ARTICLE

WOMEN'S PERCEPTIONS OF HOSPITAL-BASED POSTNATAL CARE FOLLOWING A NORMAL VAGINAL DELIVERY IN KWAZULU-NATAL, SOUTH AFRICA

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ABSTRACT

It is common practice globally for women to be discharged from a health facility within twenty-four to forty-eight hours after a normal vaginal delivery. The purpose of this article is to explore postnatal women's perceptions of hospital-based postnatal care following a normal vaginal delivery. This qualitative study used content analysis and was carried out in the postnatal wards of two hospitals in the eThekwini District of KwaZulu-Natal, South Africa. The researcher conducted individual semi-structured interviews with 20 women. The categories that emerged from the data collected were: questioning my ability, fending for oneself, insufficient information, and unacceptable staff behaviour. From the data collected, it is suggested that further studies be done to ensure the opportunity for women to receive optimal and comprehensive midwifery care during the postnatal period in the ward, as well as for the continuity of care post-discharge.

Keywords: postnatal care; normal vaginal delivery; perceptions; content analysis

BACKGROUND

It is common practice globally for women to be discharged from a health facility within twenty-four to forty-eight hours after vaginal delivery. In Africa, and more specifically in South Africa, a woman is discharged as early as six hours post-delivery, if it is not her first delivery, and if she is considered to be in a stable condition following examinations done on both her and the baby. Postnatal care (PNC), particularly in low- and middle-income countries, became the focus of the World Health Organization (WHO) in 1998

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and it remains the focus in midwifery even today (WHO 2014). The provision of skilled nursing care is often reduced during the postnatal (PN) period as compared to the care during pregnancy and labour, despite maternal morbidity (due to factors such as haemorrhage, infection, anaemia and depression) and infant and maternal mortality (MM) rates reported as being the highest during the PN period (WHO 2014).

One of the strategic goals of global health today is the reduction of MM (Landes et al. 2012). Global statistics on maternal deaths indicate that there were an estimated 342 900 maternal deaths worldwide in 2008, a decrease from 526 300 in 1980. There would have been an estimated 281 500 maternal deaths in 2008 worldwide in the absence of the human immunodeficiency virus (HIV) (Hogan et al. 2010, 1609). High MM rates continue to be reported in countries in sub-Saharan Africa, linking these reports to the HIV pandemic. The total number of maternal deaths in South Africa for 2007 was 764 per 100 000 live births. Provincial level estimates in South Africa of MM in 2007 (computed from registered deaths in 2007, based on ICD-10 codes), indicated the percentages of maternal deaths related to certain conditions or causes. In KwaZulu-Natal, it was found that 4.7 per cent of these maternal deaths were related to maternal haemorrhage, 6.6 per cent to maternal sepsis, 9.6 per cent to hypertensive disorders, 0.2 per cent to obstructed labour, 5.9 per cent to abortion, and 73.0 per cent to other maternal conditions. The total number of deaths in KwaZulu-Natal was reported as 969 per 100 000 live births (Udjo and Lalthapersad-Pillay 2014, 517). Pregnant women who are HIV positive are at a greater risk of complications during pregnancy, thereby increasing their risk for complications during the PN period (Landes et al. 2012).

Despite MM (due to factors such as haemorrhage, infection, anaemia and depression), infant and MM rates are reported as being the highest during the PN period (WHO 2014). Current literature argues that PNC, specifically hospital-based care, is often a neglected service delivery area as women in the PN wards felt that the midwives were too busy, rushed and difficult to make contact with (Mahiti et al. 2015). These women felt that this was the most neglected period for the provision of quality care, as information pertaining to infant feeding and the immediate care of the infant was the main focus, and therefore their emotional needs and long-term health needs were neglected (WHO 2014). Specifically, researchers argue that PNC is rarely recognised as a critical part of effective child and maternity care (De Souza et al. 2012). These authors suggest that the delivery of a healthy baby is seen as the final outcome of a pregnancy. The mother's role in this process is only viewed in the context of the well-being of the baby (De Souza et al. 2012). Henderson et al. (2016) recommended the review of PN clinical guidelines to ensure PNC that is relevant and appropriate to PN women's individual needs.

STATEMENT OF THE RESEARCH PROBLEM

Post-delivery, it is perceived there is no longer a need for the same or similar type of care rendered in the PN ward, the care is not focused on women as individuals with individual needs, compared to the care rendered in the labour ward. Midwives in the PN wards are viewed by the women as being friendly, approachable and encouraging, but are also seen as being too busy, and not always available when needed (Fenwick et al. 2010, 18). Concerns about infant feeding and reproductive health, and/or questions that these mothers may have are not always dealt with (Danbjørg, Wagner, and Clemensen 2014, 731; Fenwick et al. 2010, 19). Care given to the women in the PN ward is often not individualised or specific to the women's needs, and midwives are not always consistent with the information that they give to the women. The women felt that the midwives did not have time to listen to them. Thus, the midwives were missing out on the opportunity to ask the women what they may or may not know, or what they may need assistance with (Fenwick et al. 2010, 20; Ong et al. 2014, 776). First-time mothers' need for support pertaining to infant care, breastfeeding, emotional support and cultural practices is often neglected (Ong et al. 2014, 777). Researchers concluded that the PN women felt that the focus of PNC was more specifically on the immunisation of their babies; they were unsure about the care that they were supposed to receive (Rwabufigiri et al. 2016, 7; Tesfahun et al. 2014).

PURPOSE OF THE STUDY

The purpose of the study was to explore PN women's perceptions of hospital-based PNC following a normal vaginal delivery. This was part of a larger study conducted in two public hospitals in KwaZulu-Natal, South Africa, to develop a PN discharge protocol for nurses and midwives to guide the discharge of women from the PN ward.

RESEARCH METHODOLOGY

This study used a qualitative research design that applied content analysis (Graneheim and Lundman 2004, 106).

RESEARCH SETTING AND PARTICIPANTS

The research was carried out in the PN wards of two state hospitals in the eThekweni District of KwaZulu-Natal, which is an urban area. These hospitals were chosen as they are busy state hospitals within the eThekweni District, with a large volume of women accessing these facilities for pregnancy and delivery purposes.

The research participants were women whose babies were born alive, and were well enough to be with them in the PN ward. The researcher made use of non-probability purposive sampling, and inclusion criteria comprised women who must

have had a normal vaginal delivery, they had to have a healthy infant both physically and psychologically as determined by the doctor's examination, and they had to be ready to be discharged from the hospital. The exclusion criteria comprised women who had a caesarean section or an assisted delivery, women who were not well physically and/or psychologically, and women whose babies were not well, and were nursed away from them after delivery.

DATA COLLECTION PROCESS

After obtaining ethics approval and permission from the research settings, the researcher (CW) made appointments with the managers of the PN wards to discuss the research study. Permission was granted by the unit manager of each ward in order to arrange for data collection. The women were recruited after the unit manager has identified women who have had vaginal delivery, and were examined and discharged by the doctor. The researcher then approached the women individually, and discussed the possibility of interviewing them while they waited to be collected from the hospital. The researcher informed the research participants about the proposed study in a language that they understood, requesting them to sign and date the consent form provided. Before the study the researcher requested permission for the interviews to be audio-taped. Individual interviews were held with each PN woman for approximately 20–30 minutes per interview in a private room adjacent to the ward where the PN women were admitted. An interview form that was developed by the researcher, with semi-structured open-ended questions, was used. The women were asked about their experiences of being admitted and discharged from the PN ward. The researcher was aware of the fact that these newly discharged women were potentially very vulnerable, and was very aware of monitoring for any signs of emotional distress or problems such as crying during the interviews. The researcher has fifteen years of experience working with PN women, and has the necessary skills to be able to recognise such emotional distress. If discovered, the researcher would have terminated the interview immediately and would have brought this to the attention of the unit manager who then would have referred the women to the appropriate psychosocial resources within the hospital. This, however, was not required. Data were collected during October 2015.

DATA ANALYSIS

Interviews with the PN women were recorded and transcribed verbatim by the researcher. Data were analysed using manifest qualitative content analysis. Data were collected until no new information was uncovered (Graneheim and Lundman 2004, 107). The data collected from the PN women interviews were read through a few times to determine a sense of the whole (Graneheim and Lundman 2004, 108). The information was probed until data were saturated to determine whether any new information was emerging from

the data collected. Any patterns noted in the data were identified. The text was then broken down into smaller units, known as meaning units, which conveyed one central meaning. The meaning units were then shortened, ensuring that the central meaning was not lost, into what is known as condensations. Each condensation was labelled with a code. Depending on the relationship between the codes, categories were used to group these condensations. Categories were then created to link the relevant data segments to each other (Graneheim and Lundman 2004, 108).

RIGOUR

The researcher in this study used strategies as proposed by Lincoln and Guba (1985, 290) to ensure the trustworthiness of the data. Use was made of independent coding to ensure credibility. An effort was made to assure readers that any claims made had strong enough support in the data (Graneheim and Lundman 2004, 110). Sufficient detail was provided concerning the research process to ensure transferability, allowing those wishing to transfer the results to a different context the opportunity to do so. In order to strengthen the concept of transferability, the inclusion of a rich and effective presentation of the study findings was ensured, with appropriate quotations from the individual interviews (Polit and Beck 2010, 1453). To ensure dependability, the researcher analysed the collected data and reviewed the supporting documents from the field notes written during the individual interviews. Dependability was maintained by the storage of the data collected (Shenton 2004, 71).

ETHICAL CONSIDERATIONS

Ethical approval was obtained from the Research Ethics Committee of the University of KwaZulu-Natal (HSS/0713/015M). Permission to conduct the research and to access the participants was obtained from the management of the respective hospitals. After receiving information regarding the proposed research, participants were requested to provide written consent to participate in the study. They were informed that they could withdraw from the study at any stage and that the data could not be traced back to individuals. Once the de-identified data were transcribed and stored, the researcher ensured that the data were locked away in a secure place, and that only the research team had access to the data.

FINDINGS

There were 20 PN women who participated in the study and their demographic data are illustrated in Table 1.

Table 1: Demographic data of participants

Study code	Age of participant in years	Number of children alive	Support or assistance at home
(H2 PNW1) Hospital 2 Postnatal Ward 1			
PN Woman 1	20	1	Yes
PN Woman 2	19	2	Yes
PN Woman 3	16	1	Yes: Mother
PN Woman 4	22	2	Yes: Mother
PN Woman 5	37	4	Yes: Mother and sister
(H2 PNW2) Hospital 2 Postnatal Ward 2			
PN Woman 1	30	2	Yes: Neighbour with a crèche
PN Woman 2	23	2	Yes: Mother
PN Woman 3	26	1	Yes: Sister
PN Woman 4	25	2	Yes: Mother and mother-in-law
PN Woman 5	23	1	Yes: Mother and three sisters
(H1 PNW2) Hospital 1 Postnatal Ward 2			
PN Woman 1	21	2	Yes: Mother
PN Woman 2	16	1	Yes: Partner and her parents
PN Woman 3	21	1	Yes: Sister
PN Woman 4	25	2	Yes: Sister
PN Woman 5	23	1	Yes: Mother and aunt
(H1 PNW1) Hospital 1 Postnatal Ward 1			
PN Woman 1	32	2	Yes: Mother and aunt
PN Woman 2	33	3	Yes: Grandmother
PN Woman 3	23	2	Yes: Mother
PN Woman 4	20	1	Yes: Mother
PN Woman 5	34	2	Yes: Partner

Four categories emerged from the data, namely questioning my ability, fending for oneself, insufficient information, and unacceptable staff behaviour.

Questioning my ability

One of the participants felt that the nursing staff assumed that she would not be able to take care of her baby as she was a young mother:

> Ah, they, they, they, they think that I cannot take care of my child. (H1 PNW2 PN Woman 2)

One of the participants explained further that the nurses felt that they had to remind her to feed her hungry baby:

> She said don't forget to feed our [your] baby if our [your] baby is hungry. (H2 PNW2 PN Woman 3)

The participants explained how they felt that the staff did not trust that they would be able to handle or identify any problems experienced at home, and that is why they were rather advised to just go to the clinic. Two participants explained:

> I must make sure each and everything that happens to the baby, I must take it to the local clinic. (H1 PNW1 PN Woman 1)

> They told us if we meet any problem we must come back to the nearest clinic. (H2 PNW2 PN Woman 5)

Another participant had this to say:

> And then they say everything is fine, but they never tell me what I'm gonna do if I go home, or if I see symptoms like this, or something like that, I must come to hospital. (H1 PNW1 PN Woman 5)

Fending for oneself

The participants felt that those of them who delivered vaginally were usually left alone to take care of themselves; they were only attended to by the nursing staff if they experienced any problems. They felt that the nurses were busy helping others in the ward, and that they had to shout if they needed assistance or had a problem. They felt that there is a need for nurses to listen to what they had to say. The participants said:

> They take long to respond … They didn't even mind us. (H1 PNW2 PN Woman 5)

> The breakfast came, we ate the breakfast, finish. But the nurses were helping the other people, only they ask us, if we have a problem, just shout. (H1 PNW1 PN Woman 5)

Another participant explained what she thought should rather be happening:

> I think that there is something that they should do, not a lot, but something they should do. They must come and check and hear what you say, or see, not to take their time. (H2 PNW1 PN Woman 4)

Insufficient information

The participants explained that the information given was insufficient and sometimes caused confusion. A participant felt that not much was done in the way of preparing them for discharge, as is noted in the following quote:

> They don't prepare you much, besides them asking you questions like, mm, questions as if, mm, are you okay? You're going home? So that they can open up spaces for the bed. (HI PNW2 PN Woman 5)

The participants were not given sufficient information concerning their or their babies' health status. A participant said:

> I can't say anything now because they still doing some results, so I am not sure. (H2 PNW1 PN Woman 2)

Another participant had some doubts as to whether what she had been told was sufficient for what she needs to know:

> I could say they give us enough information, for me it's enough, maybe … I think. (H2 PNW2 PN Woman 5)

Some participants felt that the doctors did not speak much, or that they did not have much contact with the doctors:

> The doctor didn't talk much. He just asked how I felt. (H2 PNW1 PN Woman 3)

And another participant said:

> Most of the time we don't speak to the doctors, more often. We only spoke to the sisters. (H2 PNW1 PN Woman 5)

Unacceptable staff behaviour

The participants described occasions when they felt that the doctors or nurses did not behave in what they felt was a professional manner. A participant said:

> She, the nurse, asked me why I didn't go home yesterday, 'cos they discharged me yesterday. (H2 PNW2 PN Woman 2)

A participant went further to explain that she felt the staff were rude. She said:

> But I was not happy for [with] the fact that we not shown our children … I was not happy about it, and also the way the nurse[s] were treating the people, they, it's mmm, the way they [were]

> very rude. It's like they don't have [the] patience to deal with the patients. They don't take the courtesy to, to, to like, to treat us better as human beings … they will shout at you as if you like, you don't have feelings … and they'll be so rude at you. (H1 PNW2 PN Woman 5)

In response to the researcher asking a participant if she felt that there were certain things that can be improved in the care that the staff give in the ward, and whether she thought that what was done for her was sufficient, the participant replied:

> Ja, I think there is.
>
> No, it's not enough. (H1 PNW1 PN Woman 5)

DISCUSSION

The participants in this study felt that the nursing staff assumed that they would not be able to take care of their babies or handle any problems. They were advised by the nursing staff to go the local clinic if they experienced any problems. Researchers concluded in a study conducted in Malawi that PN women returned for a PN visit because they were told to do so, and to ensure that their babies were examined. They did not realise the importance of attending a PN visit to ensure that they were well (Adams et al. 2017). Razurel et al. (2011, 242) stated that new mothers must be reassured of their ability to care for their babies, allowing them to demonstrate the necessary skills and to avoid them feeling less than adequate as new mothers. In the current study, the participants explained how they felt excluded from the decision-making process when deciding on the care of their babies, including identifying whether their babies were well. To some extent, they were dependent on the nurses and midwives, but felt that they could make certain decisions regarding their babies. Midwives have a responsibility to ensure that new mothers are involved in the care of their babies so that they are able to make decisions concerning such care (Razurel et al. 2011, 242).

In the current study, the participants believed that if the nurses were more involved with them as new mothers, things would improve. They felt that they were perceived as being well post-delivery and capable of taking care of themselves because they had delivered vaginally, thus not requiring much care. In a study done in a private hospital in Victoria, Australia, the midwives felt that they were actually assisting new mothers by allowing them to do things for themselves (Rayner et al. 2013, 626). In nursing, and specifically in the PN wards, women are expected to take care of themselves and their babies, and to prepare themselves for their discharge. The participants in the current study stated that the nurses only listened to them if they experienced problems. They were not given much attention and they had to shout for assistance from the nurses. In a study done in Geneva, Switzerland, similar findings were reported; the participants were left alone to care for their babies, and when requesting assistance they were disappointed by the responses they received from the midwives (Razurel et al. 2011, 242).

At times, the participants in the current study found themselves confused when conflicting information was given to them. The participants were also uncertain about the correct things to do when they go home, as they felt that the information given to them was also not sufficient. The women felt that not much was done to prepare them to go home. In a study done in a teaching hospital in New York City, PN women agreed that the information they received was insufficient to prepare them for once they were discharged and at home (Martin et al. 2014). In a study conducted in a tertiary hospital in Vadodara, India, researchers concluded that the success rate for the early initiation of breastfeeding and maintenance of exclusive breastfeeding is low, as PN women are not adequately educated on breastfeeding practices (Shwetal et al. 2012, 309). The participants in the current study expressed their unhappiness concerning certain aspects of the care received because at times the doctors did not talk much about self-care and baby care at home. In a study done in the South of England, it was reported that many women felt that improvement in certain aspects of PNC was necessary, including providing information that was relevant and appropriate to assist them at home (Beake et al. 2010).

The participants in the current study also reported that the midwives were rude to them. In a study done in Malawi, participants also reported that healthcare workers were rude and shouted at them, displaying negative behaviour (Kumbani et al. 2012). In the current study, the participants felt that the doctors and nurses were not always conducting themselves in a professional manner. In a study done in Tanzania, PN women reported that the disrespectful attitudes of healthcare providers determined whether they would seek maternal care for future pregnancies (Mahiti et al, 2015). The participants in the current study felt that at times the staff were rude to them, and this led to them feeling very unhappy and dissatisfied. They felt that something should be done to improve the care given to them. In a study done in Sweden, researchers reported that PN women were not made to feel welcome in the ward (Hildingsson and Sandin-Bojö 2011, 743). In a study done in Malawi, researchers concluded that PN women's perceptions of negative experiences would determine whether they would seek care after discharge (Adams et al. 2017).

LIMITATIONS

The research was conducted in only two state hospitals; the experience in private hospitals might possibly be quite different. Another limitation of the study was that the research design used was purely qualitative. The participants may have been reluctant to report negative experiences as the researcher conducting the interviews was a midwife.

RECOMMENDATIONS

Clear guidelines that deal with PN maternal and newborn care need to be developed, to facilitate the care for women and babies in the immediate PN period. Refresher training courses for nurses and midwives on maternal and neonatal healthcare, specifically PNC, are recommended. This study may encourage other researchers to undertake research pertaining to PNC to ensure positive outcomes for all women and babies. Research that looks specifically at doctors, nurses and midwives' perceptions of PNC is necessary.

CONCLUSION

The PN women in this study were able to discuss how they perceived PNC after vaginal delivery. Feelings of dissatisfaction were expressed and they felt that they were not given enough information to adequately prepare themselves for self-care and baby care at home.

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