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Strategies to improve postnatal care in Kenya: A qualitative study

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ABSTRACT

Introduction: Postnatal care is the most neglected aspect of maternal care globally. Midwives, postnatal mothers and their families pay little attention to postnatal care, assuming that physical recovery is always guaranteed when a mother has had a normal pregnancy and childbirth. Unfortunately, preventable complications occurring during this period are considered the major causes of maternal and neonatal morbidity and mortality. The aim of this paper is to describe the strategies that can be implemented to improve postnatal care in Kenya.
Methods: A qualitative descriptive study, using a nominal group technique to gather the data was used to identify strategies that can be implemented to improve postnatal care in Kenya. The national and provincial reproductive healthcare coordinators, as the relevant stakeholders, formed the population and unit of analysis.
Findings: Thirteen strategies to improve maternal care, specifically postnatal care, were initially listed, of which six were ranked as the highest priorities by participants. Following the steps of the nominal group technique, six of these strategies were eventually considered to be very important. Capacity-building initiatives, quality data management, quality assurance processes, human resource management, supportive supervision, and the co-ordination of postnatal care services were ranked as priority strategies that needed to be implemented. The operationalisation of the guidelines developed by the Ministry of Health, Kenya, through the identification of strategies, was a unique feature of the study.
Recommendation: It is essential that departments of health implement these strategies to improve the health provided to postnatal mothers and their babies.
Prècis: Crucial strategies to improve postnatal care are capacity building, data management, quality assurance, human resource management, supportive supervision and coordination.

1. Introduction and background

Maternal and infant mortality are important health indicators for any society, and their importance has compelled the secretary-general of the United Nations (UN) to set up a commission to monitor and evaluate these two indicators (World Health Organization (WHO), 2011b). An integral part of the prevention of maternal and infant mortality is the quality and extent of postpartum care rendered.

Postnatal care encompasses a number of activities aimed at monitoring, counselling and rendering healthcare to a mother up to 6 weeks after birth (Ministry of Public Health and Sanitation, Kenya, 2012; Warren, Shongwe, Waligo, Mahdi, & Mazia, 2008). During this period, the physical and emotional needs of the mother are addressed by a midwife in partnership with other healthcare providers, including community healthcare workers, obstetricians and paediatricians.

Unfortunately, the postnatal period is the most neglected aspect of maternal care globally, notwithstanding it being an ideal time to perform interventions to improve the health of both the mother and the baby (Bixby Center for Global Reproductive Health, 2011). The majority of postnatal mothers do not seek care owing to the assumption that physical recovery is always smooth after a normal pregnancy and delivery, while others assume that they do not need special care because they are not sick (Daher, Estephan, Abu-Saad, & Naja, 2008; WHO, UNICEF, United Nations Population Fund, & World Bank, 2010).

Despite the assumption that they do not need special care, 830 women globally die daily as the result of two major preventable diseases, namely postpartum haemorrhage and postpartum infection, which are both encountered during the postnatal period and can be prevented if optimal postpartum care is rendered (WHO, 2015).

Efforts to address maternal morbidity and mortality are based on 3

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of 17 sustainable development goals (United Nations, 2015). Firstly, poverty may prevent women from seeking postnatal care because they cannot pay for such services or for transport to and from places where these healthcare services are rendered. Goal number 3 seeks to ensure healthy lives, also during the postnatal period, for both the mother and her baby. Achieving gender equality and empowering all women (goal number 5) would assist women who seek maternal services and postnatal care. All global departments of health and all healthcare providers that are responsible for rendering these services should develop and implement strategies that would help them to achieve these goals. Community healthcare workers, midwives, obstetricians and pediatricians all share an equal responsibility to contribute to postpartum care.

In 2004, the Ministry of Health in Kenya developed guidelines to improve and strengthen postnatal care by increasing the timing and assessments within the six weeks after childbirth. These guidelines were implemented and piloted in 2005 (Mwangi, Warren, Koskei, & Blanchard, 2008). Despite the fact that 80% of healthcare facilities in Kenya can offer the full spectrum of maternal care, including postnatal care, only 42% of women give birth in a healthcare facility (Akunga, Menya, & Kabue, 2014). Of the 52% that give birth at home, assisted by unskilled birth attendants, only 19% will receive postnatal care (Akunga et al., 2014). The challenges facing postnatal care still contribute to high maternal and neonatal mortality rates in Kenya despite the implementation of guidelines in 2005 and remain a cause for concern.

To improve the postnatal care provided to mothers and their babies, a number of strategies have to be implemented by governments' national departments of health to combat the complications encountered by millions of women during and after childbirth (United Nations Population Fund, 2009).

2. Methods

2.1. Aim

The aim of this report is to describe the strategies that stakeholders consider to be important to improve postnatal care in Kenya.

2.2. Design

A qualitative descriptive study, utilizing Health Systems Research as motivation and the Nominal Group Technique (NGT) for data gathering, was selected to identify priority strategies. Data on the current status of postnatal care in Kenya as well as the challenges experienced by midwives and hospital management were gathered by means of checklists and questionnaires (Chelagat, 2014). These results (Chelagat, 2014) were then shared with the NGT participants prior the discussion to ensure that the service providers also had a voice in the development of strategies and that the participants had scientific evidence from a formal study conducted (Chelagat, 2014) as well as personal experience in the postnatal service field to assist them in the development of the strategies. The Nominal Group Technique was used owing to the very nature of the process as a problem-solving, consensus-seeking method that allows all participants an equal voice and the opportunity to present ideas without feeling threatened or intimidated (Delbecq, Van de Ven, & Gustafson, 1975). The technique also eliminated the influence of the researcher – who is an experienced and trained facilitator – on the group dynamics. The structured group work that took place enabled the researcher to obtain multiple inputs from all participants.

2.3. Study population and sampling

The study population consisted of five national and eight provincial reproductive health coordinators who were responsible for maternal and neonatal programs in the country. Total population sampling was done as all the national and provincial reproductive health coordinators volunteered and formed the unit of analysis. They were supported by the government – a fact which contributed to their willingness to participate and their active involvement.

2.4. Exploratory interview

An exploratory interview was conducted with the purpose of testing the research question before the commencement of the NGT. Nurse educators from a local university were conveniently selected and asked to volunteer to participate. The following instruction was given to the group: "Please write down the strategies that can be implemented to improve postnatal care in Kenya." The participants were allowed to generate strategies in silence and to list their strategies one at a time in a round-robin manner. When the lists were exhausted, the facilitator concluded the NGT session because the ideas raised by participants were proof enough that the correct question had been asked and that the NGT would provide the researcher with the needed information.

3. Ethical considerations

Approval from the ethics committee of the custodian university and permission from the Division of Reproductive Health were obtained. Participants also signed the informed consent form. Other ethical requirements observed throughout the study included respect for people, beneficence and justice. The right to self-determination, privacy, confidentiality, and the right to be protected from harm and discomfort were adhered to (Brink, Van der Walt, & Rensburg, 2006; Grove, Burns, & Gray, 2013).

4. Trustworthiness

Trustworthiness was ensured by addressing credibility, dependability, conformability and transferability (Botma, Greeff, Mulaudzi, & Wright, 2010). Credibility of the data was ensured by inviting the key people involved in maternal and neonatal care to participate in the NGT. Rules of the NGT were explained to the participants and the step-by-step process was followed to ensure dependability of results. The manner in which the NGT was conducted aided in the conformability of the results as the facilitator maintained a neutral position and acted objectively throughout the NGT process. Regarding transferability, the results may or may not be applicable to other settings, depending on the context of potential users.

5. Data collection process

The NGT was conducted on a date, time and venue agreed upon by all participants and the facilitator. The NGT was facilitated by an experienced and trained facilitator. The data collected between 2012 and 2013 in a study by Chelagat (2014) providing evidence of the current status of postnatal care in Kenya as well as the challenges experienced by midwives and hospital management were shared by means of a Microsoft Office® PowerPoint presentation. The NGT was then utilized in 2014 to gather the data, which were then captured on a flip chart by the scribe.

The four steps to conduct a nominal group as described by Delbecq et al. (1975) were followed. These are 1) silent generation of ideas, 2) round-robin listing of ideas, 3) discussion of ideas, and 4) voting and raking of ideas. One NGT that lasted for 3 h was conducted to identify the strategies that were then validated through consensus.

6. Data analysis

Data analysis was done simultaneously with the data collection and, owing to the very nature of the NGT, all participants were actively involved in the analysis process. The facilitator followed a step-by-step approach and, together with the participants, clustered the strategies