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Humanized childbirth awareness-raising program among Tanzanian midwives and nurses: A mixed-methods study ☆

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ABSTRACT

Background: In 2014, the WHO released a statement advocating greater respect for women in their report, "The prevention and elimination of disrespect and abuse during facility-based childbirth". To address this issue, the Japan International Cooperation Agency established humanized childbirth care. However, this concept remains new in Tanzania.
Objective: To evaluate the acceptability of the humanized childbirth concept by Tanzanian nurses and midwives.
Design: Convergent mixed-methods design.
Setting: Continuing education held at Tanzania's capital city of Dar es Salaam.
Participants: The inclusion criteria were as follows: (1) registered nurses and midwives; (2) can comprehend English; (3) interested in humanized childbirth, (4) experienced in providing maternal and infant care or midwifery, and (5) attended the two-day program on humanized childbirth.
Methods: The program was evaluated quantitatively and qualitatively. The valid and reliable 23-item Women-Centered Care English version (WCC23E) questionnaire was used. Open-ended questions elicited the participants' opinions about the program.
Results: The entire program was completed by 104 participants (average age, 40.9 years; SD, 9.13). Based on the quantitative data, the mean WCC23E post-test scores showed a significant increase compared with the mean WCC23E pre-test scores, indicating improvement in awareness. The qualitative data revealed three categories: "Gaining knowledge of humanized childbirth as a general dictionary term", "Accepting and assimilating the concept of humanized childbirth in consideration of their practice", and "Manifesting their voices of barriers and challenges towards humanized childbirth".
Conclusion: The humanized childbirth awareness-raising program was useful for nurses and midwives in terms of favorably changing their perceptions of women-centered care.

1. Introduction

In the WHO 2014 paper entitled, "The prevention and elimination of disrespect and abuse during facility-based childbirth", the initial statement reads, "Many women experience disrespectful and abusive treatment during childbirth in facilities worldwide" (WHO, 2014). In Tanzania, one of the challenges to midwifery is the shortage of midwives despite the increasing number of pregnant or birthing women coming to hospitals. Nyamtema et al. (2008) found that in Dar es Salaam, one of Tanzania's largest cities, the 'Workload Indicators for Staffing Need' ratio of trained nurses/midwives to needed nurses/midwives was 0.2; that is, one nurse/midwife carries the equivalent responsibilities of five nurses/midwives. Research showed that nurses/midwives were overworked and that they struggled with the stress of having inadequate resources, inadequate supervision, and ethical dilemmas (Häggström, Mbusa, & Wadensten, 2008).

Both physical and emotional traumas have been documented. Mselle, Kohi, Mvungi, Evjen-Olsen, and Moland (2011) interviewed

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16 women and another 151 women who responded to a quantitative survey about their birth experience. The data documented the impact of inadequate staffing, specifically the lack of midwifery assistance and assistance by poorly trained personnel for women giving birth, and illustrated how the poor quality of care at health facilities led to obstetric fistulas because of prolonged labor. Shimpuku, Patil, Norr, and Hill (2013) reported that women's needs were difficult to fulfill at a busy facility in a rural Tanzania. Another qualitative study of 112 women, husbands, community workers, and public leaders from eastern Tanzania found that women experienced various types of abuse ranging from verbal (e.g., humiliation and scolding) to rough treatment and denial of pain relief (McMahon et al., 2014).

Humanized care emanates from valuing women. Wagner (2007) describes this care as follows: the woman is in charge of making the decisions about what will happen to her during her pregnancy. From 1996 to 2001, the State of Ceará in north-east Brazil established humanized care in collaboration with the Japan International Cooperation Agency (JICA) (Misago et al., 2001). Importantly, it is crucial to institutionalize women-centered care (WCC) to mitigate over-medicalization and to provide a humanized environment for birth. An effective method for achieving this is to provide high-quality midwifery education (Renfrew et al., 2014). However, as this was still a new concept in Tanzania, it was necessary to investigate how the concept would be accepted and if it could be modified to fit the context of Tanzania. Midwifery leaders from Tanzania and Japan initiated a collaboration (Shimpuku et al., 2015) to improve clinical practice and education. This development presented a good opportunity for introducing the concept to Tanzanian midwives to assess whether the concept was understood and acceptable.

The objective of this study was to evaluate the acceptability of the 'humanized childbirth' concept by Tanzanian nurses and midwives. The specific objectives were (1) to evaluate the perception of the humanized childbirth concept using WCC questionnaires at the pre-test and post-test sessions of a two-day workshop; and (2) to describe the humanized childbirth awareness-raising process using the participants' voices and opinions throughout the workshop.

2. Methods

2.1. Design

Mixed-methods with a convergent sample was used to determine the acceptability of the concept. The study design included illustrating quantitative results with qualitative findings, and synthesizing complementary quantitative and qualitative results to achieve a more complete understanding of the phenomenon (Creswell & Plano Clark, 2011).

2.2. Participants

The participants included those who met the following inclusion criteria: (1) registered nurses and midwives from primary level facilities and referral hospitals; (2) can comprehend English; (3) interested in humanized childbirth; (4) experienced in providing maternal and infant care or midwifery; and (5) attended the two-day program on humanized childbirth.

2.3. Recruitment setting and procedure

Potential participants were recruited by one of the authors (SD) by placing advertisements in hospitals at urban and rural areas around Dar es Salaam. Assistant researchers of the program at registration desks explained the research and obtained informed consent to participate prior to the start of the program.

The participants completed a pre-test questionnaire designed to elicit both quantitative and qualitative data. After the first day of the program, the participants completed a post-test questionnaire. Additionally, the participants completed a questionnaire at the end of program (second day).

A total of 123 questionnaires were distributed and received. There were 104 eligible participants who met the inclusion criteria, and this sample size was considered to be sufficient in terms of the reliability of both quantitative and qualitative data. Because the WCC23E was used for the first time among Tanzanians, it was necessary to conduct a factor analysis to identify the validity of the questionnaire. Ishii (2005) suggested including approximately five participants per item in the questionnaire to be able to conduct a robust factor analysis. The WCC23E included 23 items; therefore, the sample size should be 115.

As for qualitative content analysis, the number of participants required depends on the purpose of the inquiry, usefulness, credibility, and available time and resources (Patton, 2002). To analyze the humanized childbirth awareness-raising process of the participants, their individual voices were reflected and disclosed through a workshop based on all of the participants' responses to open-ended questions from the questionnaires, the content of group discussion achievements, and the oral presentations during the workshop.

2.4. Program

The key concepts of the program emerged from six crucial elements of 'humanized childbirth' used in the Brazil project *Projeto Luz* (Project of Light) (JICA, 2001; Misago, Umenai, Onuki, Haneda, & Wagner, 1999) as follows: "(1) is fulfilling and empowering both to women and to their care providers; (2) promotes the active participation and decision making of women in all aspects of their own care; (3) is provided by physicians and non-physicians working together as equals; (4) is evidence-based practice, including technology; (5) is in a decentralized system of birth attendants and institutions with high priority to community-based primary care; and (6) is with cost-benefit analysis for financial feasibility".

The program was aimed at providing Tanzanian midwives and nurses opportunities to learn and discuss their ideas and opinions about 'humanized childbirth' (see Table 1 for content of the program).

2.5. Instruments

2.5.1. Quantitative data

The recognition of the women-centered care-pregnancy questionnaire (WCC-preg) was previously shown (Iida, Horiuchi, & Nagamori, 2014) because of the conceptual similarity of the main elements of care between humanized childbirth and WCC. Horiuchi, Kataoka, Eto, Oguro, and Mori (2006) identified the components of WCC as respect, safety, trust, and collaboration to encourage women's empowerment.

The WCC23E is a 23-item self-administered questionnaire that was developed based on the 50-item WCC-preg (Agus, 2013; Iida, Horiuchi, & Porter, 2012; Iida et al., 2014). The original questionnaire was designed to measure women's perception of care that they received during pregnancy. In the present research, the introduction of the questionnaire was therefore stated as follows:

"Neema" gave birth at a hospital and she told us about her experience with the caregiver. Do you think the care she received was appropriate? Encircle the most appropriate number in consideration of your current workplace situation.