THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

EMOTIONAL SUPPORT OF A LABOURING WOMAN

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

NURSING RESEARCH - NR 420

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DECLARATION

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

Signed: M M Kwendakwape.
Candidate

Approved by: Deules
Supervising Lecturer

DEDICATION

The study is passionately dedicated to my husband Mr Paul Bwalya Kwendakwape, and my children, Chanda, Chileshe, Katongo and Mutale.

STATEMENT

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

Signed: M M Mwendabwape.

ACKNOWLEDGEMENT

I wish to sincerely acknowledge appreciation to persons who have devoted time and effort in giving assistance, and made it possible for me to conduct this study.

Special appreciation extends to Ms H. Burgess and Miss D. Gentles, my research supervising lecturers, without the benefit of their authoritative knowledge and nursing research expertise it would be impossible for me to conduct the study.

I am greatly indebted to Miss D. Gentles without whose constructive critisms, and mature and unbiased judgement it would be impossible to write a good report of the study at BSc. level.

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Lastly but not the least Miss Hilda Sikombe who typed my work profeciently, and my secondary scholl friend Mathilda Lukwesa, who assisted in various ways.

ABSTRACT

The purpose of the study was to find out how much emotional support is given during labour and delivery to women who deliver in the University Teaching Hospital (U.T.H.), and to further find out whether or not the same women are satisfied with the care given. This was in order to bring attention to both care givers and the authority to the factors which contribute to inability to give quality care.

The literature used in the study was obtained from text books and studies done in other countries, since no such studies were conducted in Zambia.

The sample was convenient sample drawn from postnatal mothers in lying in wards, who were waiting to be discharged. The sample size was 30 respondents.

The instrument used to collect data was interview schedule (semi-structured), because the target population consisted of mixed patients, illiterate and literate.

The Data were collected in May and June 1988 and were analysed manually. The tables were used to present data.

The findings of the study revealed that most of these patients were satisfied with emotional support given during labour and delivery. Twenty one out of thirty (70%) respondents said that they were satisfied with the care given to them, in the first stage of labour. During delivery all those who passed through second stage twenty five (83%) of the total number of respondents said that they were satisfied with the care given.

The factors below were cited by respondents as being satisfiers:-

-Informing the woman about her progress of labour and the condition of the baby in the womb.
-Explaining rationale for the care given.
-Encourage and reassuring the woman, talking in good tone of voice.
-Showing empathy and friendliness, by being present at the bedside and listening to the woman's complaints with compassion.
-Physical support, holding and touching, rubbing of the back and the abdomine.

The factors which dissatisfied the patients were: shouting at the patient, talking in hush voices, giving inappropriate re-assurance, unfriendly attitude, being left alone, no information about the condition of the baby, anticipated time of delivery and about the progress of labour. Inability of midwives to come when they were called by a woman in first stage of labour.

The authorities are advised to give praise where it is due and critically analyse the bad behaviour and culprits should be warned about that.

CHAPTER I

INTRODUCTION, STATEMENT OF PROBLEM AND DEFINITION OF TERMS

1. INTRODUCTION

Emotional support is very important in the care of a woman in labour because she comes in labour with a number of anxieties, fears and worries about labour and probably worries about the outcome of labour.

Emotional support is defined as "a term used to embrace the concept of meeting the emotional needs of a woman in labour."[1] Emotional support is one aspect of care which is quite often neglected. This is so perhaps because of the following reasons:-

(1) Limited knowledge of nurses about the emotional needs of the patients.
(2) Merely nurses negative attitude towards patients.
(3) Nurses/midwives lacking knowledge about aims and objectives of Nursing Care.

What a midwife sometimes fails to realise is that, there is probably no other time during the maternity cycle, when the midwife is in such an advantageous position to give nursing care as she is during the time of child delivery.[2]

> This miracle of giving birth is a unique and a humbling experience, not only for mother and father the main participants, but also for the physician and nurse who share this experience and upon whom so much depends. Labour looms as a critical period from the parents' point of view and often labour is considered by the parents and especially by mother as the end of a long drawn-out process rather than the begining of new life.[3]

This is why in Zambia the greeting ('Mwapusukeni') of a woman after delivery has special implications, meaning that a woman has just escaped death.

> The parents attribute enormous significance to events and people who are necessary and helpful at this time, they indicate repeatedly that they consider the midwife in particular to be one of those necessary and helpful people. Indeed a midwife can be helpful if she utilizes the opportunity.[4]

Effective nursing care during labour by a midwife provides physical and emotional support for the labouring women.

It is a known fact that child birth is a family affair and a woman needs support from her relatives especially the husband.[5] At home deliveries in Zambia, due to traditional cultural and custom attachment, male relatives including the husband are not allowed in the labour room. Therefore the emotional, and moral support and encouragement are provided by female relatives such as mother, grandmother and aunt. On the other hand, in hospital setting of Zambia, due to various factors influencing

the situation in the labour wards, such as inadequate privacy, over-crowding et cetera, none of the women's relatives are allowed in the labour wards. This leaves a midwife alone to give the total emotional support the woman needs.

2. THE PURPOSE OF THE STUDY

In view of the above observations, the Researcher thought it necessary to find out through a scientific study, whether the women who deliveryin the University Teaching Hospital (U.T.H.) maternity wards, consider the midwives working this hospital to be empathetic, friendly, encouraging, reassuring, and helpful. Furthermore to find out whether or not the same women are satisfied with the emotional support given to them by the midwives during labour, delivery, and the hospital portion of the postnatal period.

The Researcher's intentions depended on the outcome of the study. If the findings will be favourable the Researcher would recommend that the midwives/nurses working in maternity wards to be praised for the care given to boost their morale in order for them to perform to their best. The results would then be used as a criterion for staff appraisal in maternity department for quality patient care given. Furthermore, the favourable findings would contribute towards building the good image of nursing profession at large. If the findings would not be favourable the results would stand as the statistical reference for the need to improve the nursing care (especially emotional support aspect), in these maternity wards of U.T.H.

3. THE RESEARCH PROBLEM

The research problem was stated in an interrogative form, and the study was designed to answer the following questions:-

(1) How much emotional support is given to labouring mothers in maternity wards of U.T.H.?

(2) Are the same mothers satisfied with emotional support given to them during labour, delivery and in the hospital portion of the postnatal period?

Hypothesis

This was the tentative answer to the questions posed in research problem above.

"There is a positive relationship between the quality of emotional support given to labouring mothers at U.T.H. and the mothers' satisfaction with the care received."

4. THE OBJECTIVES OF THE STUDY

At the end of the study the Researcher should be able to:-

(1) identify behaviours related to emotional

support given to the labouring women by midwives of U.T.H.

(2) distinguish between behaviour that enhance satisfaction and those that have an adverse effect on the women's satisfaction.

(3) apply knowledge gained from this study;

(a) in giving quality nursing care to labouring women.

(b) in teaching student midwives about giving effective nursing care to women during labour, delivery and post-natally with more emphasis on behaviors that enhance satisfaction and discourage those which have adverse effect on the mothers' satisfaction.

5. THE SIGNIFICANCE OF THE STUDY

This is an important study, because it has tried to probe into problems associated with emotional support of the women in labour. To find out whether these women are given the necessary and essential emotional support they very much need during that particular period of labour and delivery. The future of the mother and child depends on how the mother was supported emotionally during labour.

The child birth process period is a crucial time for the mother and the baby in their life time. This is

because, the experience of childbirth may bring about permanent mental disorders for the mother as a result of emotional traumar. For instance puerperal psychosis probably develops in women who may appear normal before pregnancy, then pregnancy and labour act as emtional stress factors, which precipitate a breakdown in these women's personalities. This is the type of women if inadequate emotional support is given would develop psychosis during puerperium. One of the features of puerperal psychosis is that the mother does not want to feed or to see the baby.

Parental attitudes are important because they influence the development of child's personality. Disturbances in the early attitudes of mothers to their newborns may lead to chronic disturbances in the mother-child relationship.[6]

Secondly, this study also aimed at finding out if the public complaints about attitudes of nurses working in the labour wards are genuine. There have been often a number of complaints from the public and writing in newspapers about the negative attitude of nurses working in labour wards of various hospitals all over Zambia, U.T.H. in particular. In the number of cases some uncalled for langnange used by midwives in these wards has been quoted in the newspaper. These are some of the factors that contribute to falling standards

of Nursing in general, and tarnish the good image of the Nursing profession.

Therefore, the outcome of the study aimed at eliciting some facts on which to base the improvement of Nursing Care standards. Further investigations on the matter probably could be carried out in future to find out the predisposing factors for such negative attidues and unexpected behaviour.

Lastly, the knowledge gained from the study will contribute towards broadening the scope of knowledge in nursing, midwifery and obstetrics.

OPERATIONAL DEFINITIONS OF VARIABLES AND KEY TERMS

1. **Emotional support:** in this study refers to all good behaviours of the midwife that are related to care of the woman in labour.

2. **Emotional needs:** in this study entail; the need for encouragement, companionship, compassion, comfort and relief of pain.

3. **Behaviours:** refer to all those verbal and non-verbal actions of the midwife during nursing of the woman in labour, such as the following:

- explaining and informing,
- showing friendliness by e.g. smiling at the patient, touching her, talking to her in low, kind but firm voice,
- showing empathy by listening,
- encouraging,
- reassuring,
- being considerate e.g. for safety, comfort and privacy,
- being helpful e.g. assisting the woman on the bed pan or climbing the bed safely,
- shouting to one another or to the patient,
- having no time to explain and inform,
- not giving answers to questions asked by the patient, and
- ignoring the patient's requests.

4. Patient/mother: in this study refer to the woman in labour, and they will be used interchangeably.

5. Midwife: in this study refers to registered nurse or enrolled nurse who has been trained and recognised by General Nursing Council of Zambia to attend to a woman during pregnancy, labour and puerperium.

6. Labour and delivery refer to the whole process of giving birth to a baby.

7. Puerperium/Postnatal period refers to the first six (6) weeks following childbirth.

8. Satisfaction: refers to "a feeling of contentment on the part of the mother with the care that has been received."

9. Father refers to the husband of the labouring woman.

CHAPTER 2

LITERATURE REVIEW

Extensive research has been done regarding various aspects of patient care, but very few studies have been conducted in other countries on emotional support of a labouring woman, and on the woman's satisfaction for the care given to her during this period. In Zambia not even a single study on the same topic has been found.

The emotional support given in labour is based on the mental and physical status of the woman during that time of child delivery.

Myles states that, the onset of labour gives rise to a number of various emotions to the woman in labour especially when it is the first baby.[1]

It has been proven that these emotions affect the behaviour of that woman, and profoundly influence her reaction to discomfort and pain. The emotions are contributory factors in determining the amount of physical and mental exhaustion the woman will experience. Therefore the whole process of childbirth should be handled with sensitivity and compassion.[2] The nurses are not generally meeting the needs of distress woman as compassionately as they should.

Emotions a woman has during childbirth are attributed

to various factors, such as:-

(1) the fear of the unknown, the worry about the outcome of labour, the cause of labour, and the normality of the baby. Ojo and Briggs state that the midwife must appreciate the fact that nearly all pregnant women are victims of fear of the unknown, even after good antenatal care. This is because some mothers are not familiar with the hospital, and some associate the hospital "with operation."[3,4]

(2) The second factor, is the mother's past experience of labour, particularly multiparous patients, who are reminded of their previous experience in the labour ward. It depends on the nature of the previous experience. If it was not a good one, the onset of labour reminds her of that experience in the labour ward. Romana et al in their study report variables that predict and correlate mothers' perception of labour and their experience of the first childbirth. The underlining assumption is that a woman defines her performance and responds according to her perceptions.

That study shows that 19% of women who

delivered by ceasarean section perceived the childbirth experience more negatively than those who delivered vaginally.

According to Deutsecher, perception of performance during childbirth may serve as indications for later capabilities in the mothering role.[5,6,7].

Rising gives an account of her respondent regarding child bearing experience that:-

> I mainly wanted a good experience this time and to be dignified throughout labour and delivery. I was not happy with my actions through my first birth and wanted to be proud and have good memory this time.[8]

(3) Thirdly, the emotional stresses the woman comes with to the labour ward are either increased or reduced depending on how she is treated. The factors which maximize already existing anxiety in the woman in labour are:-

(a) inadequate information about the general condition of herself and the baby (in the womb), the progress of labour, the possible outcome of labour and the estimated time of delivery.

(b) lack of companion and friendliness, because "loneliness breeds fear"[9]

(c) Lack of encouragement reassurance and attention.

(d) Discomfort and pain.

It is inadequacy or lack of those important emotional needs what contribute to the increased emotional stress.

Emotional support of a woman in labour is therefore directed towards:-

(i) Meeting her emotional needs and those of close relatives, for example the husband.

(ii) Minimising her emotional stress such as, anxiety, worries and fear.

(iii) Establishing positive experience of her labour and develop positive perception of childbirth for subsequent deliveries. Romana et al argue that; if variables can be identified for predicting positive perception of the childbirth experience, prierities for optimal care and support during this period may be directed to those events that are alterable, and to those situations in which greater supportive intervention is needed.[10]

The emotional needs of a woman in labour entail:-

(1) The need for having good supportive persons.

(2) The need for encouragement.

(3) The need for compassion.

(4) The need for companionship all the time, and indeed the need for comfort and relief of pain.

The unmet emotional needs may result into various emotional problems such as "Nerve-wracking and emotional trauma which result from improper expressing of ones emotions such as fear, anger, and sadness."[11] These needs can be met in the following ways:-

(1) <u>Availability of Supportive Persons</u>

Broadribb states that there are three (3) team members who give important emotional support to the woman in labour, namely, the husband, the nurse/midwife and the doctor/obstetrician.[12] In Romana et al's study emotional support by mate (husband) contributed to the total positive self concept.[13]

The cooperative effort of all these team members is required to minimize the mothers fears and build-up her confidence.[14] Ernst and Forde report that Beth Maternity Centre in Philaldelphia tried to create such a place where beside other things care providers can look at what is essential for the safety of the mother and baby, and what is desired to make childbirth a meaningful, confidence building experience for patients. The support given to the woman during labour by the

members of the team contributes to the shorter labours and it gives the woman the state of al alertness following delivery.[15]

The supportive midwife/nurse who is able to:

(a) Establish good rapport with the woman, and develop positive attitude towards her is essential because personality and attitude of the midwife/nurse play an important part in influencing the behaviourof the woman in labour.[16] Hills and Knowles state that, patients reactions typically require an instantaneous response from nurses. Interactions which are characterised by empathy warmth and respect are considered to facilitate the development of the nurse-patient relationship.[17]

(b) Keep the woman company, because the woman needs someone to be present at her bedside all the time. To whom she can express her fears and worries. "I needed to express my fears to someone who could understand how I felt and give me support," expressed one woman in the study of Romana et al.[18]

Myles states that, the comforting companionship of a midwife who will listen, explain, encourage and reassure or keep silent as required is of inestimable value to the woman

at this time of labour.[19]

Loud laughing and joking are also inappropriate at this time because having a baby is a serious matter to the mother, husband and relatives.

Henschel in support of the above statement, gives an account of her experience at "birth without voilence" that, she was impressed with the ulter simplicity of the delivery room, and the peace which surrounded the labouring mother. There was no hustle, no orders and no noise, only heavy breathing and exertion of the mother, and praise from the midwife who encouraged the mother.[21]

2. Giving Encouragement

Encouragement could help the mother make best of her own strenth. Telling her that she is doing a good job, that she is breathing very well with contractions, and that she is pushing adequately, will encourage the woman to continue in her efforts.[22]

3. Showing of Compassion

Having a midwife who shows friendliness by explaining and allowing questions from patients about their own condition and care is vital, because these actions do not only alley anxiety of the

patient but also give opportunity to the patient to participate in her own care. Patient's participation in her care is one factor which contributes to patient's satisfaction for the care given. Ernst and Verde report that an increased number of mothers and fathers want active participation in decisions that influence their experience. The couples want unbiased information to enable them to know what goes on in the environment in which their childbirth takes place.[23]

The following are patient's satisfactory remarks about the service rendered at Booth hospital:

> Booth has adopted the most natural and pleasant approach to childbirth that I have heard of in these modern clinical times
>
> I did not feel like merely a number. There is a great need for an institution that puts the emphasis on family.
>
> Please go on helping people like us enjoy bringing their children into the world.[24]

4. Keeping Patient Comfortable

Iveson Iveson argues that during the first stage of labour the woman is free to choose the most comfortable position and changes the position whenever she wishes. Broadribbs adds that encouraging the patient change position frequently helps the patient to get into a comfortable position.[2] Other comfort measures

according to Lerch, are: wiping the women's sweat, cleaning of the vulva and changing of soiled pads and linen. Allowing the woman to empty her bladder as frequently as possible, frequent mouth washes, giving the woman ice cubes or sips of water for dry mouth, moisterning her lips with vaseline, and provision of dump cloth on the forehead, neck or face will make the woman feel very refreshed.[26]

Davis and Rubin add that with the aid of relaxation, deep breathing and sacral support, labour should be made as comfortable as possible"[27]

5. Relief of Pain

Ojo and Briggs state that pain has a detrimental effect on the patient. It weakens her physically and mentally and can render her uncooperative.[28] Labour is associated with pain because of the contractions which may be very painful at times. The labour pains bring about emotional stress and discomfort.

Therefore "every woman in labour should be given maximum relief from pain",[29] because according to Reeder et al, pain has potential of eliciting angry and aggressive responses. Such feeling resulting from a miserable painful childbirth

experience some times are projected onto the infant or the father. During and following very painful labours mothers have been quoted as saying that they despise their partners.[30]

The Researcher confirms having heard the above statement from Zambian labouring women during the Researcher's own experience in the labour ward. Relief of pain in labouring women can be done in various ways apart from using analgesics. Ojo and Briggs advise that midwives should know other measures especially those midwives working in rural areas of developing countries who are not equiped with adequate and suitable analgesics with which to relief pain in labour.[31] Hills and Knowles in their study report that in a majority (89%) of studies of patient outcome which reviewed positive patient responses were shown to be related to the interpersonal skills of health professionals, and such responses included relief of pain and distress.[32]

It is important to prepare the patient during the antenatal period so that the woman can withstand the stress of labour. The main aim is to bring a health woman to the labour ward both physically and emotionally. Educating the patient on what to expect in labour, for example

painful contractions especially primigravida women there by eliminating the element of fear and over reacting to pain. Teaching relaxation, deep threathing and pelvic exercises so that the patient will relax during labour.[33]

Iveson Iveson reports on Dr Barcia who believes in physiological and psychological base of modern and humanised management of normal labour that Dr Barcia does not exclude other relatives from the labour room if they have been selected by the mother. Dr Barcia feels that this choice helps to relieve the pain and anxiety the woman may feel if placed in a less humanised environment, and that it contributes to her well being during labour.[34]

In conclusion, in the study on "Maternity Nurses how patients see us", Field outlines some positive factors of emotional support which bring about satisfaction to the receivers of care rendered. They are: Explaining and informing, friendliness encouraging, efficiency, listening, pleasant, helpful and considerate. The negative comments were such as, the nurse was rude and displayed ignorance, the nurse could not listen to the complaints, the nurse was too busy to have time for the patient.[35]

CHAPTER 3

METHODOLOGY

1. RESEARCH DESIGN

Polit and Hungler refer to research design as "the plan or organization of scientific investigation"[1]. The research design used for this study was the descriptive survey. The descriptive survey was thought to be the most appropriate design for this study, because the study aimed at obtaining current information on emotional support given to labouring women in the University Teaching Hospital (U.T.H.). This was in order to find out whether the labouring women in the University Teaching Hospital were contented with the care that was given during labour or not.

Sweeney and Olivieri state that,

> the descriptive surveys are carried out for the purpose of providing an accurate potrayal of a group of subjects with specific characteristics. Descriptive studies usually entail the precise measurement of phenomena as they currently exist within a single group.[2]

In this study, current information was obtained since interviews were conducted only a few hours following delivery. The respondents were therefore able to recall their experiences in the labour ward more vividly.

[3]Descriptive studies are also used to collect demographic data. In this study patient personal particulars

like age, marital status and residence were part of information required in order to categorise respondents in certain groups, basing on demographic data . On the other hand the main group was formed by subjects with specific characteristic, that they were all postnatal women who had just gone through labour.

2. THE RESEARCH SETTING.

The research was conducted in the postnatal wards of the University Teaching Hospital maternity department.

U.T.H. is a specialist hospital comprising various special departments including the maternity (Obsteric) department. Maternity department ('B' Block) consists of six wards including the out patient clinic. The total bed capacity is two hundred and forty six (246). The wards are divided as follows:-

-Antenatal wards B21 and part of B13
-Labour ward B12
-Postnatal wards B01, B03, B11 and B13.

The postnatal wards were chosen as the most appropriate setting because of the nature of the study which aimed at interviewing mothers who had already delivered. It would have been better though if some of the data were collected in the labour ward by observation method, and then the patients would have been followed to the postnatal ward to be interviewed, but time could not allow the Researcher to do so. The patients were interviewed * P4

ithin twelve hours following delivery and before they were ischarged home. Other reasons for choosing this setting ere that:- it was easy for the Researcher to gain access o respondents as they were waiting in the lying-in (post-atal) wards before they were discharged; relatively ess time was spent on data collection since the respondents ere within the hospital, a walking distance from the Post asic Department from where the Researcher was operating. his setting also facilitated easy access to patients ecords, as the background information was obtained from tients' notes.

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Mason and Bramble define sampling as the act of drawing sample from a population.[6]

The method used for sampling in this study was 'convience' sampling in which the Researcher selected elements for her sample because they are easily accessible".[7] In this study any available member of the 'target' population was included in the sample until the required number was reached.

A target population (a well defined population) is the set of elements that the research focuses upon and to which the results obtained by testing the sample should be generalized." The target population for this study comprised mothers who had delivered during the period (May - June 1987) when the study was being conducted, regardless of the mode of delivery as long as the woman had been nursed in the labour ward, including those who had premature babies and stillborn babies.

The main criterion used for selection of subjects was language. All those mothers who were selected were able to speak either English, Kamba or Kyanja, for proper communication.

4. THE INSTRUMENT USED TO COLLECT DATA

Sweeney and Olivieri define the instrument as "the device used to record the information obtained from subjects."[9] In this study a semi-structured interview schedule (appendix 1) was used. Mason and Bramble state that interview schedule is a verbal discussion conducted by one person with another for the purpose of obtaining information."[10] An interview schedule was used because the sample consisted of a mixture of literate and iliterate respondents who would have not been able to fill in the questionnaire if it was used. In an interview questions can be translated into local languages by the interviewer. The other important reasons for choosing interview schedule were that:-

> Interviews provide the researcher with opportunity to explore and clarify issues that could be missed on a questionnaire or from an existing record. The interaction allows the investigator to get a more personal feeling about the subjects."[11]

Mason and Bramble argue that "the interview method of data collecting is quite flexible and can be easily adapted to a variety of situations."[12] Polit and Hungler say that:-

> also in face to face discussion the interviewer is in a position to observe the respondents level of understanding.[13]

However, there are some disadvantages associated with interview method, a few are mentioned below:- It is time consuming for the researcher to conduct interview than it is to administer questionnaires. The questions asked are subject to wrong interpretations; the interviewer might think that one question is being asked and the respondent might interpret it differently and answer another. The presence of the interviewer may affect the respondent reaction to a particular question, for example the respondent may give answers which the interviewer is likely to want to hear, and minimises the objectivity of the instrument.

In order to avoid some of the problems mentioned above ambigous and confusing questions were rephrased. The respondents mental state was ensured normal and the interviewer was as objective as possible when asking questions.

5. INTERVIEW SCHEDULE

The interview schedule contained forty five (45) questions. The first nineteen (19) questions, the information was got from the patients' notes and questions were about patients' background and obstestrical history. The remaining twenty six (26) questions were to elicit responses regarding emotional support given to the patient during the three (3) stages of labour and the care after delivery.

6. DATA COLLECTION

Data collection was done between the end of May and fourth week of June 1988 in evenings after visiting hours. The Researcher introduced herself each time she went to interview patients, in order to gain their cooperation. The interviews were conducted at patient's bed side and each interview lasted twenty (20) to thirty (30) minutes because the clients would have been bored if interviewes had taken long. The Researcher was actually aware that respondents would not be able to remember events;

> situations or previous activities and feelings with a high degree of accuracy. Recall may be quite poor, even over a short period and for important issues.[14]

It depends upon the "ability of respondents to reply or give information"[15] and also on whether he/she has a good memory or not.

At the end of each interview the client was thanked.

CHAPTER 4

DATA ANALYSIS, PRESENTATION OF FINDINGS BY TABLES.

1. DATA ANALYSIS

Data analysis was done manually. Two methods were used for analysis of data, because according to the instrument used to collect data (semi-structured interview schedule), two types of responses were obtained. One was for close ended questions, and another one for open ended. Coding was used for close ended, and categorisation was used for open ended type of responses. In both cases counting was done manually. Analysis of data is used to arrange raw data into meaningful manner so that it is possible to derive patterns of relationships from the data collected.

2. PRESENTATION OF DATA

Data were arranged in frequency counts and percentages. Findings are presented in tabular form.

The purpose of the study was to find out whether or not the women who deliver in the University Teaching Hospital (U.T.H.) maternity wards, consider the midwives working in this hospital to be empathetic, friendly, encouraging, reassuring and

CHAPTER 4

DATA ANALYSIS, PRESENTATION OF FINDINGS BY TABLES

1. DATA ANALYSIS

Data analysis was done manually. Two methods were used for analysis of data, because according to the instrument used to collect data (semi-structured interview schedule), two types of responses were obtained. One was for close ended questions, and another one for open ended. Coding was used for close ended, and categorisation was used for open ended type of responses. In both cases counting was done manually. Analysis of data is used to arrange raw data into meaningful manner so that it is possible to derive patterns of relationships from the data collected.

2. PRESENTATION OF DATA

Data were arranged in frequency counts and percentages. Findings are presented in tabular form.

The purpose of the study was to find out whether or not the women who deliver in the University Teaching Hospital (U.T.H.) maternity wards, consider the midwives working in this hospital to be emphathetic, friendly, encouraging, reassuring and

helpful. It was found suitable to use tables because they summarise results in a meaningful way enabling the reader to understand the authors' intention of the study.

Tables have been arranged according to questions in the instrument. The percentages are rounded up to whole numbers since they represent people and there are no fraction person.

TABLE 1: AGE DISTRIBUTION OF RESPONDENTS

AGE IN YEARS	NUMBER OF RESPONDENTS	PERCENTAGE (%)
Below 15	1	3
15 - 19	9	30
20 - 24	4	13
25 - 29	10	33
30 - 34	3	10
35 and above	2	7
Unknown	1	3
TOTAL	30	99.99 =100%

The age range was from 15 - 35 and above years. One respondent who aged 12 years and another one whose age was not known are not included in the range.

The mode of the age distribution was 25 - 29 that accounted for 10 (33%) of the total target population. Nine (30%) respondents fall in age group 15 - 19 years.

TABLE 2: RESIDENTIAL AREAS OF RESPONDENTS

RESIDENTIAL AREA	NUMBER OF RESPONDENTS	PERCENTAGE
Low density	2	7
Medium density	4	13
High density	21	70
Squater	3	10
Total	30	100

Table 2 illustrate that the majority of (70%) respondents came from high density residential area, and manority (7%) came from low density area.

TABLE 3: EDUCATION STATUS OF RESPONDENTS

EDUCATION LEVEL OF RESPONDENTS	NUMBER OF RESPONDENTS	PERCENTAGE
Primary	18	60
Junior Secondary	3	10
Senior Secondary	5	17
College	1	3
University	1	3
No education at all	2	7
Total	30	100

Table 3 shows the educational achievement of respondents.

Majority (60%) attained primary education, that is grades 1 - 7. Only 1 (3%) reached university education and 2 (7%) were not educated at all.

TABLE 4: EMPLOYMENT STATUS OF RESPONDENTS

EMPLOYMENT STATUS	NUMBER OF RESPONDENTS	PERCENTAGE
Employed	13	43
Unemployed	17	57
Total	30	100

Table 4 shows that the majority 17 (57%) of respondents were unemployed and 13 (43%) employed.

TABLE 5: MARITAL STATUS OF RESPONDENTS

MARITAL STATUS	NUMBER OF RESPONDENTS	PERCENTAGE
Married	24	80
Single	5	17
Separated	1	3
Total	30	100

Table 5 illustrates the marital status of respondents, that, the majority (80%) were married 5 (17%) were

single and only 1 (3%) was separated with her husband.

TABLE 6: PARITY OF RESPONDENTS

PARITY	NUMBER OF RESPONDENTS	PERCENTAGE
Primipara	12	40
Multipara	10	33
Grande Multipara	8	27
Total	30	100

Table 6 shows the distribution of parity of respondents. Majority twelve (40%) of respondents were primipara mothers, meaning those who had their first babies. The least were grande multipara mothers, those who had delivered 5 and more babies.

TABLE 7: RESPONDENTS' OTHER LIVING CHILDREN

NUMBER OF LIVING CHILDREN	NUMBER OF RESPONDENTS	PERCENTAGE
1 - 3	10	33
4 - 6	4	13
7 and above	4	13
None	12	40
Total	30	100

Table 7 shows number of children the respondent had. Majority 10 (33%) had number of babies ranging from 1 - 3 and only 4 (13%) had children from 4 - 6 and 7 and above. The remaining twelve (40%) accounted for primipara mothers.

TABLE 8: RESPONDENTS ANSWER WHETHER OR NOT HAD MISCARRIAGE

MISCARRIAGE	NUMBER OF RESPONDENTS	PERCENTAGE
Yes	4	13
Nos	26	87
Total	30	100

Table 8 illustrates number of respondents who had miscarriages and those who did not four (13%) had and twenty six (87%) did not have miscarriages. Out of 87%, 40% accounted for primipara (primigravida) women.

TABLE 9: PLACE OF DELIVERY OF OTHER CHILDREN

PLACE OF DELIVERY	NUMBER OF R RESPONDENTS	PERCENTAGE
Clinic and Hospital	18	60
Home	0	0
Not Applicable	12	40
Total	30	100

Table 9 shows that all those mothers who had babies before delivered either at clinic or hospital.

TABLE 10: RESPONDENTS WHO ATTENDED ANTENATAL CLINIC

ATTENDED ANTENATAL CLINIC	NUMBER OF RESPONDENTS	PERCENTAGE
Yes	29	97
No	1	3
Total	30	100

Table 10 shows that twenty nine (97%) of respondents attended antenatal clinic and only one (3%) did not attend. This was the school child of 12 years old.

TABLE 11: WEEKS OF PREGNANCY WHEN RESPONDENTS BOOKED FOR ANTENATAL CLINIC

WEEKS OF PREGNANCY	NUMBER OF RESPONDENTS	PERCENTAGE
Before 12 weeks	1	3
13 - 17 weeks	2	7
18 - 29 weeks	5	17
30 - 35 weeks	21	70
35 and above	0	0
Not booked	1	3
Total	30	100

Table 11 shows that twenty one (70%) of respondents booked for antenatal clinic at 30 - 35 weeks of pregnancy and five (17%) at 18 - 28 weeks.

TABLE 12: RESPONDENTS' NUMBER OF ANTENATAL VISITS

ANTENATAL VISITS	NUMBER OF RESPONDENTS	PERCENTAGE
1 - 4	9	30
5 - 8	15	50
9 - 12	3	10
13 and above	2	7
No visit	1	3
Total	30	100

In table 12 the majority 15 (50%) of respondents had attended antenatal clinic, 5 - 8 times. Nine (30%) attended 1 - 4 times and three (10%) 9 - 12 times and one (3%) did not attend at all.

TABLE 13A: HEALTH TALKS GIVEN TO THE RESPONDENTS AT ANTENATAL CLINIC

TOPIC TAUGHT	NUMBER OF RESPONDENTS	PERCENTAGE
What to bring to hospital when coming for delivery.	22	42
Signs and stages of labour	13	25
When to come to hospital when labour starts.	8	15
Position in bed during 1st and 2nd stages of labour.	5	9
When to start bearing down and when not to bear down.	5	9
Total	53	100

TABLE 13B: TOTAL NUMBER OF THE RESPONDENTS WHO WERE TAUGHT SOMETHING AT ANTENATAL CLINIC AND THOSE WHO WERE NOT TAUGHT AT ALL

TAUGHT	NO. OF RESPONDENTS	PERCENTAGE
Yes	23	77
No	7	23
Total	30	100

Table 13B shows that twenty three (77%) respondents were taught something (topics are shown in Table 13A above). Seven (23%) respondents said they were not taught anything.

TABLE 14: RECEPTION OF RESPONDENTS IN THE LABOUR WARD

WELCOME	NO. OF RESPONDENTS	PERCENTAGE
Yes	25	83
No	5	17
Total	30	100

In table 14 majority 25 (83%) respondents said were welcome in the labour ward. Only five (17%) said were not happy by the way they were received.

TABLE 15 RESPONDENTS ESCORTS TO HOSPITAL

ESCORT	NUMBER OF RESPONDENTS	PERCENTAGE
Husband	10	33
Mother	2	7
Sister/Sister in law	8	27
Friend	1	3
Nurse	89	30
Total	30	100

Table 15 shows that ten (33%) were accompanied by husband nine (30%) by nurses, eight (27%) by sister/ sister in law , two (7%) by mother and one (3%) by a friend.

TABLE 16A RESPONDENTS ANSWERS TO WHETHER THEY WERE WORRIED OR NOT WHEN THEY WERE IN LABOUR

RESPONSE	NUMBER OF RESPONDENTS	PERCENTAGE
Yes	21	70
No	7	23
Not applicable	2	7
Total	30	100

TABLE 16B: REASONS RESPONDENTS GIVEN FOR WORRY INDICATED IN TABLE 16A

REASONS	NUMBER OF RESPONDENTS	PERCENTAGE
Because I did not know when to deliver	4	19
It was my first time	4	19
It was too painful	2	9
I did not knwo whether I would deliver normally or not	10	48
Because I was told I would go for operation	1	5
Total	21	100

Table 16A shows that twenty one (70%) respondents said were worried when they were in labour. Seven (23%) said they were not worried and two (7%) accounted for those who delivered before arrival. Table 16B shows the reasons given by respondent for worry those who said were worried in table 16A. Ten (48%) said because they did not know whether they would deliver normally or not. Four (19%) said, because they did not know when to deliver and another same number said because it was their first time. Two (9%) said it was too painful, and one (5) said because she was told she was going to theatre, for operation.

TABLE 16C: RESPONDENTS EXPECTATIONS OF MIDWIFE'S RESPONSE FOLLOWING COMPLETION OF ADMISSION FOR DELIVERY

EXPECTATION	NUMBER OF RESPONDENTS	PERCENTAGE
Explanation about respondent's and baby conditions.	8	27
Information on when is likely to deliver.	9	30
Information on whether will deliver normally or not	7	23
None	6	20
Total	30	100

Table 16C shows that 30% of respondents expected midwife to tell them about their general condition and that of (babies in the womb especially). Six (20%) did not expect any specific response from the midwives.

TABLE 17A: THE RESPONDENTS ANSWERS TO WHETHER THERE WAS SOMEBODY AT THEIR BEDSIDES ALL THE TIME DURING 1ST STAGE OF LABOUR

ANSWER	NO. OF RESPONDENTS	PERCENTAGE
Yes	14	47
No	16	53
Total	30	100

TABLE 17B: RESPONDENTS' REASONS FOR NOT HAVING ANYBODY BY THE BEDSIDE DURING THE 1ST STAFE OF LABOUR

REASONS	NO. OF RESPONDENTS	PERCENTAGE
Number of midwives/nurses - one on duty was inadequate	5	31
There were a lot of other patients to be attended to by midwife	6	37
Nurses were not interested in me I came to hospital for delivery instead of clinic.	1	6
Reasons not known	4	25
Total	16	100

Table 17A shows that sixteen (53%) of respondents said no and fourteen said yes.

Table 17B shows that six (37%) of respondents who said no in table 17A above gave reasons for not having anybody at bedside all the time that there were other patients the midwives were attending to, five (31%) said that the number of nurses/midwives was not adequate, and one (6%) said that nurses were not interested in her becasue she came to hospital for delivery instead of going to the clinic.

TABLE 18: RESPONDENTS' FEELING WHEN LEFT ALONE

FEELING	NUMBER OF RESPONDENTS	PERCENTAGE
Frightened	9	56
Lonely	4	25
Nothing	3	19
Total	16	100

Table 18 shows that nine (56%) of respondents felt frightened when they were left alone, four (25%) felt lonely and three (19%) felt nothing.

TABLE 19: RESPONDENTS' VIEWS ABOUT THE MIDWIFE AT THE BEDSIDE DURING THE FIRST STAGE OF LABOUR

RESPONDENTS VIEW	NO. OF RESPONDENTS	PERCENTAGE
Midwife was able to listen	4	13
Explain and inform	4	13
Encourage and reassure	9	30
Rub the back, hold hands and support.	11	37
None of the above	2	7
Total	30	100

Table 19 shows that eleven (37%) of respondents said midwives were able to touch, and rub their backs. Nine (30%) said nurses/midwives were able to encourage and reassure, four (13%) said midwives were able to explain and inform and only two (7%) said that the midwives did not do any of the above mentioned things.

TABLE 20: HOW RESPONDENTS WERE ADDRESSED

ADDRESS	NUMBER OF RESPONDENTS	PERCENTAGE
Mrs so and so	6	20
My Friend	1	3
and		
My Sister	1	3
You woman	8	27
My Daughter	1	3
By my first name	10	33
Not addressed at all	3	10
Total	30	99.99 = 100

In table 20, 33% of respondents were addressed by their names and 3.3% were addressed as my friend, my sister and my daughter respectively

TABLE 21 : RESPONDENTS REASONS WHY SOME COMFORT MEASURES WERE NOT CARRIED OUT BY THE MIDWIFE

REASONS	NUMBER OF RESPONDENTS	PERCENTAGE
I do not know	17	57
I was not sweating	2	7
I was told that we do not give water here	3	10
I did not ask for water for fear of vomiting.	1	3
I had passed urine before coming.	4	14
I was to go to theatre	1	3
Nurse have no time	1	3
Total	30	100

Table 21 above shows that seventeen (57%) respondents did not know why some comfortable measures were not carried out on them and one (3%) said she did not ask for water for fear of vomiting, one (3%) said she was to go to theatre. 3 nurses have no time to do all those

TABLE 22A RESPONDENTS INNER FEELING FOR THE TREATMENT GIVEN FROM ADMISSION TO END OF 1ST STAGE OF LABOUR

FEELING	NUMBER OF RESPONDENTS	PERCENTAGE
Happy and satisfied	21	70
Dissatisfied and unhappy	7	23
Not applicable	2	7
Total	30	100

In table 22A above twenty one (70%) of the total respondents said that they were happy and satisfied with the treatment given. Seven (23%) were not happy with the treatment while two (7%) accounted for those who delivered before arrival to hospital.

TABLE 22B RESPONDENTS REASONS FOR THE POSITIVE FEELINGS IN TABLE 22A ABOVE

REASONS	NUMBER OF RESPONDENTS	PERCENTAGE
Happy and satisfied		
Because I was touched supported and my back was rubbed.	8	38
Because I was told what was going on and I was encouraged.	5	24
I was well treated, the nurse was friendly and did not complain when I called her she talked to me nicely.	5	24
I was given lolipopo sweet	1	5
I was never left alone	1	55
I was treated far much better than the previous time I was here	1	5
Total	21	101 = 100

Table 22B above shows that eight (38%) of respondents said that the reasons for their feeling contentment was because they were touched, supported and their backs rubbed.

Five (24%) said they were told what was going on and they were encouraged. Another five (24%) said the nurse was friendly and did not complain when they called her, talked to them nicely. Three (15%) said the following separately:-

(1) I was treated far much better than the previous time.

(2) I was given a lolipopo sweet.

(3) I was never left alone.

TABLE 22C: RESPONDENTS REASONS FOR BEING UNHAPPY AND DISSATISFIED

REASONS	NUMBER OF RESPONDENTS	PERCENTAGE
I was shouted at	2	22
I was left alone for so long	1	11
I did not know what was going on	3	33
I had no body to complain to	1	11
When I called no body came	1	11
I was told that this is not the place to cally your mother.	1	11
Total	9	99 = 100

Table 22C shows variosu responses of 9 women who were not satisfied with the treatment they recieved.

TABLE 23A: DURATION OF RESPONDENTS' FIRST STAGE OF LABOUR.

DURATION	NUMBER OF RESPONDENTS	PERCENTAGE
Too short	1	3
Short	2	7
Too long	10	30
Long	6	20
Fair	6	20
Not applicable	5	17
Total	30	100

Table 23A illustrates that ten (30%) said their duration of labour was long and only one (3%) found it too short.

TABLE 23B: REASONS FOR ANSWER IN 23A

REASONS FOR LONG AND TOO LONG	NUMBER OF RESPONDENTS	PERCENTAGE
Because the labour was very painful	14	88
I did not know the outcome of labour	1	6
Because I was worried about operation.	1	6
Total	16	100

Table 23B shows that fourteen (88%) of those 16 who said that the labour was long and too long, said that because the labour was painful. Two (12%) said the following separately:-

(i) because I did not know the outcome of labour.

(ii) because I was worried about the operation.

TABLE 24A: RESPONDENTS' FEELING ON THE CARE GIVEN IN 2ND STAGE OF LABOUR

FEELING	NUMBER OF RESPONDENTS	PERCENTAGE
Pleased	25	83
Not pleased	0	0
Not applicable	5	17
Total	30	100

Table 24A shows that twenty five (83%) of the total number of respondents (that is the 100% of the total number of patients who went through 2nd stage of labour) were pleased with the care given during actual delivery. Five (17%) accounted for those patients who delivered before arrival and those who went for caesarean section.

TABLE 24B: RESPONDENTS' REASONS FOR BEING PLEASED FOR THE CARE, SUPPORT GIVEN IN 2ND STAGE OF LABOUR

REASONS	NUMBER OF RESPONDENTS	PERCENTAGE
I was supported physically and helped with contractions by rubbing my abdomine	10	40
I was told when to push and when not	5	20
I was encouraged and reassured that I am doing fine the baby is about to be born.	6	24
I was well treated generally.	4	16
Total	25	100

In table 24B, ten (40%) respondents were pleased with the care given in 2nd stage of labour because they were physically held and supported. Five (20%) said they were told when to push and when not to push. Six (24%) said because they were encouraged and reassured, and four (16%) said they were well treated generally, and they were informed about the condition of the baby.

TABLE 25A: RESPONDENTS' TYPE OF DELIVERY

TYPE OF DELIVERY	NUMBER OF RESPONDENTS	PERCENTAGE
Spontaneous vertex delivery (SVD)	25	83
Forceps	1	3
Caesarean section	2	7
Delivered before arrival	2	7
Total	30	100

Table 25A shows that twenty five (83%) of the respondents delivered normally (sponteneous vertex delivery). Two (7%) delivered by caesarean section, one (3%) by forceps and two (7%) delivered before arrival to hospital.

TABLE 25B: CONDITION OF THE BABY AT BIRTH

ESTIMATED BY APGAR SCORE

APGAR SCORE	NUMBER OF BABIES	PERCENTAGE
0 - 2	1	3
3 - 4	2	7
5 - 7	8	27
8 - 10	19	63
Total	30	100

Table 25B shows that nineteen (63%) of thirty (30) the total number of babies had Apgar score of 8 - 10, which means that they were in good condition at birth. Eight (27%) had Apgar score of 5 - 7, these had mild asphyxia. Two (7%) had Apgar Score of 3 - 4 and had moderate to severe asphyxia but they were resuscitated and were alright there after. One (3%) was a fresh stillborn baby apgar score of zero.

TABLE 25C: BABIES BIRTH WEIGHT IN KILOGRAMS

BIRTH WEIGHT IN KILOGRAMS	NUMBER OF RESPONDENTS	PERCENTAGE
Below 1.000Kg	2	7
1.000 - 1.700Kg	5	17
1.800 - 2.500Kg	4	13
2.600 - 3.300Kg	14	47
3.400 - 4Kg	4	13
Above 4Kg	1	3
Total	30	100

Table 25C shows that fourteen (47%) babies weighed 2.600Kg, five (17%) weighed 1.000Kg - 1.700Kg, four (13%) weighed 3.500Kg to 4Kg. Two (7%) weighed below 1.000Kg and one (3%) weighed above 4Kg. Mean birth weight is 2.765Kg and the mode is 2.600Kg.

TABLE 26: RESPONDENTS ANSWERS TO WHETHER OR NOT THEY WERE GIVEN ANY HEALTH TALKS ON CARE OF THEMSELVES AND/OR BABY AFTER DELIVERY.

HEALTH TALK	NUMBER OF RESPONDENTS	PERCENTAGE
Given health talk on care of herself	10	33
On care of the baby	0	0
On breast care	5	17
On lactation	0	0
None at all	15	50
Total	30	100

Table 26 above shows that only ten (33%) of respondents were taught about the care of themselves, five (17%) on the breast care. Nobody was taught about baby care and lactation. The remaining fifteen (50%) were taught nothing at all.

TABLE 27A: DAY INDICATED BY RESPONDENTS WHEN THEY WANTED TO GO HOME

WHEN RESPONDENT WOULD LIKE TO GO HOME	NUMBER OF RESPONDENTS	PERCENTAGE
Tomorrow	18	60
As soon as possible	7	23
I do not know, is up to the doctors and my baby is in D11	5	17
Total	30	100

Table 27A, shows that eighteen (60%) which is the majority of respondents wanted to go the following day, seven (23%) said as soon as possible and five (17%) were not sure since their babies were in premature special care nursery.

TABLE 27B: RESPONDENTS REASONS FOR ANSWERS GIVEN IN TABLE "26A

REASONS	NUMBER OF RESPONDENTS	PERCENTAGE
I am missing my family	9	30
I want to go back to school	1	3
I would like to care about myself and the baby properly at home.	7	27
It is not nice for the baby to stay in hospital when it is alright.	1	3
I am feeling well and the baby is well too.	7	23
The baby is in D11 and I am still sick.	5	17
Total	30	100

Table 27B indicates that nine (30%) respondents wanted to go the following day because they said they were missing their families. Seven (23%) said they would

like to look after baby properly at home, another seven (23%) said they were well and baby is well too. Only five (17%) indicated that they were sick and the babies were in D11 so they did not know when to go.

TABLE 28 : RESPONDENTS' OTHER COMMENTS ON THE CARE GIVEN

COMMENTS	NUMBER OF RESPONDENTS	PERCENTAGE
Pass my gratitude to U.T.H. staff	5	17
Nothing	25	83
Total	30	100

Table 28 shows that only five (17%) had comments to make while twenty five (83%) said they had no other comments.

CHAPTER 5

DISCUSSION OF FINDINGS, NURSING IMPLICATIONS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

1. DISCUSSION OF FINDINGS

The purpose of the study was to find out whether or not the women who deliver in the University Teaching Hospital (U.T.H.) maternity wards, consider the midwives working in this hospital to be empathetic, friendly, encouraging, reassuring and helpful. Furthermore, the study was designed to find out whether or not the same women are satisfied with the emotional support given to them by the midwives during labour, delivery and the hospital portion of the postnatal period.

Table 1 shows the age distribution of respondents. The age range in years was 12 - 35 and above. Ten (33%) respondents aged between 25-29 years, nine (30%) aged 15 - 19 years, four (13%) aged between 20 - 24 years, three (10%) aged between 30 - 24 years while another one (3%) aged 12 years. Mean age was 24 years. This explains the fact that the majority (73%) of respondents were young mothers, twelve (40%) having children for the first time (table 3) and ten (33%) those

who have delivered 1 - 4 children as shown in table 7. Twelve (40%) of the respondents had no experience of childbirth. Probably they were the same women who formed the majority of the group of those mothers who were worried because they were not told when they were likely to deliver (table 16C). That may confirm Myles statement that the onset of labour gives rise to number of various emotions to the women in labour especially when it is the first baby.

Table 2 which shows respondents' residential area, illustrates that the majority (70%) of the respondents came from high density residential area (including grade 1 squater compounds). Four (13%) came from medium density and only two (7%) from low density area and three (10%) came from squater compounds. This perhaps explained the fact that the majority (60%) of respondents attained only primary education as shown in table 3. Another fact as show in table 4 is that seventeen (57%), which is the majority of respondents were unemployed. Residential area, education and employment determine the socio-economic status of the people. According to these findings it means that majority of respondets were from the low socio-economic group. Furthermore, this may explain the findings in table 22 that the majority (70%) respondents were pleased with the care, because usually people from low socio-economic group are humble, ignorant of their rights, and they do not expect too much.

Table 5 shows that, majority (80%) of respondents were married, five (17%) were single and one (3%) was on separation with the husband. Out of twenty four (80%) of those who were married only ten (33%) were escorted by the husbands to hospital when they came for deilvery, (table 15). Out of the five (17%) who were single one (3%) was a school girl of 12 years of age.

Table 9 shows that out of those respondents who had other babies, eighteen (60%) delivered those babies either in hospital or at the clinic. Twelve (40%) accounted for primipara who had their first born babies. This implied that those mothers who have had babies before had the childbirth experience in the health institution, therefore the labour ward of U.T.H. was not completely strange to them, in terms of equipment, e.g. beds, and the type of people attending to them.

Table 10 shows that twenty nine (97%) out of thirty (30) respondents had attended antenatal clinic, and only one (3%) who did not attend, this was the school girl of 12 years mentioned earlier. Table 11 shows the weeks of pregnancy the mothers were at the time of booking for antenatal clinic. The majority twenty one (70%) booked when the pregnancies were between 30 - 35 weeks, five (17%) booked at 19 - 29 weeks two (7%) booked at 12 - 17 weeks and one (3%) before 12 weeks pregnancy and one (3%) did not book for antental care at all. This is the same 12 year old school girl.

The findings in table 10 may explain the reasons why seven (23%) of respondents in table 13B said that they were not given any health talks, perhaps because they only attended the antenatal clinic 1 - 4 time as shown in table 12. Table 12 also shows that other respondents three (10%) had visited antenatal clinic 9 - 12 times while the majority (50%) of respondents their number of visits ranged from 5 - 8 time. Table 13B also demonstrates that the majority (73%) of those who ewere taught something at antenatal clinic, the topic of the health talk was on what to bring with them to hospital when they come for delivery.

Table 14 illustrates the responses of respondents as regards to whether or not they were welcome in the labour ward. Twenty five (83%) said yes they were welcome and only five (17%) said they were not received well.

Table 17 is about the responses of the respondents to whether or not there was somebody by the bedside all the time throughout first stage of labour. Sixteen (53%) of respondents said that there was nobody at the bedside all the time. Twelve (40%) said yes there was somebody, and two (7%) of the twelve accounted for those who delivered before arrival to hospital.

Table 17B indicates factors mentioned by respondents which contributed to not having anybody by the bedside. Out of sixteen (16) five (31%) said because nurses were very busy, another five (31%) said because they were few nurses on duty, and this attributed to shortage of staff in the University Teaching Hospital. One (6%) said nurses were not interested in her because she went to hospital instead of delivering in near by clinic where she was supposed to go.

Table 18 illustrates that out of sixteen (16) respondents who said were left alone most of the time, majority (56%) said that they were frightened and four (25%) said they were lonely and anxious. The total number of those who were frightened and those who felt lonely was 13 (81%) out of the sixteen who did not have anybody at their bedside all the time. These findings correlate with Myles statement that loneliness breeds fear.(9) Malinowski et al also said that loneliness is threatening especially in strange surroundings.[1]

Table 19 displays respondents views on what the midwife who was present at the bedside was able to do for them. in the first stage of labour.

The eleven (39%) out of twenty eight (28) who passed through first stage of labour said, that the midwife was able to rub the back and held and supported them. Seven (25%) said that the midwife was able to encourage and reassure them and four (14%), and another four (14%) said the midwife was able to listen and explain respectively. Two (7%) said nothing. However table 22A shows that twenty one (70%) of respondents were satisfied and happy with the emotional support given to them during this period of labour.

The reasons given for being satisfied with care given are shown in table 22B. Eight (38%) out of twenty one who said were satisfied expressed that they were happy and satisfied with care because they were touched, supported and their backs were rubbed, especially by the student midwives and student nurses. Five (24%) said they were happy because they were told what went on and they were encouraged. Another five (24%) said they were pleased because they were well treated generally and the nurses/midwives were friendly and

did not complain when they were called for help and nurses talked to the patients nicely. One (5%) indicated that she was very happy because she was never left alone. Another one (5%) pointed out that "I was happy and suprised because I did not expect the treatment I got this time, to come from U.T.H. I was treated far much better than I was treated the previous time I was here". This woman even revealed that she was actually reluctant to come to U.T.H. labour ward for delivery she wanted to go to the clinic instead, for fear of being exposed to the same bad treatment she had got the last time she had been in U.T.H.. This demonstrates clearly what is indicated in the literature review that past bad experience of childbirth affects the perception of subsquent childbirth and it influences behaviour of the woman concerned. (Romana et al)[5,6,7].

The most interesting respondent is the twelve (12) yearl old school girl, who said that what pleased her most was that she was given a 'lolipopo sweet' which the doctor promised to give to her if she stopped crying.

Out of 9 respondents who said that they were unhappy and dissatisfied with the emotional care give (Table 22C) two (22%) said that they were unhappy because the nurse midwife shouted at them. One said she was told that

"what am or I come and [illegible]." Other two (22%) said they did not know why they were given an. One (11%) said she had nobody to confide in to or express her fears to. Another one (11%) said she was left alone for too long. These support Rising's findings, in her study one respondent expressed that "I needed to express my fears to someone who will understand her I felt and give me support." Another [illegible] said that when she called for help [illegible], and when one happened to come I was told 'how can you talk when you are not ready to deliver.' Another one said I was told that 'this is no place to call your mother' when I was mentioning my mother as I cried because of pain'.

Table 23 illustrates that ten (30%) of respondents who called for majority indicated that the duration of their labour was too long. Six (20%) said it was long. Reasons for their responses are shown in table 23 and as follows: 1. because the labour was very painful (83%), 2. I did not know the out come of labour and because I was worried since I was told I had to go for operation.

Table 24 shows respondents' opinions about the care given during the second stage of labour (delivery). Twenty five (83%) of the number of respondents said that they were [illegible] the care given. That is all (100%) of those who went through the second stage of labour because five (17%) accounted for those

who delivered before arrival and those who went for caesarean section. Reasons for being satisfied with support given is indicated in Table 24B, as follows:

1. Those who said because they were supported physically and helped. Abdomines were touched to stimulate contraction ten.(40%).

2. They were told when to push and when not, five (20%).

3. They were encouraged and reassured that they were doing fine, "the baby is about to be born, you should push harder."

These women also stated that the encouragement gave them more strength. This seems to agree with Broadribb[22] statement that encouragement helps women to continue in their effort, and help mothers make best of their own strength.

In the same table 24B, four (16%) said that they were treated well generally and they were told about the condition of their babies.

The number of respondents who were satisfied with the care increased during delivery, and same reasons for satisfaction were given for both times. However, the increased number can be attributed to the fact that during second stage of labour usually women are never left alone.

The data obtained on emotional support given in labour and delivery (table 22 - 24) supported the hypothesis, that: There is a positive relationship between the quality of emotional support given to labouring mothers at U.T.H. and the mother's satisfaction with the care received. Although generalization of these findings would not be advisable because the sample was not randomly selected.

The table 25 shows that only 10 (33%) of respondents were given some health talks on care of themselves, and all of these were those who had their first babies because episiotomies (cut in perneum in order to enlarge opening of the birth canal) were made and they were instructed how to care for the wound. No health talk was given on care the care of the baby and on lactation, although five (17%) said that they were instructed to wash hands and breast before breast feeding. The total number of fifteen (50%) of total respondents said they did not have any health talk at all. There are may be many reasons why mothers are receiving inadequate health education, but the possible reasons could be that:-

1. The mothers do not stay in postnatal wards longer enough after delivery. They are discharged early due to fear of congestion in the wards.
2. Shortage of staff.

3. Lack of interest by midwives to give health talks.

Table 26A and 26B illustrates respondents time when they would go home and reasons given for time indicated. Majority (60%) indicated "tomorrow". They wanted to be discharged from hospital the following day after delivery. Seven (23%) said they would like to go home as soon as possible. These two category of groups gave the following reasons. Nine (30%) said that they want to go early because they missed their families. Seven (23%) said that they would like to look after themselves and babies properly at home. Another seven (23%) said they were feeling well and the babies werewell too. One (3%) said that "It is not nice for the baby to stay long in the hospital when it is no sick." Another one (3%) a 12 year old young mother said that she would like to go as soon as possible so that she could continue with her education. For those who were not sure when they wanted to go, five (17%) of respondents indicated that they were still sick and the babies were in premature baby care unit (011).

Table 27 shows that five (17%) of respondents when they were asked if there was any thing they would like to share with the interviewer they said that: They were very grateful with the care given in the labour ward, and asked the interviewer to pass their regards

to the labour ward staff and indeed to the U.T.H. staff. The remaining twenty five (83%) said had nothing to say.

2. NURSING IMPLICATIONS

Emotional support is one aspect of nursing care which is often overlooked. This is because emotional needs are not easily identified unless the nurse is interested in the patient as a person and as an individual. It is by being close to the patient and prepared to listen that will enable a nurse/midwife to identify these needs.

The study has revealed that closeness to the patient is the only way a nurse will be able to meet the emotional needs of the woman in labour, because it is by being at the bedside will the nurse be able to listen to patients complaints, fears and worries. It is by being by the bedside that she will be able to inform the patient of the progress of labour, her condition and that of the baby in the womb, and this will also give the nurse an opportunity to rub the patients back and hence give both physical and emotional support.

In the literature review of the study three team members who are necessary for giving this supportive care have been mentioned as being nurse/midwife, doctor, and relative. When the woman who is in labour comes to the hospital for delivery the closest

person of the three is the nurse, who should be with the patient all the time. This nurse should make herself available to the patient. Not only should the nurse be available but she should be friendly, empathetic, understanding, encouraging.

It has been found out through this study that midwives who attended to this group of respondents in U.T.H. labour ward were able to satisfy the majority (70%) of patients with emotional support. It is not advisable though to generalise these findings because:-

1. The sample was not randomly selected.
2. The sample size is not big enough to grantee generalization.
3. The sample did not include all the category of population equally.

Nevertheless, the findings of this study serve as an eye opener to nurses/midwives working in this labour ward, to identify what factors satisfy patients and which ones dissatisfy them.

These findings also give the general impression about how much quality care is given to labouring women in this ward. Therefore praise should be given to these nursing staff in this ward as to boost their morale.

The Nursing Service authorities of U.T.H. should take this opportunity for staff appraisal. In order to praise these staff for good work and warn those with bad behaviou and actions which Field called "destructors" of satisfaction.

Shortage of staff has been indicated as the major contributory factor to inefficient care. This should be brought to the attention of the authorities to do something about the shortage if they want to give quality care becausestaff shortage may be used as an excuse for giving poor care even where other factors may happen to be major contributors to poor patient care.

However, according to this study some areas where the nurse/midwife did not succeed to please the client were attributed to shortage of staff. For instance:

1. Leaving the patient alone during the first stage of labour.
2. Midwives having no time to explain to the patient what is being done to her and also no time to inform her about the progress of labour, condition of the baby and herself.

Other factors were:-

1. Nurses attitude towards the patients Mwale states that the nurses' attitudes and general personal

appearance if not checked contributes to further demoralization of the patient who is already undergoing other forms of stress."[2]

3. CONCLUSION OF THE STUDY

This study revealed a lot of insights for both the reader and the researcher. In this study it has been approved beyond doubt that labouring women come to the labour ward with a number of worries, fear of the unknown and anxieties. These emotional stresses are increased depending on how women are treated both physically and emotionally.

Some of the important needs for a labouring woman are compassion, companionship, friendliness, encouraging, comfort and relief of pain. The needs of these women are met by members of the team which includes, doctor, nurse/midwife and relatives. Among the three team members, nurse is the closest person to the patient, in hospital setting because she is always near the patient. Therefore this nurse should be friendly, empathetic, understanding, encouraging and reassuing.

It has been found out that the midwives of U.T.H. are able to give quality care to the extent of satisfying the consumers. These nurses should be

urged to continue (to those who have been doing well) and improve on some unfavourable behaviour and attitude to change for the better. Patients who come in hospital setting need the help of health peronnel as stated by Johnston that:

> Help me care about what happens to me I am so tired so lonely and very afraid. Tolk to me, reach out to me take my hand. Let what happens to me matter to you please nurse, listern.[3]

4. RECOMMENDATIONS

1. The authority of Nursing Care Services in U.T.H. should look into this problem of staff shortage and improve the situation in the labour ward.

2. The nursing personnel working in maternity should hold regular meetings with medical personnel in which latest approach to management of labour could be communicated to the people involved in the care of a woman in labour.

3. The meeting should be held in which findings of this study should be communicated to the members of the team including medical personnel who are part and parcel of emotional support givers. This will make everybody realise the need for these small actions and what they mean to the patients.

4. An extensive study should be conducted in which a bigger sample could be selected using random sampling method, after a stretched length of time, so that all categories of women will be represented to come up with appropriate inferences.

5. In-service and nursing training curriculum should also stress the importance of communication in nursing in order to implore the nurse's skill in this area, to enable them to communicate properly with patients and relatives.

6. The authorities of U.T.H. should allow patients' relatives to go as far as admission room of the labour ward. This is to enable the relatives to get correct information about the patient e.g. when she is likely to deliver, where to find her after delivery et cetera.

5. LIMITATIONS OF THE STUDY

1. Lack of literature on the emotional support of woman in labour.

2. Inadequate time was allocated to conduct the study due to other academic pressures this resulted in limiting the sample to only thirty (30) respondents. The Researcher is of the opinion that for any person to conduct a

good study one would need more free time, free from other pressures of work. In addition, only one study should be conducted at a time. Three studies were too many to be conducted in one academic year.

3. Language - translation of the questions of instrument into local languages which respondents could understand, and also interpreting responses from local language to English was time consuming and a bit difficulty.

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SEMI STRUCTURED INTERVIEW SCHEDULE

I. DATA FROM RECORDS

SUBJECT NO. CODING

Date of Admission _____ Time

Date of delivery _____ Time

1. Age group

15 - 19	a	
20 - 24	b	
25 - 29	c	
30 - 34	d	
35 and above	e	

2. Residential area

Low density	a	
Medium density	b	
High density	c	
Squatter	d	

3. Parity group

Primapara	a	
Multipara	b	
Grande multipara	c	
Other specify	d	

4. Type of delivery

Spontaneous vertex delivery	a	
Forceps	b	
Vacuum	c	
Breech extraction	d	
Other specify	e	

SUBJECT NO. CODING

5 Baby's condition at birth (Apgan Score)

0 - 2 a

3 - 4 b

5 - 7 c

8 - 10 d

6. Birth weight

1.100kg - 1.700kg a

1.800kg - 2.500kg b

2.600kg - 3.400kg c

3.500kg - 4.00kg d

Above 4.00kg e

II INTERVIEW

A Social and Obstetrical Histories

7. What is your domination?

Roman Catholic a

Anglican b

United Church of Zambia c

Jehovah's Witness d

Seventh Day Adventure e

Other Specify f

8. What education level did you complete?

Grade 1 - 7 a

Grade 8 - 9 b

Grade 10 - 12 c

College d

University e

Other specify f

Housewife a

Teacher b

Nurse c

Secretary d

Self employed e

Other specify f

10. What is your marital status?

Married a

Single b

Separated c

Divorced d

Widowed e

11. How many living children to you have ?

(i) Boys 1 - 3 a

4 - 6 b

7 and above c

None d

(ii) Girls 1 - 3 e

4 - 6 f

7 and above g

None h

12. How many miscarriages have you had?

None a

1 - 3 b

4 - 6 c

7 - 8 d

10 and above e

SUBJECT NO. CODING

13. How many still births have you had?

None	a	
1 - 3	b	
4 - 6	c	
7 - 8	d	
10 and above	e	

14. Where did you deliver your babies?

Hospital	a	
Clinic	b	
Home	c	
Other specify	d	

15. Did you attend antenatal clinic with the previous pregnancy?

Yes	a	
No	b	

16. If the answer in question 15 above is Yes at how many weeks of pregnancy did you book?

Before 18 weeks	a	
12 - 17 weeks	b	
18 - 29 weeks	c	
30 - 35 weeks	d	
35 weeks and above	e	

17 How many visits did you make to the clinic?

1 - 4	a	
5 - 8	b	
9 - 12	c	
13 and above	d	

SUBJECT NO. CODING

18. What health talks were you given in relation to labour and delivery?

What to bring to hospital when you come to deliver.	a	
When to come to hospital for delivery	b	
Position in bed in the first stage of labour and why?	c	
Signs of labour	d	
Position in 2nd stage	e	
When to start bearing down	f	
All of the above	g	
None of the above	h	

B. ADMISSION AND 1ST STAGE OF LABOUR

19. Who accompanied you to the admission room of the labour ward?

Husband	a	
Mother	b	
Sister	c	
Friend	d	
Other specify	e	

20. How were you received by the midwife/nurse on arrival.

_____

_____

_____

21 What did the midwife/nurse tell your relative before he/she left the ward?

Your progress of labour	a	
Your general condition	b	
When you were likely to deliver	c	
Visiting hours	d	

SUBJECT NO. CODING

What to bring you when they come e

Where to find you f

All of the above g

None of the above h

22. What would you have liked the midwife/nurse to do on completion of admission.

_____

_____

_____

23. Was there some one at the bedside all the time throughout 1st stage of labour?

Yes a

No b

24. If answer for question 23 above is no, how did you feel when you were left alone.

Frightened a

Lonely b

Other specify c

25. If answer is no for 23 above what was the reason for not haveing any body by your bedside.

_____

_____

_____

26. If answer for question 23 above is yes, was the midwife/nurse at your bedside able to:

Listen a

Explain where required b

Encourage you c

Reassure you d

Touch you or give back rub e

None of the above f

SUBJECT NO. CODING

28. If any of the above measures were done what exactly did the midwife/nurse do or say

_____

_____

_____

29 Were any of the following done to you during 1st stage of labour:

Given some sips of water to drink or to moisten your lips	a	
Cooling your forehead, neck and with a dump cloth	b	
Wiping your sweat	c	
Clean your vulva and change linen and pads	d	
Empty your bladder or encourage you to empty the bladder	e	
Given you injection to relief pain	f	
All of the above	g	
None of the above	h	

30 If any of the above was not done what could have been the reason for not doing them.

Nurses were very busy	a	
I was not allowed to take any thing orally	b	
I did not stay long before delivery	c	
Any other specify	d	

31. What was your reaction an inner feeling to the treatment or explanation given from time admission to the end of of 1st stage of labour.

Happy	a	
Unhappy	b	
Satisfied	c	
Dissappointed	d	
Other, specify	e	

SUBJECT NO. CODING

32 Give reason for your answer in question 24 above.

_____

_____

_____

33. How did you find the duration of the 1st stage of labour?

Too short	a	
Short	b	
Too long	c	
Long	d	
Other specify	e	

34 Give reason for your answer in question 33 above.

_____

_____

_____

35 Were you worried about the outcome of of your labour?

Yes	a	
No	b	

36 If answer is yes for 35 above give reasons for your worry.

_____

_____

_____

C 2ND STAGE AND DELIVERY

37. Were you pleased or displeased with the way you were treated during delivery?

Yes	a	
No	b	

38 Give reason for your answer in question 37 above.

_____

SUBJECT NO. CODDING

39 What did you hear the midwife/nurse say to you or to anybody else during the process of your delivery?

_____

_____

_____

D PUERPERIUM

40 What have you been taught after the birth of the baby about:

(a) the care of yourself?

_____

_____

_____

(b) the care of the baby?

_____

_____

_____

41 Are you breast feeding your baby?

Yes a ☐

No b ☐ ☐

42 What were you taught on the;

Care of the breast:

_____

_____

_____

On lactation and promotion of lactation?

_____

_____

_____

43 When would you like to go home?

_____

_____

SUBJECT NO. | CODING

44 Give reason for answer for question 43 above.

_____

_____

_____

45 Any other information you would like to share with me about your stay in hospital.

_____

_____

_____

End of Interview

THANK YOU

APPENDIX 2

APPENDIX 2

The University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O. Box 50110
Lusaka

1st March, 1988

The Principal Nursing Officer
The University Teaching Hospital
Box 50001
Lusaka.

Dear Madam,

RE: RESEARCH PROJECT IN POSTNATAL WARDS ON:-

"EMOTIONAL CARE AND SUPPORT GIVEN TO LABOURING WOMEN."

I am a 4th Year BSc student in the Post Basic Nursing Department. I am required to carry out a research project in Midwifery (as indicated above) for partial fulfilment of the course requirements.

In order to collect data, I will need to interview patients in a postnatal ward. The duration is from March to May 1988.

I am hereby seeking your permission to carryout my study in the postnatal wards of the University Teaching Hospital.

Your assistance will be greatly appreciated.

Thank you in anticipation for a favourable reply.

Yours faithfully

M M Kwendakwape

Monica Mutale Kwendakwape (Mrs)

c.c. Nursing Officer, Maternity Department

c.c. Head, Post Basic Nursing Dept.

APPENDIX 3

University Teaching Hospital

PRIVATE BAG RW 1
LUSAKA, ZAMBIA
Tel.:211440, 218881

~~OFFICE OF THE DIRECTOR~~
OFFICE OF THE PRINCIPAL NURSING OFFICER

Ref: UTHB/PNO/05/01

Ref:

7th April, 1988

Ms. Monica Mutale Kwendakwape
School of Medicine
Department of Post Basic Nursing
P.O. Box 50110
LUSAKA.

Dear Ms. Kwendakwape,

RE: RESEARCH PROJECT IN POSTNATAL WARD ON "EMOTIONAL CARE AND SUPPORT GIVEN TO LABOURING WOMEN

I am in receipt of your correspondence of 1st March, 1988 in which you requested this office for permission to carry out your study in the above mentioned wards.

I have no objection, you can go ahead, but you should liase with the Nursing Officer - Maternity Department.

I wish you all the best in you undertaking.

I am sorry to take so long in replying,this was due to circumstances beyond my control.

Yours sincerely,

M.S. Ng'ambi (Mrs)
DEPUTY PRINCIPAL NURSING OFFICER

c.c. Head of Department - Post Basic - UNZA

MSN/al

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