International Journal of Nursing, Midwife and Health Related Cases
Vol.1, No.3, pp.7-17, December 2015
Published by European Centre for Research Training and Development UK (www.eajournals.org)

# POST NATAL EXPERIENCE OF WOMEN WITH MIDWIVES DURING LABOUR AT MERU LEVEL 5 HOSPITAL, KENYA

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**ABSTRACT**: *A lot has been written on midwives' experience on women in labour, but there is little discussion on women's experience at childbirth. Women fear giving birth in hospitals, due to mistreatment by health workers. Early 2011, the Minister for Public Health was reported in the local media to have wondered why women opted to deliver at home, despite hospitals offering delivery services. She suggested that research needs to be conducted to find out why few women were delivering in the hospitals. In a study conducted in Kisumu, majority of women though using Traditional Birth Attendant (TBAs) for delivery, acknowledged hospitals and skilled attendants as their preferred source of delivery care. This paper explores the experience of women at child birth with the midwife. The study was undertaken at Meru level 5 hospital using Exploratory/ Descriptive design. Post natal women who undergoing normal delivery were the target population. Purposive sampling was used to select fifteen participants from the post natal women who met the inclusion criteria for the study. Interviews were used to gather information from the participants, after which it was recorded with their consent. The following were the study findings; that some women in labour are physically and psychologically abused, they lack continuity of care, they are not prepared on what to expect during labour, they are never informed of findings after being examined, they do not establish a relationship with the caregivers, they feel that it is necessary to persevere despite the pain and finally it is fine to deliver while being watched by other women in labour. Despite those feelings, many of the participants said they were satisfied with the care received. There is need to adjust hospital policies to support the use of interventions proven to be of benefit to women during childbirth, and develop approaches that ensure changes in midwifery practice.*

**KEYWORDS:** Midwife, Postnatal Care, Antenatal Care, Hospital, Traditional Birth Attendant.

## INTRODUCTION

Childbirth experiences are a recurring element in women's life, so it is important for the midwife to make it as positive as practicable (Lundgren & Niddon, 2009). Perception of women's birth experience is an important part of evaluating the labour and delivery process (Borquez & Wiegers, 2009).

Midwives should therefore recognize women's psychosocial and emotional needs during childbirth and the impact they (midwives) may have on the women's experiences (Baker, 2005). A woman who had gone to deliver in a public hospital was surprised to be told to go back home and do exercises and that her problem was that she was lazy (Waweru, 2011).

Midwives are important at delivery for preventing both maternal and newborn complications (Titaly, 2010); but they have a responsibility to balance the natural and medical perspectives

in the care of the childbearing woman (Berg, 2005). As such, they should not take over the situation by being too dominant which may make the woman feel her dignity is being violated (Berg, 2005).

Overall, the aim of midwifery care is to establish a caring relationship that is expressed as a mutual process between the woman and the midwife. This means that the midwife and the woman encounter each other in openness (Berg, 2005). Such an encounter can be a way of breaking down the feeling of loneliness and restoring a woman's trust in herself hence making the labour experience more positive (Nilsson, 2009).

It is important for midwives to be aware of women's experiences because it will help identify the caring behaviours as recognized by the women and this will further help health care professionals provide better care for women during childbirth (Chen-Su, 2010). Further, these findings can serve as references for future midwifery practice models and improvement in quality of care (Chen-Su, 2010). Midwives should aspire to have mothers with good childbirth experiences because this inhibits negative awareness of motherhood and later abusive behaviour towards children (Takehara *et a.l,* 2009). A good childbirth experience is happy, gratifying and safe and a woman is likely to have a good experience if they establish an early and good communication with their midwife (Haire, 2010).

There is a perception that the health facility is a harsh setting for childbirth because a woman is left alone during labour (Cotter, *et al.,* 2006); although it has been shown that good support during labour reduces anxiety and helps mothers to cope with labour pain thus improves the childbirth experience (Jangsten, 2005).

## THEORETICAL UNDERPINNING

### Relationship between childbearing woman and midwife

Women describe establishing a trusting relationship with the midwives caring for them as a key feature of effective care (Snow, 2010). Therefore, the caring act will mean more to the woman than the level of knowledge the midwife may be endowed with (Snow, 2010). In support of a good relationship, Homer (2002) reported that women who had a midwife during labour, who they felt they knew, had a significantly higher sense of control and a more positive birth experience. Also, a continuous support during labour has been found to result to shorter labour periods, increased chances of normal vaginal delivery and less need for analgesia (Hodnett, et al, 2007). An environment of trust makes the woman relaxed and remain comfortable and confident and this is enhanced by being able to trust those around them (Lothian, 2008).

Being in a new environment can lead to fear which is a strong factor in determining how a woman responds to her experience during labour (Homer, 2002). Further, fear affects women in such a way that they start to doubt themselves and feel uncertain of their ability to give birth (Nilsson, 2009). Therefore, midwives should always strive to establish a relationship of trust with the women under their care, which will make the women feel safe, more powerful hence reduce fear (Hanah, 2010).

Mothers want a caregiver who is there 'emotionally and physically' (Berecki, 2010). There is need for a holistic care which incorporates physical as well as psychological aspects in order to make women's experience more positive ( Baker, 2005).

**Women's Experience**

Midwives are failing to offer proper care and reassurance during childbirth, with one in four women reporting being abandoned during labour and soon thereafter (Rose, 2007). In Kenya, women say the experience in the maternity wards at the hands of nurses is terrible (Ochieng, 2007). During labour, nurses are said to be very rough and not bothered by the pains women go through (Ochieng, 2007). Mothers (Affirmative action, 2007) report that once in the wards, there are a lot of insults from midwives. Further a patients' rights group (Potts, 2010) says that abuse of women in health facilities when they go to deliver, is a longstanding problem in the Kenyan health sector. In addition, Chimaraoke, Ezeh and Fotso (2008) say that provider harassment and mistreatment of women in public health facilities in Kenya is rife.

The right words at the right time can make a long labour bearable (Alison, 2007). In fact childbirth can be a pleasant experience for mothers well counseled and receiving tender loving care during labour (Kahaskheli, 2010). Midwives being the key professionals caring for women at low risk of complications are best placed to offer that kind of care (Bedley *et al,* 2010).

## METHODOLOGY

This study utilized an exploratory/descriptive design and qualitative methodology using a phenomenological approach. Wood (1994) says that exploratory studies provide an in-depth exploration of a single process, variable or concept while descriptive studies examine one or more characteristics of a specific population. In this paper, the author sought to explore the experience of the women during labour and described the experiences of the women at labour.

The study was carried out at Meru Level Five Hospital, Post-natal Ward, where the participants to be interviewed were selected and later interviewed at their homes. The hospital is a 600 bed occupancy district hospital situated in Imenti North District in Meru County of Kenya. It is a referral hospital for the upper Eastern Kenya region. The maternity unit is a 64 bed facility consisting of ante-natal, postnatal and a post Caesarian room where mothers are admitted after Caesarean section. The delivery area consists of a six bed first stage room and a four delivery couch second stage room with a newborn baby unit adjacent to it.

The study population consisted Post-natal mothers at Meru Level five Hospital who had a Spontaneous Vertex Delivery (SVD). Purposive sampling was used to select participants daily for one week after which interviews were conducted. A total 15 mothers were approached who ascended to participation. To identify the women to be approached, their files were used to confirm those who met the eligibility criteria. Once identified, the women were introduced to the study, the reasons for carrying it out and its importance to future midwifery care. After signing the consent, demographic data was taken and an agreement reached on a convenient day for the interview. Despite sample inclusions of spontaneous vertex delivery (SVD) women at Meru District Hospital, an exclusion criteria was also

adopted which excluded women who had undergone; any complications at post-delivery stage such as post-partum haemorrhage, had experienced still births or neonatal death, were in unstable mental post-delivery status and those who were living more than five kilometers from the hospital. Interview schedules and observations were used for data collection, an analysis of which was then done and consequent presentation.

## FINDINGS

The 15 participants interviewed had the majority ranging between ages 18 and 34 years. Seven of the participants came to the labour ward as primigravidae while only one had delivered more than three children before the then admission. Eleven of the participants were of primary school level of education with only one having tertiary level of education. Ten of the midwives who took care of the participants were female.

**Table 1: Demographic representation of population**

| | |
|---|---|
| Age in Years; Below 18<br>19 to 20<br>21 to 24<br>25 to 29<br>30 to 34<br>35 and above | 1<br>3<br>6<br>1<br>3<br>1 |
| Parity:1+0<br>2+0<br>3+0<br>4+0<br>> 4+0 | 7<br>3<br>4<br>0<br>1 |
| Level of Education: Primary,<br>Secondary<br>Tertiary | 11<br>3<br>1 |
| Marital Status: Married<br>Single | 9<br>6 |
| Sex of Birth Attendant's:<br>Male<br>Female | <br>5<br>10 |

## DISCUSSION

### Establishing a relationship with the care giver

All participants did not know the names of their care givers save for one participant who overheard one student being called a name similar to hers. They knew the cadre of their care giver by their uniforms. A participant said she could not ask the name of the nurse because

she (nurse) was 'Mbaya sana' translated 'very bad'. Though a participant said she would be glad to know her care giver's names, she could not ask because she thought the nurses were harsh.

**Timing of Examination**

Two participants were told to pay first before being examined even though in much pain. Participants were being told to wait before examination with one saying she was ignored. Quick attendance and effectiveness is important for any mother in labour. Taking too long to respond or to heed to their help may further complications at birth.

**Walking Around**

All participants were told to walk around outside the ward after examination. Varying instructions were given to the participants including; to come after four hours and to come after they experience 'a water break'. A participant said she would prefer walking around the bed while another expressed the wish to be given a place to rest during labour instead of being told to walk around.

**Privacy**

Many workers (students) were present during delivery. Examination was also being performed by many attendants. Participants didn't mind being seen by other mothers while delivering. One thought other women were in so much pain to bother.

**Physical/ Psychological Abuse**

One of the women in labour had been slapped severally and abused. Another was talked to badly by nurses, especially those who came on new shifts. Nurses are said to be harsh. A participant was made to carry her new born baby to the post-natal ward although she was feeling weak. Old nurses were said to be the ones who talk badly to the mothers.

**Overall Rating of Care**

All except 2 participants said the care was okay. One participant said the care at Meru hospital was better than what she went through during her first delivery at another public hospital.

(Names have been changed to protect the identity of the participants)

Jane said that nurses had been shouting at her. They slapped her several times but later said sorry. She was not given any pain relief. Jane did not know the name of the person who delivered her baby but thought she was a student due to the uniform she was wearing. There were many people around her during delivery and she felt it was not good. During examination prior to delivery, she was examined by a total of five people at different times but was not told the findings. She felt she did not establish a relationship with her midwife although in general, she considers the care given as okay. Further she would have been glad to be told what the results of her examinations were.

Mary was examined initially and told she was 3 cm dilated. On request she was given paracetamol and she feels she was taken care of by a student whose name she didn't know. By the time she delivered, she was taken care of by around six people and during delivery other

women in labour were looking at her. She felt it was fine since each woman was concentrating on her pain. She was told to move around during labour but feels one need to be given a place to stay during labour. This affected her experience of labour because she felt she laboured without assistance.

Karimi arrived in the ward at 5.00 am and was told to wait by a female nurse “alinitesa sana” (she treated me so bad). Later, at about 7 am she was assisted by a male “nilisaidiwa na kijana nilipozidiwa”. Karimi did not know the name of the young man though, she was not given pain relief and was not examined before delivery. She thought women in labour were expected to persevere. After delivery, she was made to carry her newborn to the post-natal ward although she was feeling weak.

Kairuthi said nurses are very harsh, use bad language when talking to you, while you are in pain. She felt men are better care takers though she was delivered by a female whose name she didn't know. She knew the person was a nurse because of her uniform. Kairuthi didn't know one can receive pain relief during labour so did not ask for it. Nurses took a lot of time to examine her. She said, “I was assumed”. She delayed entering the delivery ward because there was nobody to direct her. Kairuthi felt it was unfair to deliver while being surrounded by many people.

Jennifer came to the hospital at 6pm and was examined at 10 pm. During first examination, many people examined her. "It appeared as if everybody wanted to examine me", Jennifer said. She was told to walk around and come back later but she delayed in coming for fear of the examination. When pain became unbearable, she went back, was examined and told she was 4 cm and to go and come back later. She however delivered within 10 minutes but doesn't know the name of the person who delivered her. She felt one should be allowed to walk around the ward and not outside.

Muthoni delivered on 9th June 2011 and was attended to by 3 people but was not given any pain medication. Before delivery, she was told to walk around. During delivery, other workers were around and kept talking although she did not understand what they were saying. Overall, she felt she was well taken care of.

Judy went to labour ward but was told to go and pay first although she was in much pain. When she went back to the ward, she was allowed to lie in bed but was not given any pain medication. Two women in labour shared a bed. She was delivered by a nurse with many students observing.

Monica went to the ward at 5 am and was delivered by a student nurse at 6 am. She does not know the name of the student who delivered her because workers do not give their names. Monica was received well but she said people (women) were complaining of being delivered by students.

Mercy went to the ward, was examined and told she was 5 cm. She was told to walk around and come back after 4 hours. When she went back, at 9 pm she was examined and told to walk around again. At 4 am she felt like vomiting and she was allowed to walk around the bed but was not given any pain medication. The nurses who assisted her first were good but those who came later talked to her badly. They slapped her. She feels the old sisters are the bad ones. “Sisters wa zamani ndio wanaongea vibaya”, she said. She felt the place was clean and she had privacy.

Lucy delivered on 7/6/011 and attended to by around four people at different times and she does not know their names. She waited for a short time before delivery and there weren't many people except other women in labour.

Gloria went to the labour ward and was examined by a nurse who told her to go and come back when the waters breaks. When she went back, she did not meet the nurse who examined her previously but another one. They discussed with others and decided the woman could not deliver normally. She was sent to theatre but delivered normally before being operated on. Gloria was not given any pain relief and did not know it exists although she would be glad to receive it. Gloria did not know the names of the people who assisted her nevertheless was satisfied with the care.

Zainab was admitted from home at night and on examination, she was told to walk around the hospital and come back after four hours. She went out with her sister who had accompanied her but after a short time the pain became unbearable and she went back to the nurse. She was shouted at but on further examination she was offered a bed and delivered after a short time.

Mukunga was brought by her husband at around 9.00 am and on examination she was told the cervix was not open: 'njia ya mtoto haijaanza kufunguka'. She was told to go and come back after the water breaks. Since she resides near the hospital, the husband and her decided to go back home. At 4.00 pm she went back to the hospital in a lot of pain. She was examined by a student nurse and told to walk around the hospital. She stayed for around 30 minutes outside and went back and delivered. She did not know the names of the nurse who conducted her delivery. She felt she was well treated.

Maiti went to the ward and was kept waiting for a long time. One nurse came and greeted her and was nice. She did not know her name. She was examined by about six nurses. They were talking in English so she did not know what they were saying. She was in a lot of pain but was not given drugs.

The case of all participants is that no therapeutic relationship was established with the care givers. No participant knew the names and qualifications of their care givers except one who had heard a student being referred by a name similar to hers. Furthermore, the relationship with the midwives was described as one of fear because midwives were described as harsh. Some participants when asked whether they inquired for the names of their midwives said they could not because the midwives were harsh. This is in contrast to what Moore (2002) says that a close relationship between the woman and care giver creates a trust and confidence which makes the woman free to say to her midwife everything. Furthermore Leap (2010) argues that establishing a relationship with midwives enhances women's ability to overcome fears and self-doubt about coping with pain which eventually improves her experience of labour. This discrepancy may be as a result of the midwife's model of care which may not emphasize establishment of a close relationship with the client. Further, the number of women being cared for by a single midwife may be so big for a personalized care or it could be due to a negative attitude on the part of the midwife.

Walking around appears to be the normal routine for women who come to labour at the hospital. The practice is not confined to around the woman's bed as would be expected but involves the woman being outside the labour ward. (Stark, 2008) Says, with something that is such an intimate and special experience, to see the same person is really important; we have developed a good rapport and it makes me feel a lot more confident.

All the participants were cared for by at least three caregivers. One actually was cared for by six people while another had an experience of two shifts, one with very kind and supportive midwives while the other had bad nurses who talked to her badly. Still another participant had an experience where many care givers wanted to examine her; this she felt was not good. While it has been argued that the true provision of continuity of care is difficult to achieve in maternity services where most midwives work in shifts (Page, 2003), a one to one model of midwifery care is considered best for continuity of care (Page, 2003).

Every woman has the right to receive all or most of her maternity care from a single caregiver or a small group of caregivers, with whom she can establish a relationship (Lamazet, 2006). Further it has been reported that women get a higher satisfaction and a stronger perception of personal control with a one to one care (Page, 2003). Women who receive continuous support were more likely to have a spontaneous vaginal birth and less likely to require analgesia (Hodnett, 2011). Continuous support during labour has clinically meaningful benefits for women and infants and no known harm. All women should have support throughout labour and birth (Hodnett, 2007). Concerning many examinations, WHO recommends fewer vaginal examinations during labour routinely as an infection prevention practice (Chongsomchai, 2004). Participants expressed the wish to establish a closer relationship with their midwives which they felt was not possible because of the many care givers and the harshness of the nurses.

Privacy was not a worrying issue among the participants except one who said it was not fair to be surrounded by many people. Many participants felt it was okay to be observed by other health workers. Two women said other women in labour do not pose a privacy problem because they are in pain and not interested in the other labouring woman. Lothian (2004) argues that the best labor support will protect a woman's privacy and ensure that she is not disturbed so that she can tap into her inner wisdom and dig deep to find the strength she needs to give birth.

It is unfortunate that some women in labour at Meru are still being subjected to physical and psychological abuse at this age and time. Two participants reported having been abused physically and or psychologically during labour. This corroborates with a report by Family Care International report of (2003) which reported that women in Kenya do not attend the hospitals for fear of being beaten or roughed up (Bowser, 2010). In South Africa, women report being beaten, threatened with beating, and slapped during childbirth at midwifery centers (Bowser, 2010). A further abuse was reported by Amnesty International who reported a male nurse confessing that he occasionally had to slap or pinch women because they don't want to push and can harm the baby (Bowser, 2010). These reports would suggest that physical abuse to women during labour is rampant especially in Africa. Urgent action is required here.

The issue of physical and/or psychological abuse was a bad experience for the participants who were subjected to it. A participant said ‘ni wabaya sana’ (they are very bad), another one said, “You are in pain and they talk to you badly." This shows the experience of these women is not good because of the physical and or psychological abuse they are subjected to by midwives.

## CONCLUSION

Some women in labour are still being subjected to physical and or psychological abuse by the midwives caring for them, a practice one would least expect at this stage of development. There is a general lack of continuity of care because one woman can be taken care of by many care givers leading to negative experience. Though one-to-one care may be difficult to achieve because of staff shortages, at least one should not be subjected to more than five care givers. Lack of knowledge on maternal health care is a prevalent element in hospitals among childbearing women. Many have no knowledge of their right to information, the right to attendance. Privacy is however something that is not so much of concern in the labour rooms.

## RECOMMENDATION

Although the rating of care was good, something needs to be done to address the shortcomings mentioned to try and make midwifery care experience more satisfying; otherwise midwifery practice is not following best available evidence in the hospital studied.

Midwives at the hospital need support and encouragement to use interventions proven to be of benefit to women during childbirth, and develop approaches that ensure good practice.

Further research needs to be done to identify women in other hospital settings including faith based hospitals and private hospitals to see what difference there may be in experience.

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