned. Fear of the unknown is indeed a common cause of tension and lack of relaxation in these patients; it is therefore the doctor's responsibility to combat this.[45]

Wassener has different views about the above idea.

> She maintains that the status of the informer is irrelevant but what is of of utmost importance is that the information programme must be planned and implemented. It must be checked and checkable like all other procedures and all team members must be aware of this responsibility.[46]

The idea in the above is that it does not matter whether there is overlap and/or repetition. It is even more beneficial than detrimental. All medical personnel have a duty to inform patients about procedures and the rationale. However, twenty-four mothers (69%) said they had understood the information and 11 (31%) said they did not understand the information given. They gave various reasons for not having understood as is given in table 22. The results still indicate that the mothers in labour are denied the needed information. "Information for its own sake cannot be justified if relevant and necessary facts are omitted."[47]

The midewives should realise that the skill of giving information lies in the quantinty and depth of the information given to the capacity of the individual person, as each will vary as to the amount of information she can tolerate at a given time. In table 23 to 25 information about pre-operative

procedures done, reasons for doing these procedures and feelings about explainations has been summarised. A substancial number of the mothers reported that i.v. drip,31 (87%), shaving 21 (74%), catheterisation, 21 (60%) and consent signing 32 (91%) were carried out. Only 8 (23%) reported that blood was also taken preoperatively.

The findings illustrate the fact that these procedures are done routinely on all patients scheduled for an operation. It appears that the midwives performed the procedures automatically without caring to inform the patients why they were performed. This was evidenced by the responses of the patients to question 24 which asked whether they were informed about the reasons why the pre-operative procedures were done. Twenty-five (71%) said they were not informed, while only 10 (29%) agreed to having been informed. Hence, the above findings do not support the second Hypothesis which states that: There is a relationship between lack of pre-operative information given to the mothers undergoing emergency ceasarean section and their knowledge about pre-operative procedures performed on them.

When the mothers were asked their feelings about the explanations given, 10 (28%) said they were

satisfied with the explanations, one (3%) said she was worried and afraid about the pending operation, and twenty-four (69%) said no explanation was given and they thought the medical personnel knew what was best for them. Although only one patient expressed anxiety about the pending operation, Phipps et al states that even if some operations are considered by hospital personnel to be minor procedures, surgery is always major experience in the life of the patient.[48] The findings reflect the dependency on medical personnel by the mothers, who look upon the medical personnel to do everything for them without questioning what they did. It also could be that the patients are not aware of their rights to knowledge about procedures, investigations and treatments done on them. "Professional persons are obliged to meet the needs of the patients whether or not the patient or his family knows he has them."[49] This attitude could have been the reason to why so many, thirty-three (94%) of the mothers said that they were not given chance to ask questions.

Medical personnel should understand the fact that all patients have some fear of surgery, although not all may express it. It is therefore the duty of all medical personnel to help such patients to

talk about their fears and should give them every opportunity to ask questions.[50] In support of the findings, Engström states that "several patients spontaneously remarked during the interview that they must indeed ask questions, otherwise they did not get to know anything."[51] Another reason to which the results could be attributed is the traditional practice in Zambia in which a woman is taught to be submissive to those in authority. It could also be that the patients were afraid to ask questions because everyone seemed so busy. Whatever the reasons, the questions remained unanswered and uncertainty and fear continued to prey on their minds.

As a result of not being able to ask questions, Table 39 shows the statements containing information the mothers would have liked to know apart from that which was given. The statements included pre- and post operative information pertaining to their care. These findings still point to the dissatisfaction with information given pre and post operatively. Engström , in supports of these findings, found that:

> many patients were dissatisfied with the information on why examinations and investigations were made, how one should prepare one self and how the actual investigation was going to be done.[52]

On the other hand twenty-one (60%) of the mothers reported that they were told about the condition of the baby. Table 29 shows information that was given in relation to the baby. It appears midwives were concerned about informing the mothers of the condition of the baby.

Finally, table 38 shows the comments about whether the operation had influenced the feelings of the mothers towards future pregnancies. Ninenteen (54%) of the mothers expressed negative feelings because they said that they were afraid they would have a repeat ceasarean section. Ten (29%) expressed positive feelings and said they still wanted to have more children therefore the operation did not influence their feelings. Five (14%) said they had already planned to stop having more children before they went into labour and therefore were not influenced by the operation. Only one (3%) reported that she did not know what to say because she was not told expectations in the next pregnancy. The high percentage of the mothers who expressed negative feelings could be attributed to insufficient information and explanation about procedures and expectations for future pregnancies. The positive feelings could have been expressed by the young mothers who were mostly having their first

or second baby. These mothers still wanted to have more children. It is common in Zambia for a husband to divorce his wife if she cannot have children or if for one reason or another cannot have any more children. Therefore it would not be surprising to hear mothers want more children even after the operation. One mother during the interviews expressed that she wanted a letter from the doctor for her husband to inform him to refrain from sexual relationships so that she could be given enough time to recover the effects of the surgery. Therefore it follows that women are willing to have as many children as possible in order to preserve the marriage.

Since the majority of the mothers expressed reluctance to have more pregnancies, Hypothesis number 3 which states that: There is a reluctance expressed by the mothers to have any more pregnancies in the future in those who receive inadequate pre-operative information before under going emergency ceasarean section, was supported by the findings.

2. NURSING IMPLICATIONS.

The study revealed that midwives did not give adequate information pertaining to procedures done on admission to the labour ward and during the

immediate pre-operative period. This contributed to the inadequate preparation of the woman in labour, who has been scheduled for an emergency ceasarean section. When information and explanations are not given to such patients, their fears and anxiety levels are increased bebause they are already under stress of labour pains. Lwatula also observed that communication with the patients was a problem among nurses.[53] Effective communication with patients must be regarded as an important component in the delivery of nursing care because the nurse is always at the bedside of the patient. This could be enhenced by regular inservice education of the qualified staff to revise principles of the communication process.

Nurse administrators should encourage subordinates to take up continuing education courses in order to update themselves with current nursing practice. This would improve the nursing care given to patients for the nurses would be equiped with adequate knowledge in the delivery of quality patient care.

Another area of concern is the finding of very young mothers in the obstetric population. This implies that the midwife must be on the look out for possible complications among this 'at risk group'.

Another implication is that there is need to research into outcomes of pregnancies among these young mothers in order to determine problems commonly faced by these mothers.

The study also found out that most mothers had negative feelings towards future pregnancies which were attributed to inadequeate information received during the pre-operative period. This may prevent the mother from seeking medical advice in her next pregnancy for fear of a repeat ceasarean section. This suggests a serious problem for the obstetric team because it means that the mother would seek advice when it is too late and would result into increased morbidity and mortality among the mothers. Therefore there is need to reinforce in the nurses the importance of effective dissemination of information to patients.

3. RECOMMENDATIONS

In view of the findings of this study the following recommendations were made:

i. The study should be carried out on a larger scale to include the midwives in order to generalize the findings.

ii. In-service education should be encouraged for all categories of midwives and doctors to review from time to time the importance of communicating information with the patient.

iii. Nurse managers at ward level should ensure that information giving is part of every care given to the patients by adequate supervision of the subordinates.

iv. The curricula of schools of nursing and midwifery should place emphasis on interpersonal relationship and communication skills.

v. Nursing Research should be encouraged at ward level involving all the midwives in order to identify problems and find solutions pertaining to nursing practice. This would help the nurses to develop an inquiring mind.

vi. There is need to introduce the midwives to the nursing process to help them learn how to identify individual problems of patients in order to give individualised care.

4. SUMMARY AND CONCLUSION

The study was conducted at the University Teaching Hospital in Zambia, which has a bed capacity of about

1,700. A purposive sample consisting of 35 patients who had undergone emergency ceasarean section was selected. An interview schedule comprising of 39 questions was administered. Data was categorised and analysed by hand with the aid of a pocket calculator. Presentation of data was done in the form of tables using frequencies and percentages. The study aimed at finding out information given to pregnant mothers who undergo emergency ceasarean section and whether the operation influenced their feelings towards future pregnancy, with the view of identifying inadequecies in the psychological preparation of the mothers.

It was concluded from the findings that midwives and doctors at theU.T.H. labour ward carried out examinations and procedures on pregnant mothers but did not give information and explanations for carrying out the procedures and examinations. It was also found that information about indications for operation was given to the mothers. Another finding was that the majority of the mothers expressed unwillingness to having another pregnancy for fear of having a repeat ceasarean section.

Medical personnel were therefore urged to share information with the patients in a competent and unhurried manner.

5. LIMITATIONS TO THE STUDY

1. There are several factors that limit the generalisations of the findings.

(a) The convinience rather than random sampling decreases the probability that the sample was representative of the target population.

(b) Time in which the study was to be conducted was too short to select a large sample.

(c) Financial constraints also influenced the size of the sample.

2. The reliability of the instrument was not pretested therefore some of the questions were not very clear.

3. Lack of literature on pre-operative information given to patients with emergency ceasarean section was another limitation to the study. It was difficult for the researcher to compare results with studies done on the topic.

4. Language differences among the respondents made it hard sometimes to elicit desired information.

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APPENDIX A

REQUEST FOR PERMISSION TO CARRY OUT A STUDY

Department of Post Basic Nursing
P.O. Box 50110
Lusaka.

11th June, 1988

The Executive Director,
U.T.H. Board of Management,
P.O. Box 50001,
LUSAKA.

u.f.s. The Head,
Department of Post Basic Nursing,
Lusaka.

Dear Sir,

Re: REQUEST FOR PERMISSION TO CARRY OUT A STUDY IN ONE OF THE POST NATAL WARDS OF THE MATERNITY DEPARTMENTS - UNIVERSITY TEACHING HOSPITAL.

I am a fourth year student in the above mentioned department of the School of Medicine, studying for a Bachelor of Science Degree in Nursing, specialising in Midwifery. In partial fulfilment of this course, I am required to conduct a research study. My research topic is "Pre-operative Information given to Mothers undergoing Emergency Ceasarean Section." I would be grateful if you could kindly allow me to interview the mothers who undergo the above operation from April to June 1988.

Thanking you in advance.

Yours faithfully,

Mary M. Chimwala (Mrs).

c.c. The P.N.O., U.T.H.
The Area Nursing Officer, Dept. Obs. & Gynae.

APPENDIX B

PERMISSION TO CARRY OUT THE RESEARCH STUDY IN MATERNITY DEPT.

UNIVERSITY TEACH HOSPITAL
Office of the Director
Private Bag RW 1
Lusaka, Zambia
Tel: 211440/218881

Our Ref: UTHB/EDO/PP/1

Your Ref:

24th March, 1988

Mrs Mary M. Chimwala
Post Basic Nursing Dept.
UTH
Lusaka

Dear Madam,

RE: REQUEST FOR PERMISSION TO CARRY OUT RESEARCH IN THE POST NATAL WARDS, MATERNITY DEPT.

I acknowledge receipt of your letter dated 11th March, 1988.

Permission is granted for you to carry out a research study in the above mentioned department.

Yours faithfully
UTH BOARD OF MANAGEMENT

M.E. Limbambala MB. ChB. Ph.D.
ACTING EXECUTIVE DIRECTOR

Dept. of Obstetrics & Gynae
UTH Board of Management
Nursing Officers Office
P.O. Box 50001
Lusaka

12th April, 1988

Mrs Mary Chimwala
School of Medicine
Department of Post Nursing
P.O. Box 50110
Lusaka

UFS The Principal Nursing Officer

Dear Madam ,

RE: RESEARCH PROJECT IN THE MATERNITY POST NATAL WARDS

We acknowledge receipt of your letter seeking permission to carry out research studies in our department, and wish to inform you that permission is hereby granted on behalf of our departmental Nursing Officer.

I hope the outcome of the research will be fruitful and beneficial not only to you, but also to our nursing staff who are directly involved in nursing these mothers. Indeed there is need for us in the clinical area to improve our communication skills with our patients.

Yours faithfully,

Sr A Sikombe
for/DEPARTMENTAL NURSING OFFICER B BLOCK

c.c. Head, Post Basic Nursing Department

APPENDIX C

SAMPLE OF DATA COLLECTION INSTRUMENT

INTERVIEW SCHEDULE

I am Mrs. M. Chimwala, a student at the Post-Basic Nursing Department of the University of Zambia. I am carrying out a study on the information given to the pregnant mothers who undergo emergency ceasarean section, before they are taken to theatre. I would like to ask you questions about yourself and what information you were given. I will also ask you about the procedures done to you before you were taken to theatre. I have a list of questions which I would like you to answer and I will be writing the answers to help me remember your responses later.

		For official use
1.	How old are you?	
	Under 20 years	☐ 1
	20-25 years	☐ 2
	26-30 years	☐ 3
	31-40 years	☐ 4
	41 and above	☐ 5
	I don't know	☐ 6

2. What is your marital status?

Single	1
Married	2
Separated	3
Widowed	4
Divorced	5

3. How many children do you have? ☐

4. How many pregnancies have you ever had? ☐

5. Where did you deliver your children?

Hospital	1
Clinic	2
Home	3
Other (Specify)	4

6. How many days have you been in hospital since you were admitted? ☐

7. Who brought you to hospital?

Husband	1
Mother	2
Others (Specify)	3

8. What was your highest grade completed in school?

Never been to school	1
Grade 1-4	2
Grades 5-7	3
Grades 8-12	4
Post-secondary	5

9. Were you referred here from a clinic?

Yes	1
No	2

10. If yes, did you know why they referred you to hospital? (explain why)

11. Who examined you first when you were admitted to the labour ward?

Nurse	1
Doctor	2

12. What were you told at time of admission?

_____

_____

_____

_____

13. Who gave you this information?

Nurse	1
Doctor	2

14. What examinations were done on you when you were admitted?

Temperature measurent	☐	1
Blood Pressure measurement	☐	2
Urine Examination	☐	3
Abdominal Examination	☐	4
Vaginal Examination	☐	5
I don't remember/know	☐	6

15. Were you told why the examinations were done?

Yes	☐	1
No	☐	2

16. If yes, what information were you given?

_____

_____

_____

_____

17. How long were you in labour before the decision was made to take you for an operation?

_____

_____

_____

18. Were you told about the nature of the operation?

Yes ☐ 1

No ☐ 2

19. If yes, what were you told?

_____

_____

_____

20. Who told you the information?

Nurse ☐ 1

Doctor ☐ 2

21. Do you think you understood the information very well?

Yes ☐ 1

No ☐ 2

22. If not, why do you say so?

_____

_____

_____

23. What procedures and investigations were done before you were taken to theatre?

Shaving ☐ 1

I.V. Drip ☐ 2

Catherter insertion ☐ 3

Consent signing ☐ 4

Blood taking ☐ 5

I don't remember/know ☐ 6

24. Were you told reasons why the procedures and investigations were done?

Yes ☐ 1

No ☐ 2

25. What were your feelings about the explanations given to you?

_____

_____

_____

_____

26. Were you given a chance to ask questions

Yes ☐ 1

No ☐ 2

27. If not, how did you feel?

_____

_____

_____

28. Did any one at anytime tell you what was happening to the baby while you were in the labour ward?

Yes

No

29. If yes, what were you told?

---

30. If not, how did you feel about it?

_____

_____

_____

31. Did you find the information given to you before operation useful?

Yes 1

No 2

32. If yes, in which way?

_____

_____

_____

33. If no, why not?

_____

_____

_____

34. Would you have wanted to know anything else apart from the information you were given?

Yes ☐ 1

No ☐ 2

35. If yes, what is this information?

_____

_____

_____

36. Do you have any comments about your pre-operative experiences?

Yes ☐ 1

No ☐ 2

37. If yes, what are yor comments?

_____

_____

_____

38.

38. Has the operation influenced your feelings about future pregnancies? (Explain how)

_____

_____

_____

39. Is there anything else that you would like to tell me?

_____

_____

_____

THANK YOU FOR ANSWERING THE QUESTIONS