JHER Vol. 25, No. 1, September, 2018, pp. 176-183

Intra-Partum Care Practices among Child Bearing Mothers: Role of Special Educators

Adama G. N.
Department of Educational Foundations
University of Nigeria, Nsukka

Abstract

The major purpose of the study was to investigate the practice of intra-partum care among child bearing mothers attending maternal and child health (MCH) clinics in Nsukka health district. Specifically, the study determined the mothers' use of pain reduction, hygiene materials, hospital facilities, consultation with midwives and doctors in intra-partum care. It tested one hypothesis at 0.05 level of significance. Survey design was used. Data were collected using questionnaire. A total of 363 childbearing mothers (CBMs) participated in the study. Data were analyzed using percentages and Chi-square (X^2). Findings revealed the various types and numbers of intra-partum care practices the mothers use: pain reduction (four); personal hygiene (five); consultation withmidwives and doctore (four); and use of hospital facilities (four). Based on this, the study recommends the involvement of special educators in maternal and child health clinic to promote intra-partum care practices.

Keywords: Intra-partum, Care, Mothers, Disability, Child Health.

Introduction

Intra-partum care is service rendered to pregnant women in labour and delivery period. Labour is childbirth or parturition which comes with uterine contractions associated with pain at waist, lower abdomen and at times rupture of membrane or baby's sac. Labour takes place in three stages: namely dilatation of the cervix uteri, passage of the child through the birth canal and expulsion of the placenta (Memon and Handa 2013). Labour pain could be reduced through various ways. Immersing in water is one of the ways to manage pain during labour in addition to Tens machine, gas and air, pethidine injection, deep breathing, massage and epidural anesthesia. Royal College of Midwives (1994). In developed countries hospitals are encouraged to ensure that birth pools are available to all women. These practices remain a mirage in developing countries due to some seemly factors like culture, belief, ignorance among others. (Leap, Dodwell Mirenada, New born & Mary, 2010).

Maternal and fetal infections have been reported due to poor personal

hygiene exhibited by mothers and attending midwives handling the mother in labour. The mother is expected to put clean pad on the vulva while in labour. Put on clean wrapper. The delivery surface should be covered with delivery mat and mother draped with sterilized delivery cloth. The midwife attending to the mother in labour should wear face mask and put on hand gloves that will reach to the elbow before delivering a woman in labour. These precautions aim at preventing infections or further infections to mother, baby and midwife or doctor attending to the woman in labour. The government also stepped into wedging war against maternal and fetal infection in 2005 with birth preparedness and complication readiness (B/P/CR) programme aimed at promoting timely utilization of skilled health care services (Iliyasu, Abubakar, Galadanci and Aliyu, 2010). This programme went a long way in creating awareness to personal hygiene and consequences of not maintaining it during child delivery.

In 2015 there were about 135 million births globally (The World facebook, 2016). About 15 million were born before 37 weeks of gestation (WHO, 2015) while between 3% and 12% were born after 4 weeks (Buck and Paltt, 2011). In the developed world most deliveries occur in hospitals while in the developing world most births take place at home with the support of a traditional birth attendant or at a health post (Fossard and Bailey, 2016). Recent antenatal records showed that most deliveries were conducted in health post and general hospitals than in federal hospitals. One of the reasons why mothers patronize general hospitals or health post could be due to nearness to them. Again, federal hospitals are used as referral centres in case of any complication. Mothers can deliver through several ways to ensure alive mothers and alive babies.

The most common way is through vaginal delivery. At times caesarean section may be recommended due to some factors such as fetal or maternal distress, multiple pregnancies such as twins, triplets, quadriplets and so on, breech presentation, cord prolapsed while in early stage of labour, cephalo pelvic disproportion among others. Vacuum delivery and forceps deliveries could also be opted for women with maternal distress but rarely used due to their untold effects on babies. Some of the pros and cones of vacuum and forceps deliveries include injury to the scalp, brain and shoulder dislocation which may lead to erb's palsy. Brain injury may lead to cerebral palsy among others.

These processes women pass through, during labour calls for specialist in different fields that will render help to minimize complications. The service of a special educator cannot be over emphasized because of composition of women in labour. The hearing impaired women in labour need a special educator to relay the instruction given during labour and delivery of baby. The special educator is needed at any point in time of labour process to interpret the rudiments of labour process. This

well help the women get relaxed, belong and empowered to deliver babies safely. Many maternal and child death and complications may be geared toward poor practice of labour process before the actual delivery takes place. The disabled women in labour need assistance from special educator that understand their need, speak their language and in good relationship with them to enhance relaxation as well as safe delivery. Not only that respiratory therapists work as educators in Asthma clinics educating people who are suffering from heart and lung problems. The respiration therapist assist an Asthmatic in labour to initiate condusive environment for delivery of baby. The therapist knows when the mother in labour needs aids for ventilation. Hence the respiratory therapist is needed to avoid intracranial emergencies due to lack of oxygen which may lead to intellectual disability or even death of unborn child or neonatal death (respiratory therapist, 2017) Intra-partum care necessitates the need for drugs, equipment facilities and properly trained medical personels (Daly Azefor Nasah, 1993).

In a study conducted by Langer, Farnot, Garcia, Barros Victoria, Belizan and Villar 1996 in Latin America on Effect of Psychological support on pregnant women well being and satisfaction. The result of the study indicated that women in the intervention or treatment group showed a statistically significant better knowledge of seven of the nine alarm signs considered and of two of the three labour-onset signs required. Furthermore, no differences between groups were observed in improvement in diet, utilization of hospital facilities for delivery.

Research was also carried out by Bello, Gummi, Hassan Shehu and Audu (1997) on impact of community education on use of emergency obstetric services in Kebbi state Nigeria using focus group discussion. The findings revealed that the community awareness of the causes of maternal death, nature of obstructed labour, signs of pre-eclampsia, need for prompt treatment increased.

Olusanya, Okogbo, Momoh Okogbenin and Abebe (2010) conducted a study on maternal morality and delay; socio-demographic characteristic of maternal deaths with delay in Irrua Nigeria. The study accessed the contribution of delay to maternal deaths and also determined the socio demographic characteristics of patients with maternal deaths associated with delay. The result indicated mortality ratio of 1747/100, 000 live births. Delay was associated with (77.8%) of all maternal deaths. Type 1 delay was the major problem contributing (57.1%). The result also identified risk factors for delay as unbooked status socio economic status and martial status.

Each year complications from pregnancy and child birth results in about 500,000 maternal deaths, 7 million women have serious long term problems and 50 million women have health negative outcome following delivery, 15 such complications

include obstructed labour, post partum bleeding, eclampsia, post partum infection. Health problems among babies include respiratory distress, jaundice, low blood sugar and so on.

In the developing countries the rate of death is more of which Nigeria is inclusive. The ugly scenario calls for urgent research like this present study.

Purpose of Study

The main purpose of the study was to investigate the level of intra-partum practice among childbearing women attending MCH clinics. Specifically the study determined levels of practice of the following by the women:

1. Use of pain reduction.
2. Use of hygiene material for personal hygiene.
3. Consultation with midwives and doctors.
4. Use of hospital facilities.

Research Questions

What is the level of practice of:

1. pain reduction practice of childbearing women during intra-partum stage?
2. personal hygiene of childbearing mother during intra-partum period?
3. medical consultation of childbearing women during intra-partum period?
4. hospital facilities used during childbearing period?

Methods

Area of the Study: The study was carried out in Nsukka Health District in Enugu state Nigeria. There are 15 clinics in the area. There are 8 clinics in the rural area and 7 clinics in Urban area.

Design of Study: A cross sectional survey research design was used for the present study.

The Population for the Study: The population was made up of 923 registered pregnant women in the Urban and rural clinics. The population comprised of mostly women who have under gone through basic education, post basic education and tertiary institution (Nsukka Health District Board, 2016).

Sample for the Study: The sample was made up of 12 functional clinics that were purposively selected. The subjects were selected from antenatal register, using systematic random sampling, 31 respondents from each of the 12 sampled antenatal clinics were selected. Sample of 372 pregnant women representing forty percent of the population were utilized for the study.

Instrument for Data Collections: The instrument used for the data collection was structured questionnaire. It was developed based on research questions and literature review.

It was face validated by three experts. The reliability co-efficient of the instrument was .82.

Data collection: A total of 372 copies of the questionnaires were distributed by hand. Only 363 copies were properly completed and retrieved. This represents 97.58 percent return.

Data analysis: The data were analyzed using percentages from answering the research questions. Chi-square(x^2) was utilized to test hypothesis at 0.05 level of significance.

Results

Table 1: Frequency and Percentages Responses on Level of Practice of Pain Reduction (n = 363)

S/n	Pain reduction practices	Yes		No	
		F	%	F	%
1	Use of pool	93	25.6	270	74.4
2	Use of pethidine	105	28.9	258	71.1
3	Use of Air bag	80	22.0	283	78.0
4	Squatting method while in pain	200	55.1	163	44.9
	Average		**32.9**		**67.1**

Table 1 reveals that 93(25.6%) of child bearing mother use pool to reduce pain, 105(28.9%) practiced use of pethidine for pain, while 200(55.1%) practice use of squatting to reduce pain during labour. The table also reveals that higher percentage of childbearing mothers do not adopt pain reduction practices during labour.

Table 2: Frequency and Percentages Responses on Personal Hygiene (n = 363)

S/N	Personal hygiene practices	Yes		No	
		F	%	F	%
1	Shaving of the pubic area	250	68.9	113	31.1
2	Use of clean pad	315	86.8	48	13.2
3	Use of delivery mat	190	41.3	213	58.7
4	Use of hand gloves	210	55.9	153	42.1
5	Drape spread	219	60.3	144	39.7
	Average		**63.04**		**36.96**

Table 2 shows, use of hygienic material for personal hygiene which reveals 250(68.9%) childbearing mothers that practice shaving of pubic area before child birth, 315(86.8%) practice use of clean pad, 210(57.9%) practice use of gloves while 219(60.3%) make use of drape spreads while giving birth.

Table 3: Percentage and Frequency on Consultation with Midwife (n = 363)

S/n	Consultation practice	Yes		No	
		F	%	F	%
1	Spontaneous delivery	315	86.8	48	13.2
2	Vacuum delivery	45	12.4	318	87.6
3	Cesarean section	155	42.5	208	57.3
4	Forceps delivery	35	9.6	328	90.4
	Average		**37.83**		**62.13**

Table 3, reveals consultation practice of childbearing women which reveals that 315 (86.8%) of women deliver spontaneously, 155(42.5%) women deliver through cesarean section while 318(87.6%) do not use vacuum and (328(90.4%) childbearing mothers do not use forceps for their delivery.

Table 4: Frequency and Percentages Responses on Use of Hospital Facilities (n = 363)

S/n	Use of hospital facilities	Yes		No	
		F	%	F	%
1	Health post	316	87.1	47	12.9
2	Private hospital	213	58.7	150	41.3
3	State hospital	220	60.6	143	39.4
4	Teaching hospital	100	27.5	263	72.5
	Average		**58.48**		**41.53**

Table 4, shows use of hospital facilities for child delivery which reveals that childbearing women of 316(87.1%) utilize health post, 213(58.7%) use private hospital, 226(60.6%) use state hospital (General hospitals) and 100(27.6%) use Federal hospitals. Some percentages do not use hospital as shown in the Table**.**

Discussions

Results in table 1 revealed that 67.1% of childbearing mothers do not practice pain reduction during labour. The finding is not surprising because some mothers believe that labour pain should be endured and if pain is expressed that one will continue to express pain each time she comes to deliver. This finding is in line with New born and Mary (2010) that discovered that culture, belief and ignorance could hinder one from seeking relief from pain during labour.

Data presented in Table 2 showed that 63.04% of women in labour practice personal hygiene. The finding is expected since childbearing mothers find in the antenatal clinics are taught the consequences of non practice of personal hygiene by material and child health workers. The improvement in the practice is also as a result of programme initiated in the year 2005 by federal government which created a lot of awareness to personal hygiene and consequences to health (Iliyasu, Abubakar, Galadanci and Aliyu, 2010).

Result in Table 3 also showed that 86.8% and 42.25% of women deliver through spontenous vaginal means and cesarean section respectively through vaccum 12.4% and for forceps 9.6% deliveries. These findings are expected since health workers (midwives and nurses) enlighten mothers found in the antenatal on what to do throughout their period of pregnancy, labour and after labour. This finding is in consonant with Bello, Gunm, Hassan, Shehu and Audu (1997) who discovered that childbearing mothers were aware of

causes of maternal death, nature of obstructed labour, sign of pre-eclampsia and need for prompt treatment.

Data presented in Table 4 revealed that 58.48% of childbearing mothers practices utilization of delivery facilities, while 41.53% did not deliver in the hospital. This is not surprising because of the existence of private maternity homes and traditional birth attendant homes. Probably, these mothers may have delivered in the later facilities. Nevertheless, the 58.48% showed that some childbearing mothers still patronized delivery facilities. This is in line with Daly, Anefor and Nasah (1993) who found out that mothers utilized delivery facilities due to availability of medical personnel, obstetric equipment, facilities and drugs which enhanced safe delivery.

Conclusions

Based on the findings and discussion of the study the following conclusions were attained.

1. Childbearing mothers practiced intra-partum care.
2. Level of education of childbearing mothers did not influence child bearing mother's practice of intra-partum care.
3. Hypothetically, level of education had no significant influence on childbearing mothers practice of intra-partum care.

Recommendations

Based on the findings discussions and conclusion of the present study, the following recommendations were made:

- ❖ More scientific research should be conducted on factors that hinder practice of intra-partum care among mothers, both qualitative and quantitative are essential for developing rational and effective responses to the problem.
- ❖ Knowledge is power, so emphasis on education of mothers on practice of intra-partum care should be made by health workers in the maternal and child health clinic because knowledge enhances practice of what is known
- ❖ Provision of obstetric emergency facilities, drugs and adequate and trained health workers to enhance practice.
- ❖ Stimulating and empowering health services like involvement of special educators in maternal and child health clinic to encourage practice of intra-partum care should be instituted in various MCH clinics.

References

Bello, S.F., Hassan, M., Shehu, D., Audu, L. (1997). Community education to encourage use of emergency obstetric services in Kebbi state, *Nigeria International Journal of Gynecology and obstetrics*, 59, 5191-5200.

Buck, G.M. & Platt R.W. (2011). Reproductive and perinatal epidemiology oxford. Oxford University press.

Daly, D., Aofor, M. & Nasah, B. (1993). Safe mother in francophone Africa: Some improvement but not enough University of Pennsylvania. African studies centre.

Fossard, E. & Bailey M. (2016). Communication for Behaviour change: using Entertainment Education for Distance Education. India. SAGA publication.

Larger, A., Farnot, U., Garcia, C., Barros F., Victoria, C., Belizan, I.M. & Villar, J. (1996). The Latin American Trial of Psycho social support during pregnancy: Effects on mothers' well-being and satisfaction social science and medicine, 42 1589-1597.

Leap; Dodwell N. Mirada; Newburn Mary (2010). Working with pain in labour. New Digest. National childbirth trust. https://en.m.wikipedia.org/wiki/birthpool.

Iliyasu, Z., Abubakar, I.S., Galadanci, H.S. & Aliyu, M.H. (2010). Birth preparedness, complication readiness and fathers' participation in maternity care in a northern Nigerian community. *African Journal of Reproductive Health,*14(1):21-32.

Memon, H.N., Harda, V.L. (2013). Vagina childbirth and pelvic floor disorders" Women's health England 9 (3) 265-77; quiz 276-7 doi, 0 22171 whe 13.17 PMC 3877 300.PMID 23638782.

Okusanya, B.O. Okogbo, F.O. Momoh M.M. Okogbenin, S.A. & Abebe, J.O. (2010). Maternal mortality and Delay. Socio-Demographic characteristics on maternal deaths in Iruna, Nigeria. Retrieved from www.ncbi.n/m.nih.gov. retrieved on 2/02/2011.

Respiratory Therapist (2017). http://en.m.wikpedia.org/wiki/ retrieved 8 May, 2017.

Royal college of midwives (1994). Joint statement by Royal college midwives and RCOG https://enm.wikipedia.org/wiki/birthpool

The World facebook (2016). www.cia.gov. Retrieved 30 July, 2016/

WHO (2015). Preterm birth fact sheet. https://en.m.wikipedia.org/wiki/pain-in-labour. Retrieved 30 July 2016.