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ORIGINAL RESEARCH – QUALITATIVE

Women's experiences of self-reporting health online prior to their first midwifery visit: A qualitative study

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ABSTRACT

Background: Information and communication technologies are increasingly used in health care to meet demands of efficiency, safety and patient-centered care. At a large Danish regional hospital, women report their physical, mental health and personal needs prior to their first antenatal visit. Little is known about the process of self-reporting health, and how this information is managed during the client-professional meeting.

Aim: To explore women's experiences of self-reporting their health status and personal needs online prior to the first midwifery visit, and how this information may affect the meeting between the woman and the midwife.

Method: Fifteen semi-structured interviews with pregnant women and 62 h of observation of the first midwifery visit were carried out. Conventional content analysis was used to analyse data.

Findings: Three main categories were identified; 'Reporting personal health', 'Reducing and generating risk', and 'Bridges and gaps'. Compared to reporting physical health information, more advanced levels of health literacy might be needed to self-assess mental health and personal needs. Self-reporting health can induce feelings of being normal but also increase perceptions of pregnancy-related risk and concerns of being judged by the midwife. Although women want to have their self-reported information addressed, they also have a need for the midwife's expert knowledge and advice, and of not being perceived as a demanding client.

Conclusion: Self-reported health prior to the first midwifery visit appears to have both intended and unintended effects. During the midwifery visit, women find themselves navigating between competing needs in relation to use of their self-reported information.

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Statement of significance

Issue

Self-reported health has been used in antenatal care for a number of years. Little is known about the self-reported health of women outside of the clinical setting prior to the initial antenatal appointment, or of the midwife's use of this information.

What is already known

Self-reported health information can serve as a predictor for mental, social and physical health. Rating personal health is influenced by several factors.

What this paper adds

Some types of health information are more complex for women to self-report than others. The midwife's use of women's self-reported information during the first visit influences women's perception of their relationship with the midwife.

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1. Introduction

Self-reported health information has been used in antenatal care for a number of years, and it has proven valuable to predict mental and physical morbidity as well as use of health care services.¹ In relation to screening, self-reported health has mainly been used within the physical boundaries of the antenatal care setting. Currently, Danish health care strategies aim to increase citizens' involvement in their own care by, amongst other things, expanding the physical boundaries of health care to also include patients' homes.² Since 2012 pregnant women in a large Danish regional hospital have reported their health status and needs using an online questionnaire prior to the first visit with the midwife.³ In antenatal care, self-reporting health seeks to meet simultaneous demands of efficiency and safety, while tailoring midwifery care to women's individual needs.³ However, increasing user involvement in antenatal care places new demands on women and midwives alike. Women will have to make use of existing knowledge and skills when undertaking the task of self-reporting, and midwives will need to adapt to new ways of inclusion during the antenatal visit incorporating the health information reported in advance.

1.1. Background

The World Health Organization (WHO) has defined health literacy as the cognitive and social skills which determine the motivation and ability to gain access to, to understand, and to use information in ways which promote and maintain good health.⁴ According to WHO, health literacy is critical to empowerment. Health literacy has proved an important personal asset for pregnant women to possess. For example, low levels of health literacy have been associated with less use of early screening programs in antenatal care.⁵ A multinational cross-sectional study by Lupattelli et al. found that low levels of health literacy is positively associated with smoking, having an unplanned pregnancy, and poorer compliance with medical treatment during pregnancy.⁶ Furthermore, low levels of health literacy have been related to less use of the internet as a source for pregnancy-related information.⁷

Within antenatal care, most studies have applied information from self-reported health for screening purposes, including as a method for detecting domestic violence during pregnancy.^{8,9} In a large randomized trial, MacMillan et al. found that women preferred to report domestic violence on paper or online compared to face-to-face interviews,⁹ which suggests that the method could play an important role in facilitating communication of intimate health information. Several studies have explored self-reported health as a screening method for postnatal depression. A review by El-Den et al. found that the majority of women reported high acceptability of using postnatal depression screening tools.¹⁰ However, a qualitative study by Godderis et al. found that although pregnant women expressed high acceptability of the Edinburgh Postnatal Depression Scale, these women would also interpret the scale items differently, and some women expressed concerns over disclosing thoughts of self-harm, including how health care professionals would respond to such replies.¹¹ Several factors impact self-reported health. Gender has been found to affect self-rated health, and men rate their health better than women during the pregnancy period.¹ Partner support seems to affect women's emotional and physical health during pregnancy and post-partum according to self-reported data.¹ In addition, a range of socio-demographic factors impact pregnant women's self-reported health negatively, such as low educational level and non-western origin.^{1,12} These factors have also shown to negatively affect women's health control beliefs and lifestyle during pregnancy.¹²

Previous studies on self-reporting health during pregnancy have mostly utilized cross sectional and longitudinal designs. Only a few studies have explored self-reported health in maternity care using qualitative methods. With a rapidly increasing use of information and communication technologies in health care,² a better understanding is needed of how pregnant women feel that they adapt to new tasks of assessing both mental and physical health, and to reporting their personal needs within the setting of their own home. In addition, greater knowledge of how an increasing consumer involvement (i.e. client-reported health information for use in antenatal care) affects the client-professional relationship is needed.

The aim of this study was to explore women's experiences of self-reporting their health status and personal needs online prior to the first midwifery visit, and how this information may affect the meeting between the woman and the midwife.

1.2. Setting

In Denmark, antenatal care (ANC) is publically funded and free of charge, and almost all (>99%) pregnant women access the ANC program.^{3,13} For women with uncomplicated pregnancies, the program entails five to six visits to the midwife and three visits to the general practitioner.¹³ The present study was carried out in a large regional hospital in the Capital Region of Denmark. This hospital was the first in Denmark to implement (in 2012) self-reported health online prior to the first midwifery visit.³ When a woman signs up for the nuchal translucency scan, she receives an email with a link to a questionnaire, available in Danish and English. On average, women respond to the questionnaire in their 10th gestational week.³ The questionnaire collects information on the woman's socio-demographic characteristics, reproductive, obstetric, and medical history, general health status, intake of dietary supplements, lifestyle factors before and during current pregnancy, WHO-5 well-being index, and Cambridge Worry Scale. The women also have the possibility of stating personal needs by describing their thoughts and wishes for the pregnancy. The first midwifery visit takes place around the 15th gestational week.³

2. Participants, ethics and methods

The primary data source in this study was individual semi-structured interviews. Additional exploratory and structured observations were performed to allow for different perspectives of the same phenomena.¹⁴

Data were collected in 2015–2016 over three consecutive phases:

1. Exploratory observations (winter 2015)
2. Individual semi-structured interviews (summer 2015 to winter 2016)
3. Structured observations (winter 2016).

2.1. Participants

Participants for the interviews were recruited face-to-face by a midwifery department manager while waiting for their first midwifery visit at an antenatal care facility. The same person recruited midwives for the observations, and these midwives recruited participants for the observations. It was expected that women's experiences of self-reporting their health status would vary, and to ensure heterogeneity in the sample,¹⁵ both women expecting their first child and women who had given birth before were invited. In addition, a variation in maternal age was sought.

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