

**NURSE-MIDWIVES' PERCEPTION ON
PROMOTION OF SELF-CARE AMONG PATIENTS
ADMITTED AT KENYATTA NATIONAL
HOSPITAL MATERNITY WARDS.**

**A THESIS SUBMITTED IN PARTIAL FULFILMENT OF
THE REQUIREMENT OF THE DEGREE OF MASTER OF
SCIENCE IN NURSING, UNIVERSITY OF NAIROBI.**

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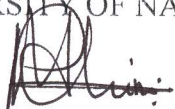
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DEDICATION

To my beloved husband, Wilson, and our dear children Kelvin, and Alvin for your support and endurance during the trying, difficult, and challenging moments of my studies.

To my parents the late Mr. Daniel Kipkemboi Talam and Mrs. Sally Chepkemboi Talam who worked hard to educate me in my formative years and for not giving up even at the most trying moments.

May the almighty God bless you.

ACKNOWLEDGMENT

I appreciate the continued and invaluable guidance from my academic supervisors. Mrs. J. Oyieke, Dr. Anna, Karani, Dr. B. O. Omuga, and Mr. P. M. Waithaka and the rest of the staff of the school of nursing sciences.

I wish to thank the Kenyatta National Hospital administration for granting me a paid study leave to pursue the graduate study.

To Isaac, and Millicent for their support in typing and editing this report.

Finally to my classmates Noah, Pamela, Dorcas and Lillian and any other persons not mentioned for their contributions and moral support in compiling the research thesis.

ABBREVIATIONS.

AIDS	–Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral Therapy
C/S	Caesarean Section
HIV	Human Immunodeficiency Virus
KNH	Kenyatta National Hospital
KDHS	Kenya Demographic and Health Survey
L/W	Labor Ward
M/W	Maternity Ward
MOH	Ministry Of Health
NASCOP	National AIDS Control Program
NM	Nurse-midwife
NST	Nursing System Theory
PMTCT	Prevention of Mother to Child Transmission
SCD	Self-care Deficit
SCDT	Self-care Deficit Theory
SCDNT	Self-care Deficit Nursing Theory

SPSS _ Statistical package for social scientists

STIs _ Sexually Transmitted Infections

UNAIDS United Nations Agency for International Developments

WHO _ World Health Organization

OPERATIONAL DEFINITIONS.

Antenatal care- routine review of antenatal mothers whereby history, complete physical examination, and laboratory investigations are done prior to delivery, to ensure health and wellbeing of the mother and fetus (22).

Empowering- to make a mother and or family to understand or attain the knowledge about a concept in order to make informed choices or solve problems.

Health seeking behaviors - a state in which an individual in stable health, actively seeks ways to alter personal health habits, and or the environment in order to move toward a higher level of wellness (1).

Nursing care- actions done by nurse-midwives that are focused on the health and wellbeing of women.

Nursing systems deliberate practical actions of nurse-midwives, performed at times in coordination with actions of their patients to know and meet components of patients' therapeutic self-care demands to protect and regulate the exercise or development of their self-care agency (1).

Self-care requisite- a formulated and expressed insight about actions to be performed that are known or hypothesized to be necessary in the regulation of an aspect(s) of human functioning and development conditions and circumstances (1).

Self-care _ the production of actions directed to self and the environment in order to regulate one's functioning in the interests of ones life, health, integrated functioning and wellbeing (1).

*Self-care agency*_ The power or ability of an individual or individuals to know and meet their continuing requirements for self-care in order to regulate their human functions and development (1).

*Self-care deficit*_ limitations in the ability to perform self-care activities. A relational construct that expresses the disparity between therapeutic self-care demand and self-care agency when the self-care agency is inadequate (1).

*Well-being*_ Individuals' perceived condition of normal existence.

TABLE OF CONTENTS

DECLARATION.....	I
APPROVAL.....	II
DEDICATION.....	III
ACKNOWLEDGMENT.....	IV
ABBREVIATIONS.....	V
OPERATIONAL DEFINITIONS.....	VII
TABLE OF CONTENTS.....	IX
ABSTRACT.....	XIII

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND INFORMATION.....	1
1.2 STATEMENT OF THE PROBLEM.....	3
1.3 MAJOR ISSUES FROM PROBLEM STATEMENT.....	4
1.4 RESEARCH QUESTION.....	5
1.5 BROAD OBJECTIVE.....	5
1.6 SPECIFIC OBJECTIVES.....	5
1.7 HYPOTHESIS.....	6
1.8 STUDY VARIABLES.....	7
1.9 THEORETICAL FRAMEWORK.....	8
1.10 CONCEPTUAL FRAMEWORK.....	9
1.11 OPERATIONAL FRAMEWORK.....	10
1.12 JUSTIFICATION OF THE STUDY.....	13
1.13 EXPECTED BENEFITS OF THE STUDY.....	15

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION.....	16
2.2 PROMOTION OF SELF-CARE.....	21
2.3 THE ROLE OF NURSE-MIDWIVES IN PROMOTING SELF-CARE AMONG POSTNATAL PATIENTS.....	23

2.4	KNOWLEDGE AND ATTITUDES OF NURSE-MIDWIVES ON SELF-CARE PROMOTION.....	25
2.5	FACTORS THAT AFFECT POSTNATAL WOMEN'S SELF-CARE.....	26

CHAPTER THREE: MATERIALS AND METHODS

3.1	STUDY DESIGN.....	30
3.2	STUDY AREA.....	30
3.3	STUDY POPULATION.....	31
3.4	INCLUSION CRITERIA.....	31
3.5	EXCLUSION CRITERIA.....	31
3.6	SAMPLE SIZE DETERMINATION.....	32
3.7	SAMPLING PROCEDURE.....	33
3.8	STUDY INSTRUMENTS.....	34
3.9	PRETESTING OF STUDY INSTRUMENTS.....	34
3.10	SELECTION AND TRAINING OF RESEARCH ASSISTANTS.....	35
3.11	DATA COLLECTION, CLEANING AND ENTRY.....	35
3.12	DATA ANALYSIS AND PRESENTATION.....	35
3.13	ETHICAL CONSIDERATION.....	36
3.14	STUDY LIMITATIONS.....	37

CHAPTER FOUR: RESULTS

Results.....	38
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**CHAPTER FIVE: DISCUSSIONS, CONCLUSIONS AND
RECOMMENDATIONS**

5.1	Discussions	56
5.2	Conclusions.....	62
5.3	Recommendations.....	66

REFERENCES.....	68
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APPENDICES

APPENDIX I	PREVIEW OF STUDY AREA.....	i
APPENDIX II	CONSENT AND INFORMATION LETTER TO RESPONDENTS.....	ii
APPENDIX III	RESEARCH QUESTIONNAIRE.....	iii
APPENDIX IV	APPROVAL LETTER FROM THE MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY.....	ix
APPENDIX V	APPROVAL LETTER FROM THE KENYATTA NATIONAL HOSPITAL ADMINISTRATION.....	x

LIST OF FIGURES

FIGURE 1	THEORITICAL FRAMEWORK.....	8
FIGURE 2	CONCEPTUAL FRAMEWORK.....	9
FIGURE 3	OPERATIONAL FRAMEWORK.....	10

LIST OF TABLES

TABLE 1:	Demographic characteristics of the respondents'	39
TABLE 2:	Relationship between demographic factors and nurse-midwives' involvement in promoting client self-cares.....	42
TABLE 3:	Relationship between respondents' years of service and designations with nurse-midwives' involvement in promoting client self-care.....	44
TABLE 4:	Respondents understanding of self-care by definitions given.....	46
TABLE 5:	Relationship between level of education and understanding of self-care.....	47
TABLE 6:	Nurse-midwives' attitude towards promotion of client self-care.....	50
TABLE 7:	Relationship between nurse-midwives' attitude to	

	self-care promotion and their involvement in promoting client self-care.....	51
TABLE 8:	Nurse-midwives' practice factors that influence their involvement in promoting client self-care.....	53
TABLE 9:	Patient factors that may influence nurse-midwives' involvement in promoting client self-care.....	55

LIST OF CHARTS

Chart 1:	Percentages of nurse-midwives' involvement in promoting client self-care.....	41
Chart 2:	Respondents' score of activities of self-care promotion in the wards.....	48
Chart 3:	Percentage of staff involved in self-care who say promotion of self-care needs improvement.....	49

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND INFORMATION

Promotion of self-care is an evidence based practice in nursing and midwifery (2). Self-care is the practice of activities that individuals with the capacity of decision making, initiate and perform, within time frames in the interest of maintaining life, healthful functioning, personal development, and well-being (1).

Self care is a part of daily living. It includes the actions people take for themselves, their children and families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital (3).

The role of the nurse – midwives in promoting women's self care during pregnancy and after delivery is the most cost – effective way of ensuring quality health care. The economics of health care and the rising tide of health care demands mean that the nurse-midwives must consider carefully just what role they should play with a patient or client (4).

Strategies to increase patient motivation to self-care lie predominantly with the nurse since it is she or he who spent more time with the client. Nurse-midwives should look into there nursing or midwifery systems to suit the changing trend. There is need for services to be women centered, to make information available to all women through the

focused women care and increase women's involvement by empowering them through promotion of self-care behaviors (2).

An understanding of the personal factors, the organizational factors and the societal factors which affect midwifery practice is needed so that midwifery care may be developed to enable all women to experience midwifery care which is supportive and personal. One strategy of ensuring client involvement in their care is through promotion of self-care behaviors. The nurse-midwives must therefore be knowledgeable and have the necessary skills to promote client self-care (5).

The knowledge, skills and models of midwifery care held by the nurse-midwives and the women for whom they are caring may have a significant influence on the type of care that they are able to provide. For example, if a nurse-midwife lacks communication skills, it may be more difficult for a woman to become an active participant in her care. If a woman expects health-care professionals to take responsibility for her care, she may react with hostility when asked to assume this responsibility herself (6).

There is need for further studies on self-care needs and activities in different acute and chronic illness centers in order to promote clients' health seeking behaviors. Until recently, no comprehensive guidelines or standard tool existed to define necessary skill required of the nurses or midwives to promote client self-care behaviors (5).

This study is therefore intended to investigate and determine factors that influence the nurse-midwives level of promoting client self-care behaviors.

1.2 STATEMENT OF THE PROBLEM

Self-care promotion is an important component of nursing and midwifery but is often given low priority when compared to other care practices (7). The lack of published protocols for promotion of self-care has been noted in clinical nursing literature.

Poor self-care among postnatal patients may be one of the factors contributing to maternal and infant mortality and morbidity.

Worldwide, it is estimated that nearly 600,000 women die yearly from complications of pregnancy and childbirth – (about one woman every minute). (world health organization (WHO) health survey (8).

In Kenya, the Kenya demographic health survey (KDHS) reported 600 maternal deaths in every 100,000 live births in 2003, which is an increase compared to 395 per 100,000 births in 1994 and 590 in 1998 (9).

Recent evidence indicates that poor self-care among postnatal patients is one of the contributing factors that lead to preventable complications such as puerperal infections, thrombo-embolic disorders, and pneumostatic pneumonia. Such complications may lead to maternal and infant morbidity or mortality and eventually directly affect socio-economic status of the society at large (7).

Self-care promotion may therefore be an important preventive and promotive measure to ensure maternal and infant health. Teaching self-care measures such as infection control measures like hand washing, postnatal diet, deep breathing exercises, care of the neonate, are important strategies that could ensure optimum maternal and infant health (7).

Although nurse-midwives are involved in provision of care to antenatal and postnatal patients, the maternal and infant mortality and morbidity rate is an issue of concern that needs to be addressed. Literature indicates that the high rate has lead many initiatives such as the millennium development goal 5, which is aimed at measures to improve maternal health and reduce mortality by the year 2015 (10).

From the above, it is evident that there is need to conduct studies on the knowledge, attitudes and practices of nurse-midwives on promotion of client self-care, since poor self-care or self-care deficit among the clients could be personal or arising from the perspectives of the nurse-midwives or the clients. Optimal client self-care benefits the clients, the hospital, and society at large; so there is need to identify some of the direct and indirect variables that have implications on client self-care and quality of care, and that is the reason for this research.

1.3 Major issues from problem statement.

The major issues involve:-

- (a) High rate of maternal and infant mortality and morbidity,
- (b) Nurse-midwives' knowledge and attitudes that influence involvement in promoting self-care

- (c) Self-care behaviors among postnatal patients,
- (d) Risk for or rate of preventable postnatal complications such as infection,

1.4 Research questions

- (1) Does the knowledge and attitudes of the nurse-midwives influence their involvement in promoting self-care among postnatal patients?
- (2) What are the attitudes of the nurse-midwives towards promotion of self-care?
- (3) What are the nurse-midwives' perceptions towards the institutional support on promotion of client self-care?

1.5 Broad objective

The broad objective of the study is to assess or establish the perspectives or knowledge and attitudes of nurse-midwives that may influence their involvement in promoting self-care among postnatal patients at KNH maternity wards.

1.6 Specific objectives

To achieve the broad objective, the study will be guided by the following specific objectives;

1. To establish the nurse-midwives' demographic factors that influence their involvement in promoting client self-care.
2. To establish the knowledge level of nurse-midwives on promoting postnatal women's self care.
3. To establish attitudes of nurse-midwives toward promotion of self-care.

4. To determine the nurse-midwives' professional and educational background on self-care.
5. To determine the nurse-midwives' perception of the hospital's support in self-care promotion.
6. To identify factors that affect the level of nurse-midwives' promotion of client self-care.

1.7 HYPOTHESIS

Perspectives of nurse-midwives towards self-care promotion do not influence the self-care among postnatal women admitted at Kenyatta National Hospital maternity wards.

1.8 STUDY VARIABLES

Interacting variables in nurse- midwives involvement in promoting self-care among post natal women included the following:-.

Independent

Variables

- Demographic factors
- Level of education
- Knowledge, and attitude of nurse midwives to self-care
- Nursing/midwifery systems in promoting self-care i.e.
 - (1) Wholly compensatory
(Performing all care for patients)
 - (2) Partly compensatory – support care needs
 - (3) Supportive – educative

Intervening variables

- Promotion of self-care practice by nurse-midwives through **Client health education** on infection prevention, management of own and newborn nutrition, ambulation and exercise, rest and sleep, breast feeding and newborn
- Self decision making

Dependent / Outcome Variables

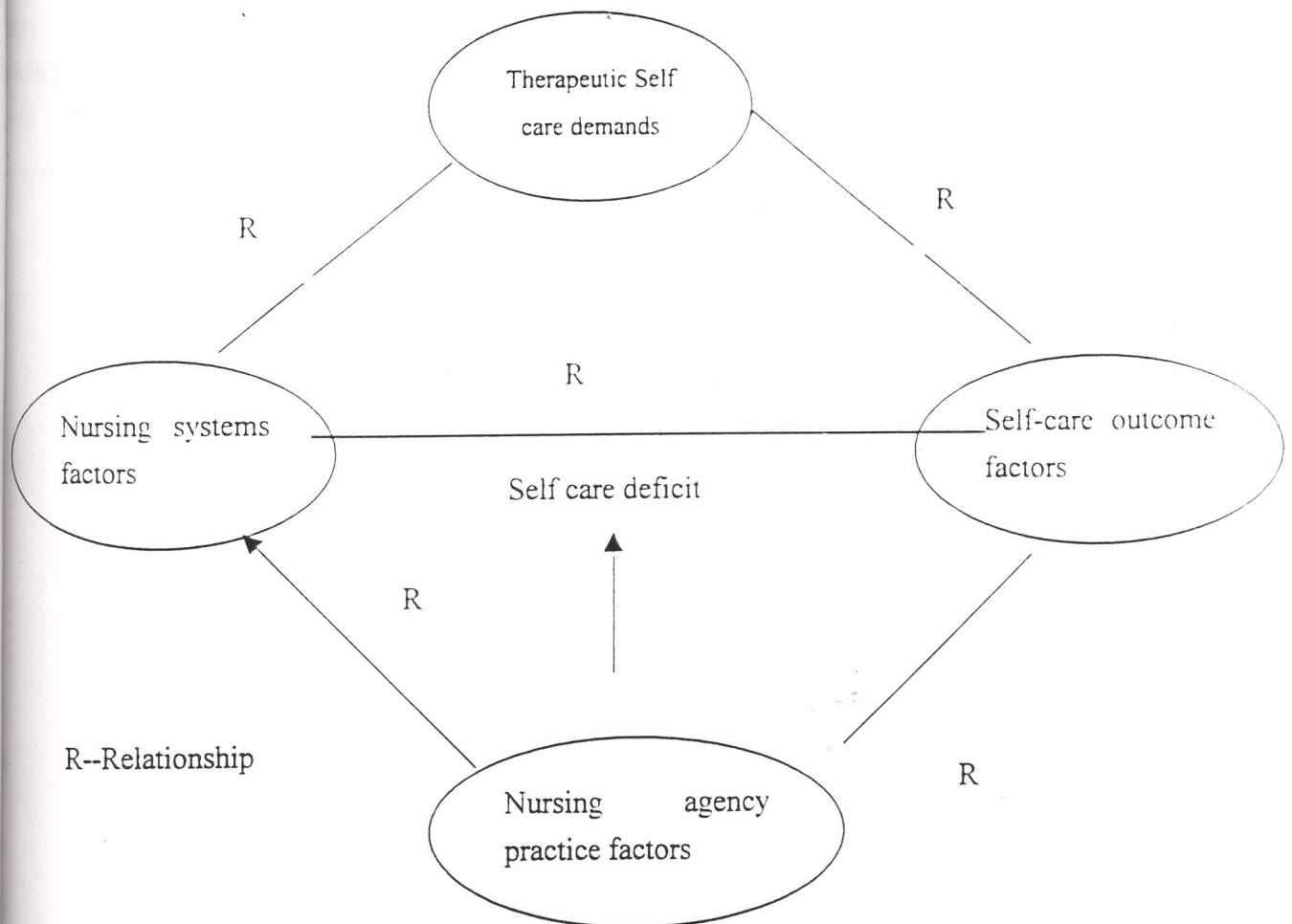
- Nurse- midwives involvement in promoting self-care among post natal women
- Morbidity and mortality rate
- Behaviors of self-care among women to initiate preventive, promotive and Protective self-care
- knowledge about self-care

1.9 THEORITICAL FRAME WORK

DOROTHEA OREM'S THEORY OF SELF-CARE.

The theory of self-care was used to guide the study. Self-care theory (SCT) the self-care deficit theory of nursing (SCDNT) will be operationalized in line with the study's specific objectives based on the following assumptions and theoretical statements derived from the theory. The SCT emphasizes self-care, self-care agency, the therapeutic self care requisite (2).

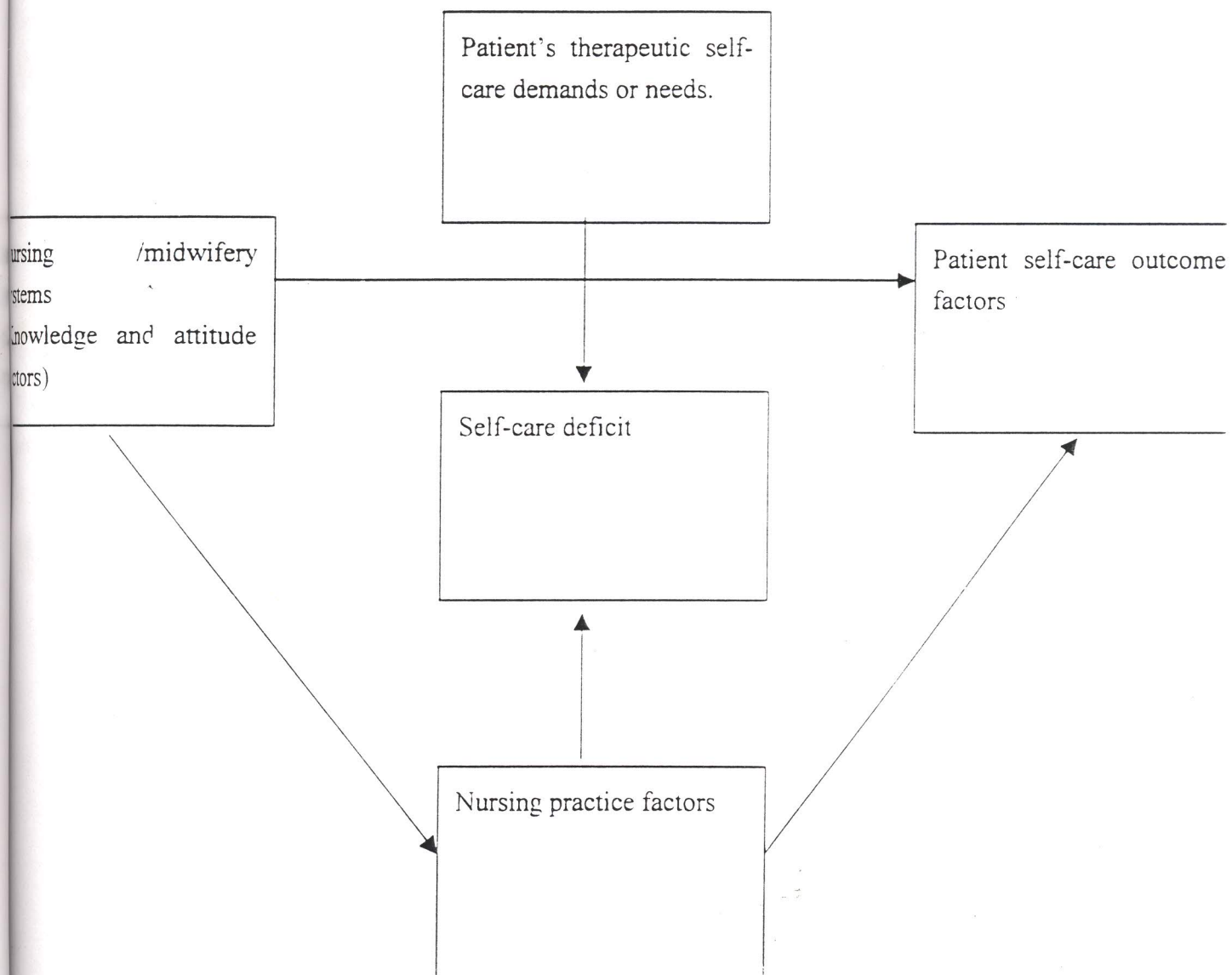
Figure 1: Orem's self-care theoretical frame work



Orem's nursing systems framework.

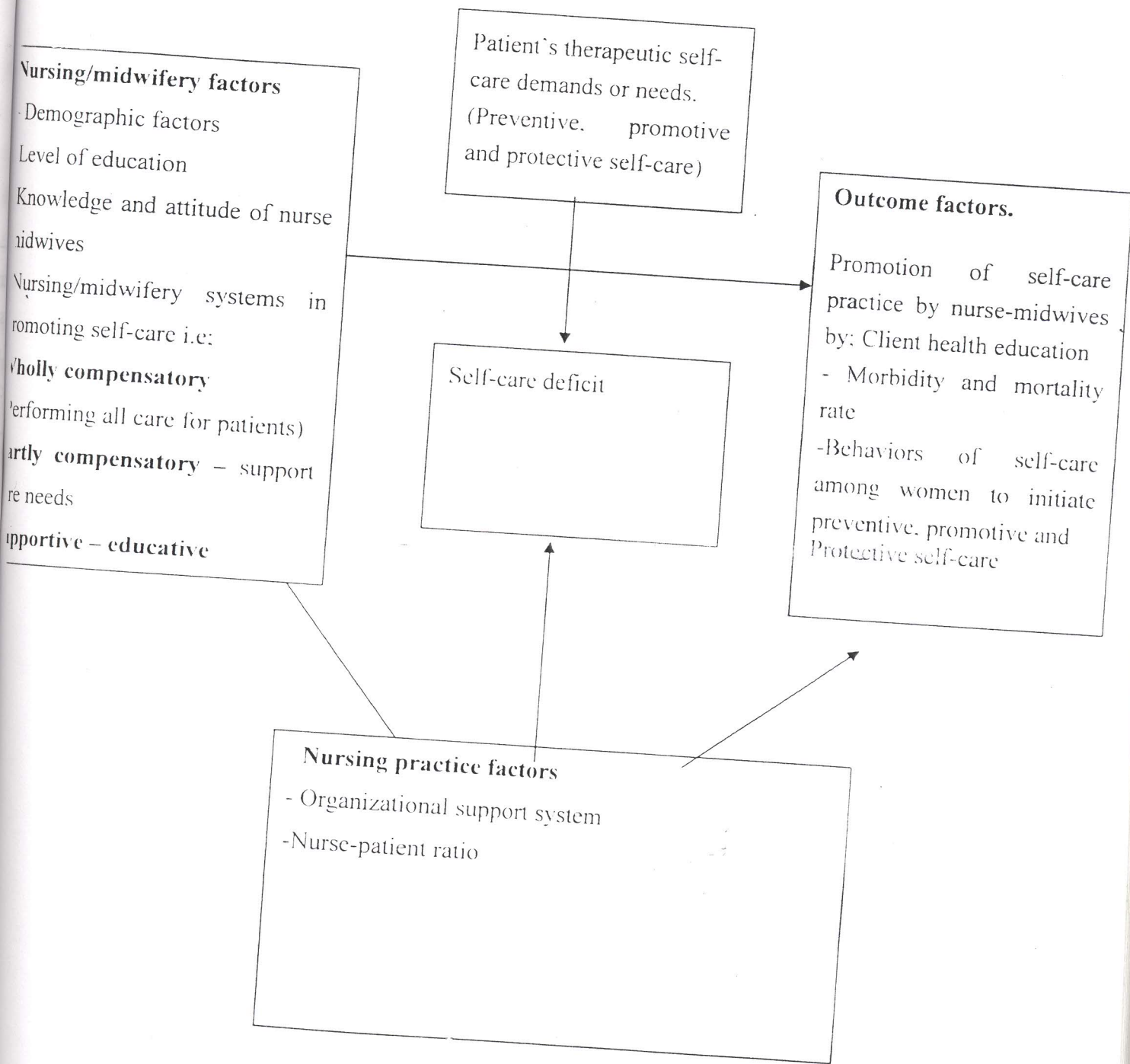
1.10 CONCEPTUAL FRAMEWORK

Figure 2: Conceptual Framework is based on the belief that nurse-midwives have a role in promotion of postnatal mothers' self-care as shown below;



1.11 OPERATIONAL FRAMEWORK

Figure 3: Operational Framework on promotion of self-care by nurse-midwives.



Orem's nursing systems theory (NST)

The above theory represents the following factors:-

Types of self-care

(i) Health promotion self care involves development and maintenance of lifestyle that maintain and support wellness. The clients' perception of control on health behavior forces identification and augmentation of movement towards health (12).

In the postnatal period, women promote health by behaviors such as eating a healthy diet, avoidance of drugs toxic to the baby, regular exercising to name but a few. The idea of health promotion is based on a philosophy of holism; this includes a belief in the interaction effects of the mind, body, spirit and environment. The concept of health promotion differs from disease prevention, which focuses on protecting the self from harm (12).

(ii) Health protection self care

The objective of health protection is for the family to develop and maintain a sense of control over health or ill health rather than feel that their health default has control over them. Self care activities for protection include getting enough rest, and activity, learning to cope with stressors in the environment and meeting extra demands in postnatal period, and coping with changes experienced in the pregnancy and postnatal period.

(iii) Preventive health self care

It involves knowledge of the natural history of disease or pregnancy, preparation for labor and delivery, and knowledge of the combination of etiologies that are actualized when specific disorders of human structure and functioning occur.

In the theory of self care, Orem (1), explains what is meant by self-care and lists the various factors that affect its provision. In the self care deficit theory, she specifies when nursing is needed to assist the individual in the provision of self care.

The above self-care deficit theory delineates when nursing is needed. Nursing is required when an individual or family is incapable or limited in the provision of continuous effective self-care (12).

Nurse – midwives should be able to intervene when the clients and their families have a deficit.

This theory outlines how the clients self-care needs will be met by the nurse – midwives the client or both.

The nurse – midwives system, designed by the nurse – midwives is based on the self-care needs and abilities of the client to perform self care activities.

Orem (11) identifies three classifications of nursing systems to meet the self care requisites of the client. These systems are; the wholly compensatory system, the partly compensatory system and the supportive educative system.

1.12 JUSTIFICATION OF THE STUDY

It is evident that there is need to conduct studies on the knowledge, attitudes and practices of nurse-midwives on promotion of client self-care, since poor self-care or self-care deficit among the clients could be personal or arising from the perspectives of the nurse-midwives or the clients. Optimal client self-care benefits the clients, the hospital, and society at large; so there is need to identify some of the direct and indirect variables that have implications on client self-care and quality of care, and that is the reason for this research.

There is growing evidence to show that supporting self-care leads to:

Improved health and quality of life, increase in patient satisfaction, significant impact on the use of services with fewer primary care consultations, reduction in visits to outpatients and accident and emergency (A&E), and decrease in use of hospital resources (11).

Impact of promotion of self-care among patients or clients include: better symptom management, such as reduction in pain, anxiety, depression and tiredness; improved feeling of well being; increase in life expectancy, and improvement in quality of life with greater independence (11).

Promotion of self-care allows clients to be involved in informed decision making specific to their plan of health care. Hence care during pregnancy, should be client centered, that is, focused on the client and family. The nurse has to involve the client by promoting

self-care behaviors. A major outcome of effective self-care is that the individual is able to perform self-care with only minimal contact with health care personnel. This permits the individual to exert control over the environment, and work toward predetermined health care behaviors. These behaviors during the antenatal and postnatal period are deliberate and transcend through the action – oriented self-care process (11).

Due to the high rate of maternal and infant mortality and morbidity rates and postnatal complications, a lot of research needs to be done on how to promote quality of post-natal health care. One of the strategies to improved care is through empowering and motivating women to be involved in their self-care; this lies predominantly with the nurse since it is he or she who spends more time with the patient (2).

More research needs to be done on how to promote self care in order to: - improve quality of care, improve client participation in their care and prevent complications that can arise out of poor maternal postnatal care. The research results will reduce costs, for maternity health care through shortened hospital stays; It will increase customers' satisfaction with care, job satisfaction for staffs, and promotion of quality of outcome of maternal and child well-being, and will also decrease maternal and perinatal mortality because these have direct impact on the society at large (11).

1.13 EXPECTED BENEFITS OF THE STUDY

The study findings may be used by the hospital administration in policy making related to quality nursing/ midwifery care through promotion of self-care among the clients and their families.

- 1 It will enhance an understanding of the role of nurse – midwives to meet self care requisites of their clients and families i.e. the wholly compensatory system partly compensatory and supportive educative roles
- 2 It will enhance an understanding of the roles of postnatal clients on promotive self care, protective self- care, and preventive self- care.
- 3 The study findings will be used for publication to promote self-care education and stimulate further research on related issues.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION.

Although motherhood should be a time of joy and expectation for a woman and her family, the experience women in developing countries undergo entails suffering and death in certain instances. For these women, motherhood is often marred by unforeseen complications of pregnancy and childbirth (13). Some of these complications and death arise due to lack of appropriate self-care, knowledge and failure of the women to take care of themselves during pregnancy, and after delivery. The high maternal mortality rate, and the complications may be prevented, and the mortality may reduce if women were involved in the planning and execution of their care by promoting their self-care behaviors. Complications such as maternal post partum infections, neonatal sepsis may be prevented through promoting self-care of women during the antenatal and post natal periods and this can be a cheaper measure to reduce maternal and perinatal mortality (13).

Self care includes the actions people take for themselves, their children and their families to maintain good physical, mental, social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital (3).

(13).

Self care includes the actions people take for themselves, their children and their families to maintain good physical, mental, social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital (3).

Worldwide, it is estimated that nearly 600,000 women die yearly from complications of pregnancy and childbirth – (about one woman every minute). It also estimated that a woman's lifetime risk of dying from birth related complications is almost 40 times higher in developing countries, than that of her counterparts in developed countries (8).

In Kenya, a study by the Kenya demographic health survey (KDHS) 2003 reported 600 maternal deaths in every 100,000 live births, which is an increase compared to 395 per 100,000 births in 1994 and 590 in 1998 (9).

At Kenyatta National Hospital (KNH), which is the largest teaching and referral hospital in East and Central Africa, a study conducted in 2006 reported a maternal mortality rate (MMR) of about 921.5 per 100,000 live births. Ten years earlier, a similar review done in 1980 reported a MMR of 258 per 100,000 live births. This indicates a tremendous increase in mortality rates over the years (14).

Due to the high rate of maternal and perinatal mortality rate, a lot need to be done to improve on evidence based practice to reduce maternal-infant mortality and improve the

Thrombo-embolic disorders such as deep venous thrombosis, pulmonary embolism are also reported to contribute to maternal mortality and morbidity (15).

Postnatal depression and puerperal psychosis is another major cause of maternal mortality and morbidity. Research indicates that approximately 10% of all mothers develop clinical depression following childbirth and that a further 10% exhibit considerable emotional distress (16). Such depression is disabling for the mother and causes considerable disruption of family life and maternal-child relationships. Research evidence indicates that depression in the mother has an adverse effect upon her baby's performance in developmental tests at 9 months of age (16). Low self-esteem, anxiety, lack of self-care knowledge and lack of close support network are contributing factors to poor self-care (17).

The safe motherhood initiative which was launched in Kenya in 1987 helped to raise awareness about the impact of maternal morbidity and mortality. Ten years after the launch, strategies were formulated by the World Health Organization (WHO) to be implemented worldwide to ensure safe motherhood. One of the strategies was to reform laws to expand women's access to health services and promote women's health care interests. The other was to educate women and their families about obstetric complications, as well as where to seek medical care to ensure early recognition of complications and promote self-care behaviors (18).

The prevalence of HIV infection among pregnant women is 7.3 percent (9), and estimated 50,000 – 60,000 infants are infected with HIV annually due to mother-to-child-

laws to expand women's access to health services and promote women's health care interests. The other was to educate women and their families about obstetric complications, as well as where to seek medical care to ensure early recognition of complications and promote self-care behaviors (18).

The prevalence of HIV infection among pregnant women is 7.3 percent (9), and estimated 50,000 – 60,000 infants are infected with HIV annually due to mother-to-child-transmission (19). About 5–8 percent of the babies become infected with HIV during pregnancy through transmission across the placenta; while 10-20 percent becomes infected during labor and delivery; and another 10-15 percent get infected through breastfeeding. These are all preventable through promotion of client self-care.

In responding to the high HIV prevalence rate, the National AIDS Control Program (NAS COP) has developed national evidence-based standards and guidelines for the antenatal management of HIV positive women and the Prevention of Mother to Child HIV/AIDS transmission (PMTCT), intrapartum care, postpartum care including infant feeding and care (19). These guidelines are intended for use by health professionals and health institutions that provide ANC services.

The prevalence of Sexually Transmitted Infections (STIs) that are commonly associated with poor self-care and pregnancy-related problems such as abortion, macerated stillbirths and low birth weights is also high among pregnant women. A study that included 815 ANC clients found that 21 percent of them had at least one STI, including

To promote the health and survival of mothers and babies, Kenya in 2001 adapted the WHO focused Antenatal care (ANC) package that promotes interventions that address the most prevalent health issues that affect mothers and newborns (20). The major goal of focused ANC is to help women maintain normal pregnancies through targeted assessment to ensure normal progress of the child bearing cycle and newborn period. Focused antenatal care also facilitates early detection of complications, chronic conditions, and other problems or potential problems that will affect the pregnancy. It also ensures individualized care to help maintain normal progress, including preventive measures, supportive care, health messages and counseling (including empowering women and families for effective self care), and birth preparedness and complication readiness planning (20).

A study on the influence of health education on self-care among cancer patients reported that patients who received health education reported confidence and ability to initiate more self-care behaviors to counteract effects of chemotherapy. The increase in self-care behaviors was attributed to increased knowledge level (21).

In 1987, studies on nutritional self-care of myocardial patients demonstrated that promotion of health self-care through education could influence the self-care agency (22). Variables such as age, marital status, and socio-economic status have inconsistently correlated to self-care. In some instances, direct support of health deviation self-care failed to materialize despite the connection between selected basic conditioning factors and universal self-care.

Myocardial patients were compliant to taking low cholesterol diet after having health education on nutritional self-care (22). The study stated that studies on self-care needs and activities associated with different acute and chronic illnesses and health promotion need to be conducted.

A study conducted in 1990, examined the impact of patient personal characteristics and environmental constraints on self-care provision by home nursing residents. This study linked self-care to basic conditioning factors that included; age, marital status, socio-economic status, and the results were inconsistently correlated to self-care. In some instances, direct support of health deviation, self-care failed to materialize despite the connection between selected basic conditioning factors and universal self-care (23).

2.2 PROMOTION OF SELF-CARE

The concept of self-care is harnessed with a wide range of meanings, given the various perspectives from which self-care is viewed in relation to dependence or interdependence of clients with the health care system and its professional practitioners (24). Self-care is described as a process whereby lay people function on their own behalf in health promotion, disease prevention and treatment at the level of the primary health resource in the health care system (24).

Professional care and support can stimulate self-care rather than function in a conventional and directive manner (25). Often to intervene strongly, to act for patients is

inappropriate, undermining their motivation to look after themselves when they have the capacity to do so. This may be not only an untherapeutic approach but one that invades personal privacy and threatens the individuals' dignity (26).

Traditionally, health care personnel have been known as the only resources for health care, and seldom involve their clients with ability in the planning and execution of care (26). On the contrary, more and more individuals & families are viewing themselves as competent, responsible and motivated for maintaining their own health, either independently or by contracting with professionals. The professionals are expected to assist individuals and families to define concerns but instead, many of them offer solutions (26).

A study on adult patients' self-care supported the view that patients can be more active in dealing with their own health problems (27). Professional care and support can stimulate self-care rather than function in a conventional and directive manner. The study findings indicated that readiness to learn about health or disease-related situation, knowledge of what to do, and a functional ability to perform self-care activities are common strands in the self-care literature concerning factors important in motivating self-care (27). There is need to chart the dimensions of self-care, and obtain information and insight into existing self-care practices (27).

2.3 THE ROLE OF THE NURSE-MIDWIVES IN PROMOTION OF CLIENT SELF-CARE

Self-care as a specific approach to midwifery places primary emphasis on the individuals' ability to promote and protect health. An important task of the nurse-midwives in relation to the management of the client's self-care is to offer the person a realistic view of management of self during pregnancy, labor, and postnatally; i.e., care of self and the newborn. Teaching about self-care is an attempt to provide a model of care that equips the individual with strategies to manage their care, symptoms of treatment or experience through a lifetime if appropriate (28).

Teaching self-care may encourage clients to increase their sense of self-control and lessen the feelings of helplessness. This may be undertaken through information giving and health education (28).

2.3.1 Information and education.

The terms information and education are not synonymous with one another. Through providing clients with information, nurse-midwives and other health-care providers are fulfilling one aspect of their educational role. Health education is a broader process than information giving, the goal of which are ; to impart information, help clients participate effectively in care, help clients to adjust to the reality of their conditions and management, and help clients to realize the fruits of their efforts (28).

To achieve these goals, the health-care providers (nurse-midwives included), may need

to adopt a broader approach to client education. Although factual information is essential for providing individuals with the necessary knowledge, clients may need **practical demonstration** to establish the required skills. Furthermore, clients require **encouragement** to adopt an unfamiliar relationship with their healthcare team, rather than being passive recipients of their care prescribed for them. They may need encouragement in becoming partners responsible for aspects of their care. N/m's should work to encourage and empower clients to take control for themselves and their care (28).

2.3.2 Benefits of education to clients' self-care

Education is a crucial aspect of the self-care process, as without it, patients may not be knowledgeable or confident enough to engage in self-care. One of the benefits of education on self-care include: increased satisfaction, which can be reflected in increased compliance with treatment (29).

Education geared to prepare parents-to-be for pregnancy and child care, play a crucial role in midwifery practice. A study done in Australia in 1980, found that primiparous subjects who had attended antenatal classes had more knowledge of childbirth and were more likely to have formed expectations of childbirth than had untrained women(30).

The research showed that although antenatal class attendance seems to offer some benefits, these appear to be limited. Pain and stress in labor are reduced to some extent in women who attend classes (30).

Antenatal education generally seems to provide accurate procedural and obstetric information but women may benefit more from the provision of accurate experimental information of sensory nature. Such provision might make expectations of childbirth more realistic. However, people have different ways of coping with the anticipation of a stressful event such as childbirth. Some people want to receive as much information as possible while others attempt not to think of what is coming. The professional who aims to prepare women for childbirth thus has to consider the wishes of the client regarding the nature and amount of information to convey (30).

For effective client education to take place, there has to be effective nurse-patient communication. However, the extent to which nurses utilize effective nurse-patient communication is a matter of concern for many researchers in this area. (31).

2.4 KNOWLEDGE, ATTITUDES AND PRACTICES OF NURSE-MIDWIVES ON PROMOTION OF SELF-CARE

Many nurse-midwives view the issue of promoting self-care in patients as a chore of their profession while others perceive it as a challenge (28). As caregivers, midwives on occasion act as the significant other and as role model, and thus their own value systems and those of the employer organization must be called upon into question. Certainly, where there has been a previous positive experience, the chance of compliance will be greater, as it will when there is an effective relationship between members of the health care team and the patient.

The systems approach when implemented in nursing and midwifery implies feedback between the nurse/midwife and the patient during interaction; which subsequently foster the developmental elements of self-care (32). Shared beliefs between the client and the nurse-midwife encourages positivism thereby improving patient teaching, motivation and satisfaction. They note that even though a patient may believe in the efficacy of the treatment, compliance may be absent if the patient believes that treatment regimens are too arduous (32).

2.5 FACTORS THAT AFFECT POSTNATAL WOMEN'S SELF-CARE.

The postnatal period has a unique meaning for each family. The physical postpartal care a woman receives can influence her health for the rest of her life. The emotional support she receives can influence the emotional health of her child and family (33).

The period after delivery is deemed special by many communities in Kenya (34). The Abaluhya community refers the period as "Bwibu", and it lasts up to three months. During the postpartum period, the mother is considered very fragile and vulnerable to infection. The mother who has undergone c/s is considered more fragile and requires more support for a longer period. The expectations in terms of social supports and health care are even more than during pregnancy. Good care in terms of nutrition and avoidance of physical work and sexual relations is expected for a period of time. Generally, friends, spouse, family and traditional birth attendants care for her. The belief that a postnatal mother should rest and limit activity can have direct impact on self-care behaviors of women (34).

2.5.1 Previous experiences of birth.

Traumatizing experiences of previous births may be accountable for anxiety and lack of self-care among postnatal women (30). Women's perception of self-care during previous pregnancy may have a direct impact on the self-care behaviors of women. Previous neonatal loss can preoccupy a mother to give all her attention to the newborn and forget about herself due to anxiety or fear of another loss (30).

2.5.2 Emotional stress.

Severe, prolonged tension from any cause may alter the post-cesarean section women's emotional state (30). The outcome of pregnancy plays a significant role on the emotional status of women; preterm delivery that leads to care of the neonate at the newborn intensive care or nursery is a source of stress to the mother since she cannot predict the fate of the high risk situation of the infant (30).

Neonatal death after delivery is another source of severe stress to the mother as she mourns the loss. Such emotional stress can be detrimental since it can influence the way a postnatal mother is involved in her care. The nurse-midwife has a major role to play in counseling the mother after loss or organizing for a counselor to have some sessions with the mother. The aim counseling to ensure emotional wellbeing of the mother and family thus promotes the mother's interest and involvement in her self-care activities (30).

2.5.3 Maternal age.

A pregnant teenage girl, whether married or not, presents a serious problem, thus requiring a lot of support. She and her partner usually are emotionally and intellectually immature and often are unable to successfully cope with the difficult social, economic and educational problems created by pregnancy and its outcome (35). There is a high risk of cephalopelvic disproportion in young girls hence predisposing them to undergo cesarean section (35).

In a study done in four districts of western province of Kenya, Bukura women believe that young girls and elderly women are at risk during delivery hence they are not supposed to be attended to by the traditional birth attendants (TBAS) and those who for reasons like lack of money to deliver in hospital, are known to risk their lives (19). The women noted with concern that in their community, women give birth at as late as 47 years and this is risky to their lives, but acknowledged that if delivered in hospital, the risks are reduced (19).

2.5.4 Educational level.

Illiteracy among women is a major contributing factor to maternal and infant mortality. Girls who do not go to school, are likely to marry at a very early age and as a result, they are exposed to various complications, particularly obstructed labor due to a small pelvis leading to birth by c/s or if at home they may end up with complications like, vesico-vaginal and or recto-vaginal fistulas (19).

Due to lack of education, many illiterate women have no chance of securing a salaried employment and are therefore forced to remain with very low income from small businesses such as hawking or with no income at all. They, therefore have to totally depend on their husbands. Without economic power, they are likely to have no power over their own self-care behaviors (19).

Women from affluent background are more likely to deliver by elective caesarean sections than those from deprived backgrounds (4); while much of this variation may be due to increased maternal age and higher infant birth weight, the association persists even after adjustment of these factors thus suggesting that social factors may play an important role. Because they are prepared in advance for elective caesarean section, the mothers are also prepared for self-care after surgery, hence have greater chances of better self-care (4).

2.5.5 Economic factors.

Lack of money or poverty in general, can be an important reason why women are not able to participate in their own self-care activities, such as those that involve good diet, and adequate rest (4).

CHAPTER THREE:

METHODOLOGY

3.1 Study design

This is cross-sectional descriptive survey that is to establish the perspectives of nurse-midwives on promotion of client self-care at KNH maternity wards.

3.2 Study area

The study was conducted at Kenyatta National Hospital (KNH) maternity wards. KNH is the largest national teaching and referral hospital in East and Central Africa with a bed capacity of 2000 patients. It is at the apex of the referral system in health care provision in Kenya.

The hospital has different departments according to specialties of medicine and surgery. The department of obstetrics and Gynecology handles issues relating to reproductive health. Reports from the department indicate that averages of twenty five deliveries are conducted daily. Five out of the twenty five deliveries are cesarean section deliveries. The postnatal patients are admitted into the maternity wards where care is provided until discharge. There are five maternity wards, Labor ward, Ward GFA, Ward GFB, Ward 1A, and Ward 1D.

Clients in labor were admitted for delivery or management depending on the admission diagnosis. The patients who required emergency obstetric care were also triaged and

admitted to labor ward and are later admitted to the other maternity wards for further management as in-patients if necessary.

Wards GFA, GFB, and 1A, at the period of study, admitted antenatal patients with medical or surgical problems, and postnatal patients delivered within KNH and those referred to the hospital within 48 hours of delivery.

Ward 1D at the time of study admitted patients referred with obstetric or gynecologic complications.

Each ward at the time of study had an average of about twenty five (25) nurse-midwives thus: the total population of nurse-midwives working at the maternity wards was 125.

3.3 Study population

All nurse – midwives working at KNH maternity wards during the study period.

3.4 Inclusion criteria

All nurse-midwives who were working at the maternity wards at time of study.

3.5 Exclusion criteria

All nurse-midwives who were away from duty on either annual, maternity, or study leave, or those away from duty for any other reason at the time of study.

3.6 Sample size determination

Sample size for the nurse-midwives was determined using the Cochran's formula (37) as follows:-

$$N = (1 - n/N) \times [t^2 (p \times q)] / d^2$$

= Finite population correction x [probability level x variance] / confidence interval

Where

n = the desired sample size

N = the size of the eligible population (There are about 25 nurse-midwives working in each unit and there are five maternity wards eligible for this study. Therefore, the total population of nurse-midwives eligible for the study is $25 \times 5 = 125$).

Z^2 = the standard value of the standard deviation score that refers to the area under a normal distribution of values (in this study confidence level will be at 95% whose critical value corresponds to 1.96 from the table of standard normal distribution).

p = the percentage category for which we are computing the sample size (p for this study is 0.50 because there is no reference proportion of the population with the characteristic of interest).

$$q = 1 - p \text{ (In this study } q = 1.00 - 0.5 = 0.5)$$

d^2 = the squared value of one-half the precision interval around the sample estimate (in this study, d will be set at ± 0.05)

$$n = \frac{(1.96)^2 (0.50) (0.50)}{(0.05)^2} = 384.16$$

Because the sample calculated (384.16) is more than 5% of the eligible population size (125), the sample size is re-adjusted using the population correction factor.

The population correction factor is represented by:

$$\begin{aligned} n' &= n / [1 + \{(n-1)/N\}] \\ &= 384.16 / [1 + \{(384.16-1)/125\}] \\ &= 384.16 / 4.06528 \\ &= 94.49 \end{aligned}$$

A total of 94 nurse-midwives were therefore selected by random to participate in the study.

3.7 Sampling procedure

A purposive sampling procedure was used to select the nurse-midwives. During the period of study, there was a major reshuffle of staff within the whole hospital. Older staffs in the units were transferred to other units while new staffs were received to the wards during the time of study. A lot of orientation was going on and many new nurses to the units admitted that they could not participate in the study because they were still on

preceptor orientation on the care of maternity patients. A purposive sampling was therefore used to select older nurses at the units. The number of staff on annual, maternity, study or emergency leave reduced the expected population; hence readjusting the Cochran's, formula using the population correction factor. A list of names was collected from the unit in-charges and all nurse-midwives on duty and not on preceptor orientation were selected to participate. The selected ones who consented signed the consent form (appendix II) and were the study participants.

3.8 Study instruments

This was a self administered semi structured questionnaire with both closed-ended and open-ended questions. A Likert scale was also used to generate qualitative and quantitative data. It was in three parts: section 1- demographic data, section 2- self-care, and section 3 – knowledge, attitudes and practice (Appendix III).

3.9 Pre-testing of study instruments

To ensure that the questionnaire is stated clearly and has the same meaning to all the participants, it was pre-tested among randomly selected respondents at the private wing maternity ward at KNH, which beard similar characteristics with the research sample. Items identified as sensitive, confusing or biased in any way were modified or omitted. Information obtained during pre-testing was used to revise the instrument and was not used as part of the actual research.

Pre-testing was done one week prior to the study period and results were be used to refine the study instruments.

3.10 Selection and training of research assistants

One registered nurse and a nurse intern were research assistants and they were oriented on their expected roles through a discussion conducted for three hours.

The questionnaire was given to each of them to study, followed by a discussion on how the questionnaires were supposed to be filled. The inclusion and exclusion criteria were also be discussed.

3.11 Data collection, cleaning and entry

Questionnaires which were filled by the nurse-midwives were collected by the research assistants and the principal investigator examined them for completeness and accuracy. Properly filled questionnaires were entered into a computer for analysis.

3.12 Data analysis and presentation.

Data collected from the questionnaires was entered into the computer and analyzed by the statistical package for social scientists (SPSS) version 11.5 for windows, as well as spread sheet (Excel package) for windows 2000.

Frequencies of various parameters of the study were obtained. Descriptive methods of data analysis and presentation were applied as well as tests of significance for reliability, validity and for purposes of data interpretation. The Pearson Product –Moment correlation coefficient (r) was determined. The correlation coefficient ranges between -1 to 1. The magnitude of the relationship between variables is determined by the fact that

the bigger the coefficient (absolute value), the stronger the association between the variables. Positive correlation coefficient (r) means that as one variable increases, the other increases too; and as one decreases, the other decreases too. A negative relationship means that the variables vary in opposite directions (inverse relationship). Test of analysis of the correlation coefficient was done. A biostatistician was involved at various stages for authentication and credibility of the analysis process.

Data are presented in form frequency counts, in tables, charts and graphs. The findings will be prepared for presentation in various forums for discussions, recommendations and further actions. Such forums include the school of nursing sciences, and publications in various journals.

3.13 Ethical consideration.

Approval to carry out the study was obtained from the Kenyatta National Hospital Research and Ethics Committee, and the ministry of Education (Appendix IV and V).

Authorization letters were forwarded to Kenyatta National hospital and consent was given for data collection. Informed consent was obtained from the participants before recruiting them into the study (Appendix I).

Confidentiality was observed and no names indicated on the questionnaires and a commitment was made that findings of the study would be made available to Kenyatta National hospital.

3.14 Study limitations.

The first limitation was that study was conducted at KNH only. Findings therefore may not necessarily reflect the true situations in other hospitals locally and in other hospitals in other parts of the country since this is a referral urban based health setting.

Secondly, extraneous variables like the educational level of the subjects could not be controlled therefore may have resulted in the threats to internal and external validity.

Thirdly, there was major reshuffle of the nurses and midwives at the hospital during the time of data collection and this led to a delay in data collection and change of sampling method to purposive sampling to ensure that the questionnaires were availed to consenting nurse-midwives who had worked at the unit for more than three months and not those on preceptor orientation.

The fourth limitation was that Nurse-midwives were too busy with nursing care activities and hardly had time to sit and fill the questionnaires. This made the research assistants and principal investigator to look for the nurse-midwives at a time convenient to fill the questionnaires even night duty.

CHAPTER FOUR

4.0 DATA ANALYSIS AND RESULTS

4.1 Introduction

This study was conducted at the Kenyatta National Hospital Maternity Wards. Respondents were consenting nurse-midwives working in the maternity wards during the period of the study. A sample of 94 nurses was purposively selected from a population of 125 nurses working in the maternity wards. This chapter presents the results at two levels. Firstly, nurse-midwife factors which include, demographic factors, Knowledge factors, attitude factors, and practice factors. The second level is patient factors that may influence nurse-midwives' involvement in promoting client self-care

4.2 NURSE-MIDWIFE FACTORS

4.2.1 Respondents' Profile

Most of the respondents in the study were female (accounting for 94.7%), of the total number of respondents. Males accounted for only 5.3 %.

The study elicited that of the 94 respondents, 56 (59.6%) were aged 35 years or less. Just above 40.0% (38) are aged above 35 years.

The distribution of respondents by religion shows that almost three-quarters (or 73.4%) profess the Protestant faith. Catholics account for one-fifth (or 20.2%) while Muslims comprised 6.4% of the respondents. The information on respondents' demographic characteristics is shown in Table 1:

Table 1: Demographic characteristics of the respondents (n= 94)

CHARACTERISTIC	FREQUENCIES	PERCENT
RESPONDENTS' GENDER		
Female	89	94.7
Male	5	5.3
TOTAL	94	100
AGE GROUP		
Below 25 years	1	1.1
26- 30 years	26	27.7
31- 35 years	29	30.9
36- 40 years	22	23.4
Above 40 years	16	17.0
TOTAL	94	100
LEVEL OF EDUCATION		
Basic certificate in nursing	34	36.2
Post basic Certificate in midwifery	10	10
Certificate in psychiatric nursing	2	2.2
Diploma in community health nursing	15	16
Post-basic diploma in midwifery	24	25.5
Post-basic diploma in public health nursing	6	6.4
Diploma in advanced nursing	1	1.1
Bachelor of science in nursing(BSc.N)	1	1.1
Masters in psychology	1	1.1
TOTAL	94	100
YEARS OF SERVICE		
Below 5 years	27	28.7
6-10 years	17	18.1
11-15 years	26	27.7
16-20 years	18	19.1
Above 21 years	6	6.4
TOTAL	94	100
DESIGNATIONS		
Senior Nursing Officer(SNO)	5	5.3
Nursing Officer I (NOI)	20	21.3
Nursing Officer II(NOII)	9	9.6
Nursing Officer III(NOIII)	16	17
Senior enrolled nurse(SECN)	8	8.5
Enrolled community nurse I (ECN I)	23	24.5
Enrolled community nurse II (ECN II)	7	7.4
Enrolled nurse-midwife (EN/EM)	6	6.4
TOTAL	94	100

The distribution of respondents by religion shows that almost three-quarters (or 73.4%) profess the Protestant faith. Catholics account for one-fifth (or 20.2%) while Muslims comprised 6.4% of the respondents.

The largest percentage of respondents had a basic certificate in midwifery (36.2% of the total). The next largest percentage was of respondents holding a post-basic diploma in midwifery was 25.5% while respondents with a diploma in community health nursing and certificate in midwifery were 16.0% and 10.6% of the total respectively as shown in the Table 1.

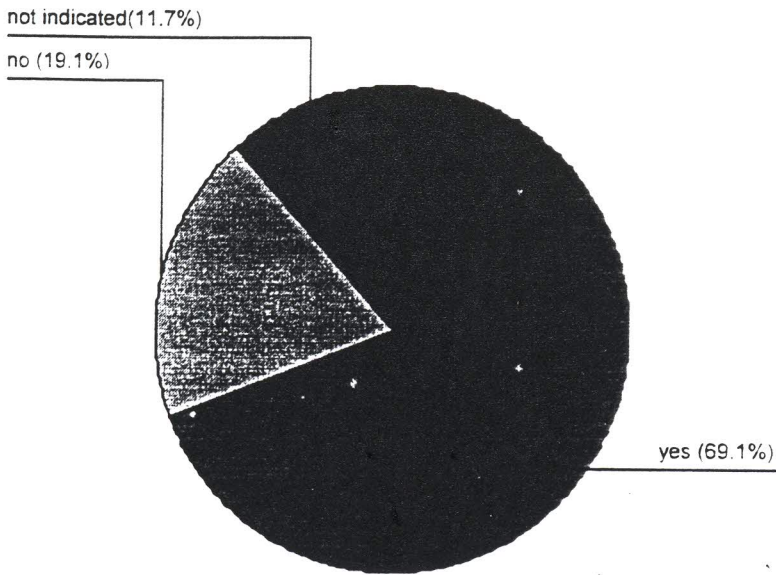
The distribution of years of service is shown in Table 2. It shows that about three-quarters of respondents have worked for 15 years or less while about one-quarter have worked for sixteen years and above.

Respondents were drawn from various designations among them the Senior nursing officers- SNO (5.3%), Nursing Officer- NO I (21.3%), NO III (16.0%), and Senior Enrolled Community Nurse- SECN I (8.5%), Enrolled Community nurse I(ECN I) (24.5%), and Enrolled nurse with certificate in midwifery EN/EM (6.4%).

4.2.2 Nurse-midwives involvement in promoting client self-care at the maternity units

A significant percentage of respondents (69.1%) reports that they promote self-care in their wards. Just under one-fifth (or 19.1%) report that they do not promote self-care in their wards while 11.7% do not answer this question. This is shown on chart 1 below.

Chart 1: Percentages of nurse-midwives' involvement in promotion of client self



4.2.3 Relationship between the socio- demographic factors and involvement in promoting client self-care

There were no statistically significant correlation between the above demographic factors and nurse-midwives' involvement in promoting client self-care as shown on table 3 above.

The relationship between gender and nurse-midwives' involvement in promoting client self-care was not statistically significant. Table 2, shows the correlation coefficient (r) was 0.084, and P-value was 0.993.

Table 2: Relationship between the socio- demographic factors and involvement in promoting client self-care (The figures in parenthesis indicate percentages)

Demographic factors	Nurse-midwives' involvement in self-care promotion (Frequencies) and percentage frequency				Correlation coefficient (r)	P-value
	Yes %F	No %F	Not indicated	Total		
Respondents' gender					0.084	0.993
Female	62 (69.7%)	16 (18%)	11 (12.3%)	89 (100%)		
Male	3 (60.0%)	2 (40.0%)	0	5.0 (100%)		
Respondents' age					0.009	0.993
< 25 Years	1.0 (100%)	0	0	1 (100%)		
26-30 yrs	17 (65.4%)	6 (23.1%)	3 (11.5%)	26 (100%)		
31-35 yrs	22 (75.9%)	3 (10.3%)	4 (13.8%)	29 (100%)		
36-40 yrs	13 (59.1%)	7 (31.8%)	2.0 (9.1%)	22 (100%)		
Above 40	12.0 (75%)	2 (12.5%)	2 (12.5%)	16 (100%)		
Religion					0.455	0.650
Catholics	13 (68.4%)	4 (21.1%)	2 (10.5%)	19 (100%)		
Protestants	49 (71%)	12 (17.4%)	8 (11.6%)	69 (100%)		
Muslims	3.0 (50%)	2 (33.3%)	1 (16.7%)	6.0 (100%)		
Level of education					-0.028	0.791
Basic certificate in nursing	23 (67.6%)	6 (17.6%)	5 (14.7%)	34 (100%)		
Post basic Certificate in midwifery	9.0 (90%)	0	1 (10%)	10 (100%)		
Certificate in psychiatric nursing	2.0 (100%)	0	0	2.0 (100%)		
Diploma in community health nursing	9.0 (90%)	4 (26.7%)	2 (13.3%)	15 (100%)		
Post-basic diploma in midwifery	15 (62.5%)	6.0 (25%)	3 (12.5%)	24 (100%)		
Post-basic diploma in public health nursing	4 (66.7%)	2 (33.3%)	0	6.0 (100%)		
Diploma in advanced nursing	1.0 (100%)	0	0	1.0 (100%)		
Bachelor of science in nursing(BSc.N)	1.0 (100%)	0	0	1.0 (100%)		
Masters in psychology	1.0 (100%)	0	0	1.0 (100%)		

There was no statistically significant relationship between the respondents 'age and religion with nurse-midwives involvement in client self care promotion. Correlation coefficient(r) was 0.009 and 0.455 while $p=0.993$ and 0.650 respectively.

There was no statistically significant relationship between level of education and nurse-midwives' involvement in promoting client self-care, $r=-0.028$, $p=0.791$ as shown on table 3

Table 3: Relationship between the years of service, and designations with involvement in promoting client self-care

Characteristic	Nurse-midwives' involvement in promotion of client self-care (frequency and percentage frequency)				Correlation coefficient (r)	P(probability value)
	Yes	No	Not indicated	Total		
Years of service						
Below 5 years	18 (66.7%)	6 (22.2%)	3 (11.1%)	27 (100%)	0.065	0.948
6-10 years	12 (70.6%)	4 (23.5%)	1 (5.9%)	17 (100%)		
11-15 years	19 (73.1%)	2 (7.7%)	5 (19.2%)	26 (100%)		
16-20 years	11 (61.1%)	6 (33.3%)	1 (5.6%)	18 (100%)		
Above 21 years	5 (83.3%)	0	1 (16.7%)	6 (100%)		
Designations						
Senior Nursing Officer(SNO)	4 (80.0%)	1 (20.0%)	0	5 (100%)	0.066	0.948
Nursing Officer I (NOI)	12 (60.0%)	7 (35.0%)	1 (5.0%)	20 (100%)		
Nursing Officer II(NOII)	7 (77.8%)	1 (11.1%)	1 (11.1%)	9 (100%)		
Nursing Officer III(NOIII)	9 (56.3%)	4 (25.0%)	3 (18.8%)	16 (100%)		
Senior enrolled nurse(SECN)	6 (75.0%)	1 (12.5%)	1 (12.5%)	8 (100%)		
Enrolled community nurse I (ECN I)	18 (78.3%)	1 (4.3%)	4 (17.4%)	23 (100%)		
Enrolled community nurse II (ECN II)	5 (71.4%)	1 (14.3%)	1 (14.3%)	7 (100%)		
Enrolled nurse-midwife (EN/EM)	4 (66.7%)	2 (33.3%)	0	6 (100%)		

Relationship between the respondents' years of service with nurse-midwives' involvement in promoting client self-care was not statistically significant as shown on table 3 above. The correlation coefficient $r = 0.065$ and the p value = 0.948.

There was no statistically significant correlation between the respondents designations and involvement in promoting client self-care. The correlation coefficient $r = 0.660$ while the probability value $p = 0.948$.

4.3 NURSE-MIDWIVES' KNOWLEDGE FACTORS.

4.3.1 Understanding Self-Care

Most respondents (86.2%) generally understand what self-care means. These are all the respondents (of various educational levels) that gave a correct definition of self-care. Only a small percentage of all the respondents (7.4%) do not understand what it means (as they gave a wrong definition). Another 6.4% did not give any definition as shown in table 4 below.

Table 4: Definition of self-care (n-94)

<i>Characteristic</i>	<i>Frequencies</i>	<i>Percent</i> <i>N=94</i>
Correct definition	81	86.2
Wrong definition	7	7.4
No definition given	6	6.4
Total	94	100

4.3.2 Relationship between Level of Education and Understanding of Self Care

There is a generally high level of understanding the meaning of self-care across various educational levels. In total, 86.2 % of all respondents gave a correct definition of self care. 76.5% of respondents holding a basic certificate at the time of study gave a correct definition of self care compared to persons with higher and more specialized

qualifications. Those who gave a wrong definition and no definition were 7.4% and 6.4% respectively. This information is shown in Table 5 below:

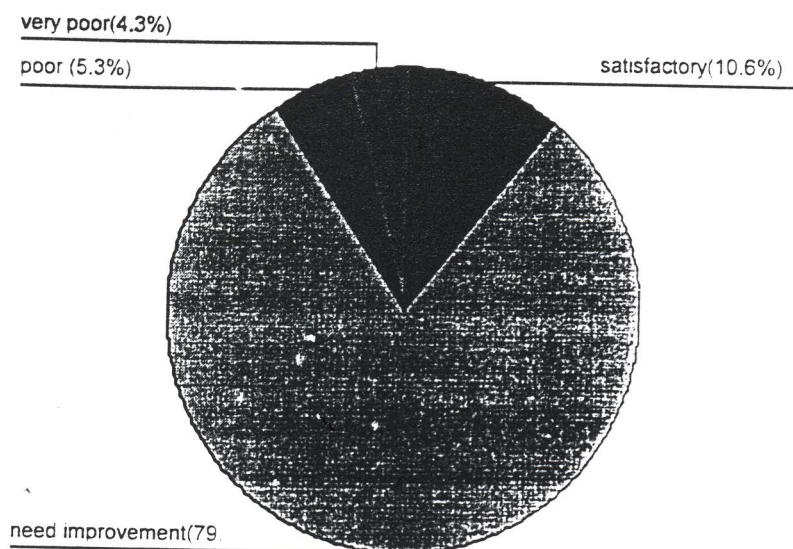
Table 5: Relationship of level of education and understanding of self care (n=94)

<i>Highest qualification held at the period of study</i>	<i>Frequencies</i>	<i>Number defining self-care correctly</i>	<i>Percentage defining self care correctly (%)</i>
Basic certificate in community nursing	34	26	76.5
Post basic Certificate in midwifery	10	10	100.0
Certificate in psychiatric nursing	2	2	100.0
Diploma in community nursing	15	13	86.6
Post-basic diploma in midwifery	24	21	87.5
Higher level qualifications	9	9	100.0
Total	94	81	

4.3.3 Respondents' score of activities of promotion of patient self-care in their wards during the period of study.

79.8% of respondents report that the state of self-care promotion activities in their wards needs improvement, 10.6% say that the state of self-care in their wards is satisfactory while 9.6% say it is poor or very poor. Thus, it can be concluded that much still needs to be done in the area of improving the state of self-care in the wards.

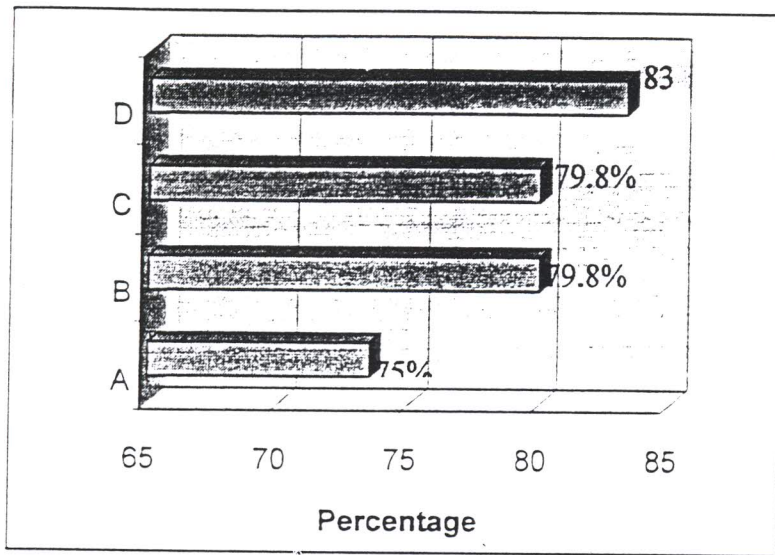
Chart 2: *Respondents' score of activities of promotion of patient self-care in their wards during the period of study.*



4.3.4 Relationship Level of Education and Staff Score in Self-Care Promotion in Units.

Most respondents (79.8%) across the various educational qualifications report that there is need for improvement in staff involvement in self care promotion. Only 10.6% of the respondents feel that the current level of self care promotion is satisfactory. There is a relatively higher percentage of staff reporting that the level of self-care involvement needs improvement among staff with higher qualifications compared with staff holding relatively lower qualifications. However, this difference is not significant as the chart 3 below shows:

Chart 3: Percentage of staff involved in self-care who say self-care program needs improvement (n=94)



Legend:

A	Basic Certificate
B	Post basic Certificate in midwifery
C	Diploma in Community Health Nursing
D	Post-basic Diploma in Public Health Nursing

Respondents who are involved in promoting self-care in their units are relatively more likely to report that the score for the health self-care education and counseling in their wards as satisfactory (13.8%) compared to those who do not promote self-care in their units (0.00%). They are also less likely to report that the score of self-care in their wards is poor or very poor (7.7%) compared to those who do not promote self-care (11.1%). Therefore, nurse-midwife involvement in promoting self-care translates into a higher score for self-care.

4.4 NURSE-MIDWIVES' ATTITUDE FACTORS

4.4.1 Nurse-midwives', Attitudes on their involvement in promotion of Self-care

All the respondents agreed or strongly agreed that there is need for nurse-midwives to learn to identify client ability and deficit to perform self care. They also agreed or strongly agreed that self-care can reduce the rate of maternal to child transmission of HIV infection. Respondents also agreed that promotion of self-care postnatally prepares patients for informed family planning choices and family size decision-making.

The table below shows the mean scores for variables on knowledge, attitudes, and practice on promotion of self-care:

Table 6: Nurse-midwives' attitude towards their involvement in promoting patient/client self-care. (n=94)

<i>Variable</i>	<i>Mean Score (4= agree, 5=strongly agree)</i>
Nurse-midwife should be able to identify client ability and deficit to perform self-care	4.41
Self-care can reduce rate of maternal to child transmission of HIV infection	4.51
Promotion of self-care enhances clients' informed family planning choices	4.51
Self-care improves health of both mother and child	4.52

(Where 1=strongly disagree, 2= Disagree, 3= neither agree nor disagree, 4= Agree, and 5= strongly agree).

The mean scores on table 6 show that respondents agree or strongly agree with the stated variables. Respondents also agree or strongly agree that they have knowledge and confidence to assess and manage clients' individual self-care needs (mean score of 4.51). Results also indicate that self-care skills acquired in the course of continuous development programs are necessary for improved performance (4.51) and that maternal level of education has direct impact on antenatal and postnatal health care (mean score 4.49) at 95% confidence interval.

Table 7: Relationship between nurse-midwives' attitudes and involvement in promotion of self-care (N=94)

Characteristic (Attitude factors)	Nurse-midwives involvement in promoting client self-care			Pearson Correlation coefficient(r)	P- value
	Strongly agree (% F)	Agree (% F)	Total (%)		
Nurse-midwives should identify client self-care deficit	39 (41.5%)	55 (58.5%)	94 (100%)	0.013	0.904
Self-care education reduces MTCT of HIV/AIDS	48 (51.1%)	46 (48.9%)	94 (100%)	0.110	0.291
Promotion of self- care enhances reproductive health self-care decision making	48 (51.1%)	46 (48.9%)	94 (100%)	0.141	0.176
Promotion of self- care improves maternal and infant health	49 (52.1%)	45 (47.9%)	94 (100%)	0.189	0.068

4.4.2 Involvement of Patients in planning and implementing their Self-Care

The study findings showed that 65 (69.1 %) respondents report that it is necessary to involve postnatal patients in planning and executing their self-care. They also indicate that it is important to assess patients' attitudes and cultural perspectives on post-natal self care before inviting them to be involved. This is in recognition of the role that patients can play in their own self-care, lack of involvement which can easily curtail the success of the self-care programs.

A half 49 (52.1%) of the respondents indicated that self-care enhances maternal and child health and reduces mortality rate as shown on table 7.

4.5 NURSE-MIDWIVES PRACTICE FACTORS THAT INFLUENCE THEIR INVOLVEMENT IN PROMOTION OF SELF-CARE.

A very large percentage of respondents 85 (90.4%), disagree or strongly disagree that the hospital provides them with the materials they need to execute self-care education programs. 18 (19.1%) strongly disagreed while 67(71.3%) of the respondents (n=94) that they have the necessary materials to execute self-care programs in their units.

94 (100%) of the respondents reported that inadequate staffing directly affects the quality of midwifery care and there involvement in promoting self-care. This shows that organizational support is seriously lacking and its absence hampers nurse-midwives in their work of teaching and promoting self-care among patients.

A 100% of all the respondents agree or strongly agree that the nurse-patient ratio has a direct impact on their involvement in promoting client self-care as indicated on table 8. This again confirms that the hospital administration needs to provide the human resources to make it easy for nurse-midwives to promote self-care in the patients.

Table 8: Nurse-midwives practice factors that influence their involvement in promotion of Self-Care.

Characteristic (factors)	Nurse-midwives involvement in promoting client self-care			Correlation coefficient(r)	P- value
	Strongly agree (% F)	Agree (% F)	Total		
Low staffing affects self-care activities	34 (36.1%)	60 (63.9%)	94 (100)	0.209	0.043*
High patient population affects promotion of self-care	50 (53.2%)	44 (46.8%)	94 (100)	0.607	0.000*

* Correlation is significant at the 0.05 level (2-tailed).

Above 90% of the respondents either agreed or strongly disagreed that low staffing and a high patient population that increases the nurse-patient ratio has influence on their involvement in promoting self-care. The relationship between the above variables and the respondents' involvement in promoting self-care was statistically significant. The

correlation between low staffing and involvement in promotion of self-care was statistically significant. The correlation coefficient (r) of =0.209 at a significance level of 0.05 (2- tailed) with a Probability (p) value of 0.043 as shown on the table 9 above. This means that the lower the staff in relation to patient ratio, the lower will be the staff involvement in promoting self-care.

The study findings also showed a statistically significant correlation between the patient population and promotion of self-care. The correlation coefficient (r) is 0.607 at a significance level of 0.01 (2-tailed) with a probability (P) value of 0.000 as shown on the table 9 above. The higher the patient population, there is increased demand on the nurse-midwives which directly affects the quality of midwifery care and nurse-midwives' involvement in promoting self-care.

4.6 PATIENT FACTORS THAT MAY INFLUENCE NURSE-MIDWIVES' INVOLVEMENT IN PROMOTING SELF-CARE.

The study found that above 95% of the respondents agreed or strongly agreed that maternal age, maternal level of education, economic factors and cultural beliefs influence involvement in promoting self-care. Maternal cultural beliefs had a statistically significant relationship with nurse- midwives' involvement in promotion of self care. Correlation coefficient (r) =0.220 (2-tailed), p-value =0.33 at significance level of 0.05. These findings are shown on Table 10.

Maternal age, did not have a statistically significant correlation with nurse-midwives' involvement in promoting client self-care $r=0.173$, with a probability value $(p) = 0.960$.

Table 9: Patient factors that may influence nurse-midwives' involvement in promoting self-care.

Characteristic (factors)	Nurse-midwives involvement in promoting client self-care (Frequency and percentage frequency)			Correlation coefficient(r)	P- value
	Strongly agree	Agree	Total		
Maternal age	46 (48.9%)	47 (50%)	94 (100%)	0.173	0.960
Maternal level of education	30 (46.2%)	35 (53.8%)	65 (100%)	1.670	1.080
Maternal economic factors	30 (46.2%)	35 (53.8%)	65 (100%)	1.670	1.080
Maternal cultural belief	30 (46.2%)	35 (53.8%)	65 (100%)	0.220	0.330

The correlation between maternal level of education and economic factors with nurse-midwives' involvement in promoting client self care was not statistically significant, $r=1.670$, and $p=1.080$ respectively as shown on table 9.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 DISCUSSION.

This study was conducted at Kenyatta national hospital maternity wards. The study aimed at establishing the factors that influence nurse-midwives' involvement in promoting client self-care. Promotion of self-care among patients has many advantages. It ensures client participation in personal care, improves patient-customer satisfaction of care given, reduces the cost burdens of health care for both the patient and the institution and also prevents recurrence of preventable diseases (29). Self-care has been suggested as a means of promoting more successful symptom control and as a way of handing control of the treatment situation over to the patient (24). Self-care does not mean that the role of the professional is eliminated; rather, it means that professional care and support should stimulate self-care rather than functioning in a conventional and directive manner (25). Self-care is an approach that various researchers have advocated (21). Dodd's study in Australia in 1990, for example, supports the view that patients can be more active in dealing with their own health problems (21).

5.1.1 Nurse-midwives' Involvement in Promotion of Self-care.

This study has shown that the level of nurse-midwives involvement in promoting self-care influences client self-care behaviors. Nurses who are involved in promoting self-care in their wards are more likely to report that the score for self-care among their patients is satisfactory compared to those who are not involved in promoting self-care. They are

also less likely to report that self-care score in their wards is poor or very poor compared to nurses who do not promote self-care. Therefore, nurse-midwife involvement in promoting self-care translates into a higher score for self-care activities.

Promotion of self-care has an important contribution to make to the patient's educational level. When the patient has sufficient education, she would be in a better position to take charge of her self-care and would not see it as the work of the nurse or the hospital. Similar studies on the influence of education on self-care among cancer patients show that patients who receive health education have increased confidence and ability to initiate more self-care behaviors to counteract the effects of the chemotherapy treatment (21). It is expected that education in self-care among post-natal patients would have the effect of reducing postnatal depression and other postnatal disorders which can contribute to maternal mortality and morbidity (30).

A significant percentage of nurses (almost 70.0%) are involved in promoting self-care among their patients. The level of self-care is higher in wards where nurses actively promote this program to their patients. Although self-care is higher where there is active promotion, the relative percentage uptake of self-care is not high enough to make a significant impact on patients. This finding agrees with reports from earlier studies that observed that although self-care promotion is an important component of nursing and midwifery, it is often given low priority when compared to other care practices. Nurses participating in this study conclude that organizational state of self-care programs needs improvement from current levels (33).

This study has shown that nurse-midwives generally understand the meaning and importance of self-care. Earlier studies in New York observed that it is only as nurse midwives are knowledgeable and have necessary skills that they can best promote client self-care (5). The study reveals that that nurses know that major advantages relating to low cost among others would be gained if patients took responsibility for planning and executing their self care. Because patients would heal faster, they would require less period in hospital leading to savings in hospital bills which have a huge socio-economic and psychological impact on the family and the society. In fact, this would have the effect of reducing the almost 20% of preventable complications that are reported to the KNH postnatal clinic.

The role of the patient in planning and executing self-care programs is very important. Without the cooperation of the patient, self-care programs may fail in situations where patients resist what they consider intrusion to their privacy and individual dignity. It is therefore important to observe that nurses in this study agree or strongly agree that they regularly involve postnatal patients in the planning and executing of their self-care. Earlier studies pointed out that the professionals' role is to assist the patient define her own health concerns, with the patient herself taking active charge of her life as a competent, responsible individual motivated to maintaining her own health (7). Strong intervention by health professionals to do for the patient what she can do for herself is bound to be inappropriate and may undermine the patient's motivation to look after herself when she has the capacity to do so (27).

The nurse-midwives report that promotion of self-care can reduce the rate of maternal to child transmission of HIV infection and makes patients better placed to undertake self-care. A study in Britain showed that accurate information before the experience increases patients' knowledge about disease and can prepare them for forthcoming investigation and treatment (29). Patients report less anxiety and distress with medical procedures and treatment when their expectations are realistic and consistent with their actual experiences. Education geared towards preparing parents-to-be to handle issues related to self-care makes patients more ready to face the issues of child-birth and the period thereafter. A 1980 Australian study found that subjects who had attended antenatal classes had more knowledge about childbirth and were more likely to have formed expectations of childbirth than had untrained women (30).

5.1.2 Obstacles to Uptake of Self-care Programs

5.1.2.1 Organizational Obstacles

The study shows that nurses face various obstacles in promoting self-care programs. The hospital organization is one important obstacle. Nurses report that the hospital does not provide adequate support for self-care programs. Almost all the nurses do not receive the materials and hospital support they need to implement self-care education. An understanding of the organizational and societal factors that affect the uptake of self-care programs is very important (24).

Knowledge of the limitations posed by the organization would ensure that such limitations are removed leading to better success of the self-care initiatives.

Organizational limitations include inadequate materials and lack of hospital support to implement self-care education and a low ratio of nurses to patients which has a direct impact on nurse-midwives involvement in promoting client self-care. Inadequate staffing of wards also directly affects the quality of midwifery care and nurse-midwives' involvement in promoting self-care.

Organizational issues are directly connected to the availability of resources. Without adequate resources, it is difficult for the hospital organization to provide the materials needed to run a successful self-care program. Without enough nurses in the wards, it would be difficult to have people running the self-care programs. This then directly ties in with the allocation of funds to the hospital as a whole and to the various departments within the hospital.

5.1.2.2 Educational Level of Patients

Nurse-midwives report that maternal level of education of patients has direct impact on postnatal patient's self-care. Illiteracy among women is a major contributing factor to maternal and infant mortality. Self-care increases with higher level of education among patients. Level of education also correlates with economic factors. Higher-educated women are more likely to show higher uptake of self-care programs than lower-educated ones.

Lack of education bars most women from securing good economic opportunities. Without a good economic base, patients are limited in their choice of self-care programs. Lack of money in particular, and poverty in general, has an important impact on women's participation in self-care activities, especially those relating to good diet and adequate rest.

A study in Britain, in 1999, observed that women from affluent backgrounds are more likely to deliver by elective caesarian sections than those from deprived backgrounds. Because such mothers elect to have caesarian procedures, they are more likely to be prepared in advance for self-care after surgery, hence have greater chances of better self-care (4).

5.1.2.2 Educational Level of nurse-midwives

This study shows some correlation between nurse-midwives' educational level and their involvement in promotion of client self-care. The study findings show a positive but very low correlation between level of education of the nurse-midwife and nurse-midwife's ability to identify client ability and deficit to perform self-care (correlation coefficient is 0.117). The correlation between level of education and promotion of self-care postnatally preparing clients to make informed reproductive health decision making is positive (0.098); meaning that nurse-midwives with low level of education directly affects self-care decision making of the clients negatively. The lower the educational level of the nurse-midwives, the poorer is the decision making of the clients.

5.1.3. Correlation between Other Variables and Self-care promotion.

This study shows some correlation between socio-economic variables and self-care. These results are in agreement with an earlier study which observed that variables such as age, marital status, and socio-economic status have inconsistently correlated to self-care (4). The study reported that in some instances, direct support of health deviation self-care failed to materialize despite the connection between selected basic conditioning factors and universal self-care. The same study also stated that studies on self-care needs and activities associated with different acute and chronic illnesses and health promotion need to be conducted (4).

5.2 CONCLUSIONS

This study demonstrated clearly that promotion of self-care is an evidence based practice in nursing and midwifery (2). Self-care is the practice of activities that individuals with the capacity of decision making, initiate and perform, within time frames in the interest of maintaining life, healthful functioning, personal development, and well-being (1).

The role of the nurse – midwives in promoting women's self care during pregnancy and after delivery is the most cost – effective way of ensuring quality maternal and infant health care. The economics of health care and the rising tide of health care demand mean that the nurse- midwives must consider carefully just what role they should play with a patient or client health care (4). Nurse-midwives should therefore promote client self-care through health education and counseling. This enables identification of client educational needs and implementation of education as per the deficit identified. This means that nurse-midwives should utilize the nursing process in promotion of client self-care.

Strategies to increase patient motivation to self-care lie predominantly with the nurse since it is she or he who spent more time with the client. Nurse-midwives should look into there nursing or midwifery systems to suit the changing trend. There is need for services to be women centered, to make information available to all women through the focused women care and increase women's involvement by empowering them through promotion of self-care behaviors (2).

An understanding of the personal factors, the organizational factors and the societal factors which affect midwifery practice is important and requires a lot of research so that

midwifery care may be developed to enable all women to experience midwifery care which is supportive and personal. One strategy of ensuring client involvement in their care is through promotion of self-care behaviors. The nurse-midwives must therefore be knowledgeable and have the necessary skills to promote client self-care (5).

The prevalence of HIV infection among pregnant women is 7.3 percent (9), and estimated 50,000 – 60,000 infants are infected with HIV annually due to mother-to-child-transmission (19). About 5–8 percent of the babies become infected with HIV during pregnancy through transmission across the placenta; while 10-20 percent become infected during labor and delivery; and another 10-15 percent get infected through breastfeeding. These are all preventable through promotion of client self-care (19). Health education of HIV positive mothers on infant feeding options during the antenatal period is an important and least expensive measure of prevention of parent to child transmission of HIV infection (28). In responding to this, the National AIDS Control Program (NASCO) has developed national evidence-based standards and guidelines for the antenatal management of HIV positive women and the Prevention of Mother to Child HIV/AIDS transmission (PMTCT), intrapartum care, postpartum care and infant feeding and care (19).

Nurse-midwives should always be informed of the current guidelines which are constantly changing as per the continuing research on HIV/AIDS as per NASCO recommendations and standards (36).

The knowledge, attitude and skills held by the nurse-midwives directly significantly influence their level of involvement in promoting client self-care hence rejecting the hypothesis that perspectives of nurse-midwives towards self-care promotion, do not influence client self-care.

There is need for further studies on perspectives of patients on self-care needs and activities in different acute and chronic illness centers in order to promote clients' health seeking behaviors. Until recently, no comprehensive guidelines or standard tool existed to define necessary skill by the nurses or midwives to promote client self-care behaviors (5).

This study therefore determined the factors that influence the nurse-midwives level of promoting client self-care behaviors. Identification of the factors enabled the development of recommendations for use in policy making and for stimulation of further research in relation to promotion of client health care.

5.3 Recommendations from the Study and Areas of Further Study

The study brings out clearly the following facts that can be used as a basis for further research and policy making:-

- Nurse-midwives involvement in promotion of self-care translates into higher score for client self-care hence nurse-midwives should be supported and encouraged by the health institutions and the ministry of health to promote self-care of clients by health education and counseling.
- Self-care promotion should be given high priority as compared to other nursing care practices since it is one of the most cost effective ways of ensuring quality health.
- Client / patient educational level was found to have an important impact on client self-care. Improving educational opportunity for women may have a large impact on self-care. This is however a long term goal.
- Health educational programs should target women with little or no educational background. Women should be empowered and educated on their reproductive health management. Antenatally, there should be several copies of brochures on self-care promotion; and health institutions, supported by the government should be on the forefront in educating self-care. A program such as "Malezi bora" (Healthy living) by the department of reproductive health involves self-care promotion, and has high impact on client health education if given priority (34).
- Patients or clients should be involved in their own self-care planning and implementation.
- An understanding of the organizational and societal factors that affect uptake of self-care programs is very important. Organizational and societal support is crucial in the planning and implementation of self-care promotion programs.
- Promotion of self-care reduces the rate of maternal to child transmission of HIV/AIDS (PMTCT) and ensures compliance of mothers to the treatment regime and management hence should be implemented by all health institutions.

- Similar research should be carried out in other health institutions and other parts of the country to bring out the current practices in relation to promotion of self-care, and to come up with a more generalized view.
- Health institutions should have health education committees at unit level and organizational level that should be actively involved in developing goals and time-frames, for planning, implementation, monitoring, and evaluation of health self-care education and counseling of patients.
- The study did not look into the patients' perspectives in relation to involvement in promotion of self-care. More research needs to be done to come up with broader perspectives.
- The study was conducted at KNH only. Findings therefore may not necessarily reflect the true situations in other hospitals locally and in other hospitals in other parts of the country since this is a referral urban based health setting. There is need to replicate the same research in other parts of the country to come up with a more generalized view.

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APPENDIX I: OVERVIEW OF THE STUDY

KENYATTA NATIONAL HOSPITAL

Kenyatta National Hospital is the largest National Teaching and Referral Hospital in Kenya. It is the apex of the referral system in the Health sector in Kenya. It covers an area of 45.7 Hectares and within the KNH complex are the college of Health Sciences (University of Nairobi) and the Kenya Medical Training College. It has a long-standing history for excellence and Research performance.

The hospital has out-patient, ICU, Casualty, Laboratory, administrative, medical records, theatre, pharmacy and many other support units and has a tower block housing many wards of different specialties. It has a complex management structure divided into administrative, nursing and clinical units with many divisions and sections of management.

APPENDIX II: INFORMED CONSENT AND EXPLANATION FORM

Principal investigator: Emmy T. Yatch

Address: School of Nursing sciences, University of Nairobi,
P. O. Box 30197, Nairobi, Kenya.

I am a level two master's student at the University Of Nairobi School Of Nursing Sciences, pursuing a course in obstetric nursing/midwifery.

I would like to conduct a study on **Nurse-midwives' involvement in promoting self-care among in-patient postnatal women at Kenyatta National hospital maternity wards.**

You have been selected to participate in this study. Your participation is entirely voluntary.

Refusal to participate will involve no penalty. Your answers on the research questionnaire will be treated with strict confidentiality and will be used strictly for academic purpose.

Apart from your time spent filling the questionnaire I do not think there will be any risk in participating in this research. Your participation will help in providing information that will assist in quality improvement by promotion of client self-care.

The information collected will be kept private. The questionnaires will be marked only with codes and not with names. The list of numbers will be destroyed at the end of the research. Research reports and any publications will only discuss large groups of participants and will not reveal individual names. Every effort will be made to protect the confidentiality of the information provided.

If you have any questions or concerns, please feel free to contact me using 0722 764306 or contact KSH Research and Ethics Committee, phone number 2726300 extension 4410. This committee reviews research studies in order to help protect participants.

Your cooperation and support is highly appreciated.

PARTICIPANT AGREEMENT

I have fully understood the objectives of the research and hereby sign as a show of willingness to participate as a volunteer.

Signature-----date-----

WITNESSED BY

Signature-----date-----

APPENDIX III: NURSE-MIDWIVES RESEARCH QUESTIONNAIRE

QUESTIONNAIRE NO:

Research assistants?

Initials.....

INSTRUCTIONS:

Please answer the following questions. Do NOT write your name or any information that can identify you as an individual. Tick the appropriate option that applies to you in the boxes provided. Please answer all the questions.

SECTION 1: Demographic information.

Directions: kindly check the boxes that best describe you. Print other information that is required.

1. Respondent's gender:

Female

Male

2. Age (years) 21-25 years

26-30 years

31-35 years

36-40 years

Above 40 years

3. Respondent's religious affiliation:

Catholic

Protestant

Muslim

Other (Please specify).....

4. Level of education: (tick one)

Certificate

Diploma

Degree

Masters

Other (please specify).....

5. Designation (please tick appropriately)

S.N.O

S.E.C.N

NO. I

E.C.N I

NO. II

E.C.N. II

N.O. III

E.C.N. III

8. Work station:

Labour ward

GFA

GFB

Ward 1A

Ward 1D

9. Years of service as a nurse-midwife:

1-5 years

6-10 years

11- 15 years

16- 20 years

21 years and above

SECTION II: This is on what you think about self-care in general.

1. In your own words, what is self-care?.....
.....
.....

2. Do you routinely promote client self-care in your ward? (Please tick one choice only)

(a) Yes

(b) No

3. In your own opinion, how would you rate or how would you score the health self-care education and counseling activities in your ward or unit? (Please circle one).

(a) Very good

(b) Satisfactory

(c) Need improvement

(d) Very poor

(e) Other (Please specify).....

4. What are the advantages of promoting client self-care? (Please list any three).

(a).....
.....

(b).....
.....

(c).....
.....

5. What do you think about promotion of client self-care? (Please answer each with Yes or No in the spaces provided).

(a) All staff working in maternity wards should be involved in promotion of client self-care

(b) Client self-care can be managed by the nurse-midwives only.....

(c) Promotion of self-care ensures the participation of clients in their health care.....

(d) Promotion of self-care behaviors improves patients' satisfaction of maternity services.....

(e) Promotion of self-care is cost-effective to the client and the hospital.....

6. In your opinion, what are some of the factors that may hinder provision of self-care education by the staff? (Please tick your acceptable choices only).

- (a) ~~Lack of time for health self-care education~~
- (b) Unfavorable learning/ teaching environment
- (c) Lack of culturally relevant information and material for learning purposes
- (d) Inadequate staffing
- (e) Staff cultural and religious believes towards postnatal self-care

7. What are some of the maternal /client factors that hinder self-care education? (Please tick your acceptable choices only).

- (a) Lack of enthusiasm by mothers/clients for self-care education due to psychological or emotional reactions to motherhood
- (b) Communication barrier whereby the client cannot understand language of communication
- (c) Lack of special needs education requirements for those clients with deafness, or visual impairment
- (d) Crying or sick neonate
- (e) Other (please specify).....

8. In your own experience, what are some of the cultural practices that have direct impact on postnatal patients' self-care?

- (a).....
- (b).....
- (c).....

9. What are some of the health self-care education programs that are implemented at your unit?

- (a) Hygiene and nutritional self-care
- (b) Breastfeeding and alternative feeding options for mothers who opt not to breastfeed
- (c) Prevention of mother to child transmission of HIV infection (PMTCT)
- (d) Family planning and papanicolau (Pap) smear
- (e) Other (please specify).....

10. Do you desire training on the knowledge and skills of self-care promotion?
 (Please tick one)

(a) Yes

(b) No

11. Please indicate any of the following update courses on client self-care education and counseling that you have attended (attach additional list if necessary).

Title of the course/workshop/CME seminar attended	Venue	When (Month and Year)	Duration of update (In Days or Hours)
(EXAMPLE) Health education	K.N.H	Jan. 2000 - Dec 2000	1 year

12. Do you have a client/patient health education committee at your department or hospital? (Please tick one).

Yes

No

Don't know

13. If yes, what are some of the activities that the committee undertakes? Please circle all that apply).

- (a) Supervision
- (b) Organizing for continuing education for staff
- (c) Research on client self-care education and counseling
- (d) Policy development on health self-care education and counseling
- (e) Other (please specify).....

SECTION III: Nurse-midwives' knowledge, attitudes and practice on promotion of self-care

		Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
1	Nurse-midwives should be able to identify client ability and deficit to perform self-care					
2	Self-care education can reduce the rate of maternal to child transmission (PMTCT) of HIV infection.					
3	Promotion of self-care postnatally prepares patients for informed family planning (FP) choices and family size decision making					
4	Self-care education and counseling improves the health of both mother and child/ newborn					
5	I have knowledge and confidence to assess and manage the client's individual self-care needs					
6	Self-care skills acquired by nurses in continuous development programs are necessary for improved performance					
7	I have all the materials needed to execute self-care education to postnatal women at the unit					
8	I involve postnatal patients with ability in planning and execution of their care					
9	I routinely assess patients' attitudes and cultural perspectives on postnatal self-care before inviting them to be involved in their self-care.					
10	Maternal level of education has direct impact on antenatal and postnatal health self-care					
11	Maternal age has direct impact on postnatal patients' self-care					
12	Economic factors such as poverty has direct impact on postnatal patients' self-care					
13	The large patient number has seriously affected staff ability to promote patients self-care.					
14	Inadequate staffing directly affects the quality of midwifery care given to post natal patients.					

APPENDIX IV: RESEARCH AUTHORIZATION- KNH ETHICS
COMMITTEE



KENYATTA NATIONAL HOSPITAL
Hospital Rd. along, Ngong Rd.
P.O. Box 20723, Nairobi.
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi.
Email: KNH1plan@kenhealthnet.org

Ref: KNH-ERC/01/4421

15th June 2007

Talim Enny Yalich
Dept. of Nursing Sciences
School of Medicine
University of Nairobi

Dear Enny

RESEARCH PROPOSAL: "NURSE-MIDWIVES' PERCEPTION ON PROMOTION OF SELF-CARE AMONG POSTNATAL PATIENTS AT KNH MATERNITY WARDS" (P28/2/2007)

It is to inform you that the Kenyatta National Hospital Ethics and Research Committee has reviewed and approved your revised research proposal for the period 15th June 2007
14th June 2008

You will be required to request for a renewal of the approval if you intend to continue with the study beyond the deadline given. Clearance for export of biological specimen must also be obtained from KNH-ERC for each batch.

On behalf of the Committee, I wish you fruitful research and look forward to receiving a summary of the research findings upon completion of the study.

This information will form part of database that will be consulted in future when processing related research study so as to minimize chances of study duplication.

Yours sincerely

Prof. A.N. Guantai
SECRETARY, KNH-ERC

c.c. The Deputy Director CS, KNH
Prof. K.M. Bhatt, Chairperson, KNH-ERC
The Dean, School of Medicine, UON
The Chairman, Dept. of Nursing Sciences, UON
Supervisors: Mrs. J. Oyieke, Dept. of Nursing Sciences, UON
Dr. A. Karani, Dept. of Nursing Sciences, UON
Dr. B. O. Omuga, Dept. of Nursing Sciences, UON
Mr. P. M. Wainaka, Dept. of Nursing Sciences, UON

APPENDIX V: RESEARCH AUTHORIZATION- MINISTRY OF
EDUCATION, SCIENCE AND TECHNOLOGY



REPUBLIC OF KENYA
MINISTRY OF SCIENCE & TECHNOLOGY

Telegrams: "SCIENCE TEC", Nairobi
Telephone: 02-318581
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JOGOO HOUSE "B"
HARAMBEE AVENUE,
P.O. Box 9583-00200
NAIROBI

When Replying please quote

Ref. MOST 13/001/ 37C.510/2

8th August 2007

For PERMANENT SECRETARY
MINISTRY OF EDUCATION
SCIENCE AND TECHNOLOGY
Talam Emmy Yatich
University of Nairobi
P.O. Box 30197
NAIROBI

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on, '*Nurse Midwives Perspectives on Promotion of Self Care among Post Natal Patients at Kenyatta National Hospital*'

I am pleased to inform you that you have been authorized to carry out research at the Kenyatta National Hospital for a period ending 30th June 2008.

You are advised to report to the Director Kenyatta National Hospital before embarking on your research project.

On completion of your research, you are expected to submit two copies of your research report to this office.


M. O. ONDIEKI

FOR: PERMANENT SECRETARY

Copy to:

The Director
Kenyatta National Hospital
NAIROBI