

Keeping Them in the Dark: Pregnant Mothers' Reaction and Attitude towards Pre-Natal Care in Sri Lanka

(1) Department of Social Sciences, Faculty of Arts and Culture,
South Eastern University of Sri Lanka, Oluvil, Sri Lanka.

Abstract: Medical knowledge is used as a power and maternal institutions claim about their quality services. It led the researcher to think how far pregnant mothers' psychological attitudes prevail towards the treatment they receive in between medical power and improved physical resources. In requisites of finding answers for four objectives, data was collected by using 48 interviews, 5 case studies and observation based on purposive sampling method. It was found that the physical treatments received by pregnant mothers are much appreciated but psychological treatment is trifling.

Keywords: Maternal health, Reaction, Attitude, Emotional support,

Introduction

Development of specific services for mothers in Sri Lanka can be traced back to ancient and medieval times. The history of Sri Lankan health sector is not that old. The declining trend in the maternal mortality rate (MMR) from the 1930s to the late 1990s resulted from several strategies implemented within and outside the health sector. Expansion of both field-based and institutional services through the past decades contributed to improved geographical access and provision of 'free' services improved economic access. These led to increased use of antenatal and natal services provided by trained midwives and other personnel followed by improvements in the availability of specialized care and emergency obstetric care. Integration of family planning and other inputs to the maternal health programme has yielded positive results.

The role of the private sector is limited to provision of a component of antenatal services. The organization for service provision and an information system made significant contributions towards improvement. The commitment of the health sector to provide services free of charge supported by non-health inputs, especially female education, has enabled Sri Lanka to make gains in maternal health (Fernando, Jayatilleka & Karunaratna, 2003 p.85).

Background

Development of specific services for mothers in Sri Lanka can be traced back to ancient and medieval times. According to ancient chronicles, the first maternity home was probably established between 522 and 524 AD (Uragoda: 1987). The Portuguese introduced the western system of medical care to the country in 1505. The Dutch, who ruled the country from 1658 to 1796, established a few hospitals in the Maritime Provinces (Uragoda 1987). The present day health services of Sri Lanka aimed at provision of the 'western' system of medicine evolved from the military and estate medical services introduced by the British, during the period when they ruled Sri Lanka.

The earliest indication of a health service aimed specifically at mothers and children was the establishment of a Maternity Hospital in 1897. The next recorded maternal and child health activity was the setting up of a Public Health Department in the Colombo Municipal Council in 1902 and the establishment of a Maternal and Child Health (MCH) Department in 1906. In 1927, the midwifery services in the Colombo Municipality were re-organized by training all midwives working in the Municipality

(Uragoda 1987). By this time, Sri Lanka had experience of the positive economic impact of a preventive programme aimed at the community.

When Sri Lanka gained independence in February 1948, several social welfare schemes that included food subsidies, free education system, food supplementation and a health service provided free of charge were available and continued after independence. Availability of an organizational structure for provision of maternal health services at the time of independence and the political commitment at the highest level for implementation of welfare measures were crucial factors that influenced the programme aimed at improving maternal health. By 1960, the state sector health services responsible for the major component of the maternal care services identified the need for development of appropriate policies and programmes, to further improve the situation. In the next few decades, with the changing needs and emphasis on a wider scope for prevention of maternal mortality and disability, changes were made in the organizational structure for provision of maternal care. In Sri Lanka, Family Health Bureau is responsible for planning, co-coordinating, monitoring and evaluating the programme provision of family health services through the health infrastructure of the Ministry of Health. In addition, it provides support services for programme implementation by way of in-service training, provision of supplies and equipment for family health programmes and technical guidance. Government maternal hospitals provide its service in prenatal maternity care and childbirth.

When talking about health, functionalist point of view is important rather than looking at conflict or violence, because health is a major issue which has a dominant place in the progress of the society. As a common public view about health is “a condition of well being free of disease or infirmity and a basic and universal human right.” It is reflected in the universal Declaration for Human Rights, in 1978 declarations at Alma – Ata lent new pushes to tackle ill-health.

Vasak (1977) also affirms that several new human rights such as, to right to development, to a healthy environment and to peace were already beginning to energy in international law. The special problems of financing health services stem from the growing belief

that people ought to receive medical care for humanitarian reasons, regardless of their ability to pay. The preamble to the constitution of World Health Organization states, “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”. Many countries have attempted to provide for this right to medical care by legislation. In some countries, the question of whether medical care should be provided as a legal right or as a privilege is still not resolved. In others, it would involve a high proportion of national resources to attempt to provide comprehensive health services.

David Armstrong (1987, p.70) concerned doctor's and patient's share in their consultation. He uses the word ‘mutual co-operation’. It omits another power more innocent and more concrete, even casual. He shows lines of medical surveillance, such as ‘what is your complaint?’, ‘How do you feel?’, ‘please tell me your troubles?’ and he shows the routine clinical techniques such as the rash is displayed, the hand applied to the abdomen, the stethoscope is placed gently on the chest. He says that this is the staff of power. In this case stethoscope is an important instrument of power. So these arguments lead us to think more. Cicilia Van Hollen (2003) in her work “Birth on the Threshold: Childbirth and Modernity in South Asia” discuss this issue. She mentions that “in the context of the Industrial Revolution, women's reproductive bodies came to be viewed as machines which should operate in uniform and efficient ways to facilitates (re)productivity”.

Ann Oakley (1993, p.124) in her book, *Essays on Women, Medicine and Health*, mentions that, “in many places in the world today, birth is considered an abnormal event. It is an episode in women's lives and in the lives of families which is not part of everyday life, but an occasion for medical surveillance and treatment”. Thus, to think about the possible normality of birth requires a deliberate refocusing of one's attention. But what is significant is that such a refocusing was not necessary before birth became the province of experts. She further mentions that, obstetricians and pediatricians are not the only experts on birth who have helped to make it special in this way. Other professional groups have also participated, and benefited, including childbirth educators, social

workers, health visitors, psychiatrists, psychologists, sociologists, anthropologists, epidemiologists, technicians and other members of the commercial world surrounding birth. While these different professional groups have had different perspectives on birth, we have all, in effect, collaborated in transforming birth.

Medical knowledge is used as a power not only by the doctors but also from the top to bottom all the worker and maternal institutions claim about their quality services. It led the researcher to think how far pregnant mothers' psychological attitudes prevail towards the treatment they receive in between medical power and improved physical resources. Here I attempted to pay my attention on psycho-social aspects of maternity and childbirth of pregnant mothers at Antenatal Clinics (ANCs) conducted by government maternity hospitals and village clinics under the management of Family Health Bureau.

The background and the interest in this area was a result of my own experience as a pregnant mother at an ANC and a government hospital. Especially some of the maternity hospitals in Sri Lanka claim to have the about their best and quality services. For an example Castle Street Hospital for Women mentions in their name boards as "a hospital with a sense of quality" and it has won several quality awards too. It motivated me to think that not only the quality but also the psychological response about the services received by pregnant mothers is also very important. So the problem for the research was created as 'why pregnant mothers are not happy even they are provided with the best services?'

Research objective specifies much more precisely about my goals. That was what I intend to find in the research study. In the study, were four basic objectives,

- q To find out the views of doctors about how pregnant mothers should be treated medically and psychology while they are in the clinic.
- q To explore whether the above views are practiced by doctors and medical staff.
- q To discover the feelings, anxiety and psychology of pregnant mothers due to the treatment given by doctors and medical staff at Ante Natal Clinics.

- q To examine the possibilities given to pregnant mothers to be involved in the decision making about their child birth.

Methods

Since this was an empirical work and in a need to use case studies as examples of some of the themes which I had identified in my literature review, my approach was a mixed meaning of a combination of the quantitative and qualitative methodologies. The focus in qualitative approach was on meanings and experiences and the research attempted to understand the lives of those being studied, their behavior, values, beliefs and so on, from the perspectives of the people themselves. In this study the researcher paid more attention on meanings and real life experiences of pregnant mothers. Since my research was a more qualitative one, the data was gathered by semi-structured interviews, case studies, individual narratives and observation. This study contained semi-structured interviews, which allowed the respondents to reveal their experiences freely. Further to cover my themes, I used some case studies. As an additional method data was gathered by using observation too. Observation is one of the most important methods of data collection.

Here as the researcher it was able to observe every physical and other aspects of maternity health care providing services by the researcher since the researcher was also a pregnant mother during the researching period. So here the self and the personal knowledge were used as the primary instrument to gather useful data. Since the researcher was a pregnant mother in the whole data collection period, it became an opportunity to access the places easily. It did not need special permission to enter the field locations. Further it was very easy to discuss with pregnant mothers as the researcher too was in the same position. They did not feel uncomfortable when discussing their feelings. Furthermore, the researcher had a great chance to be involved in the study as a participant observer. My observation was an unstructured observation. It is to sit at the side or back of the room and detailed notes were taken later to refrain from disturbing the setting.

In this study all the maternity hospital and village clinics functioning under Family Health Bureau considered as the total population or the universe. But considering the convenience of the researcher, it was decided to select few places situated in the Colombo city.

Selection of the research field was done on the purposive basis. It was selected according to the researcher's convenience. Accordingly Castle Street hospital for Women, De Soysa Maternity Home and Sedawaththa and Gotthuwa village clinics were included in the whole process of data collection. In the designing stage it was decided to select respondents from the particular clinics of these hospitals. Later based on the comments made by the panel board in the proposal presentation, pregnant mothers were selected from outside the hospital based on the rapport build during the clinic sessions. But observations were based only inside the hospital and village clinics.

Since my study was done for an academic purpose within a limited time and funds, I selected a non probability sampling method here. I selected this sampling method to gain fruitful data on 'treatment received by pregnant mothers and their psycho-social reaction at ANCs', as going for other three types of non probability methods were not that appropriate

To achieve the objectives of the research data was collected by spending more time. It was decided to complete 50 semi-structured interviews based on the place where pregnant mothers are cared. But after the discussion held to examine the methodology it was advised to conduct interviews at home premises of the pregnant mothers. After completing semi structured interviews, 8 interviews were considered as interesting cases. So, based on that 5 cases were studied in-depth. Further to the respondents 5 doctors and 2 nurses 2 midwives and an attendant were interviewed to find out their attitude related to expected services and the delivered services.

This study presented minimal risk to participants pertaining to psychological harm. Care was taken to ensure that the participants fully understood the nature of the study and the fact that participation was voluntary. A statement was made that confidentiality

of recovered data would maintained at all times, and identification of participants were not available during or after the study. Confidentiality was assured and maintained on information provided by the respondents.

Results and Discussions

This section presents findings on psycho-social aspects of maternity and childbirth of pregnant mothers at Antenatal Clinics (ANCs) conducted by government maternity hospitals and village clinics under the management of Family Health Bureau. The health care that a mother receives, during pregnancy, at the time of delivery, and soon after delivery are important for the survival and wellbeing of both mother and child. The study reveals that Psychological and emotional support is appreciated as the physical and human resources. Further these findings are important to policymakers and programme implementers in formulating programmes and policies. When they improve reproductive and child health care services it will stress the importance of considering psychological and emotional support.

Almost all the respondents included in the research had at least primary education. 20% of them are teachers. 45% had secondary education. Women of all educational levels are equally likely to see a public health midwife during pregnancy, but women with more education see doctors more frequently than those with only primary education. 80% had Rs.10000-15000 or above as their or their spouse' monthly income.

The study confirms that regular attendance and the advices received helped the pregnant mothers to go for a safe delivery. Annual Health Bulletin (2007) validates that, regular antenatal care throughout pregnancy contributes to positive outcomes at delivery.

Dissanayake (2007) highlights, that the major objective of antenatal care is to identify and treat problems during pregnancy such as anaemia and infections. In addition he mentions, early contact with the health care system can improve the timely and appropriate use of delivery care services. This study also reveals that all the respondents had the chance to

find out their problems related to anaemia and infections. All the respondents had been given advice on physical exercises during pregnancy. They have attended class on 'how to feed their new born babies. There were seminars conducted to pregnant mothers about the health care that a mother receives, during pregnancy, at the time of delivery, and soon after delivery inside the hospital. 96% of the respondents had attended this seminar.

The study shows that almost all pregnant women studied have been received core antenatal services. At their first visit they have been weighed, their blood pressure checked, and blood and urine tests done (virtually 100 percent for each item). Almost all the pregnant mothers seemed and mentioned that they are happy with provided services such as tests and the advices. But 90% of them mentioned that the mental support given by the doctors and entire staff is not significant. They revealed that they had several questions and doubts which they do not know. Doctors did not have enough time to answer to such questions. 40% of the respondents had a fear to ask questions due to the hurry of the doctor.

Annual Health Bulletin (2007) shows that women are less likely to be informed about pregnancy complications. Almost three quarters of women having their first birth got such information, but the proportion declines steadily for second- and higher-order births. Women living in estate areas are also less likely to report that they had received information on complications (50 percent) compared with women in other rural (70 percent) and urban (66 percent) areas. But the study found that almost all the respondents revealed that they really wanted to know about their complications but the staff on duty did not have any communication related to their complications. This has led the respondents to feel that they are (baby and mother) in danger.

20% of the studied had experience inside a Pre-mature Baby care Unit(PBU). They had neither been given reasons for the admission of the baby to the PBU nor emotional or psychological support given.

When the case number III reveals her experience, "I was not happy even I got my baby. They time to time

took the baby to inject. I had no idea about what was going on. I was always crying thinking that my little one is sick. When I came back home we consulted a pediatrician to get to know everything. Then only, we came to know the situation. It was very easy explaining what was wrong. But they do not think that we are affected emotionally and psychologically due to their silence. I think parallel to the well advanced developed physical services, psychological and emotional services should be implemented during pregnancy, at the time of delivery, and soon after delivery"

Being pregnant is a very personal experience for each patient. They mentioned that they had new challenges and problems. How they respond to these challenges is dependent on their emotional maturity or lack of it. It is the responsibility of the doctors, nurses, midwives, etc. to help her understand and meet these challenges appropriately. Throughout pregnancy, their emotional reactions had described as ambivalence, fear and anxiety, introversion or narcissism, and uncertainty. These feelings predominate at different periods of the pregnancy; other tends to fade in and out as the pregnancy progresses. So as suggestions pregnant mothers mentioned that psychological and emotional support should be given throughout the progress of the pregnancy. They further mentioned that during the delivery period, inside the labour room or the theatre, inside wards psychological and emotional support must be given. It was found that the physical treatments received by pregnant mothers are much appreciated but psychological treatment is trifling.

References

- Academic Learning Support, 2007, *Harvard (author-date) referencing guide*, Central Queensland University, Queensland, viewed on 2013 March 19, <http://www.library.uow.edu.au/content/groups/public/@web/@health/documents/doc/uow025425.pdf>
- Armstrong, D, 1987, 'Bodies of knowledge: Foucault and the Problem of Human Anatomy', in G Scambler (ed), *Sociological Theory and Medical Sociology*, Tavistock Publications, London.

Dissanayaka, D 2007, *Reproductive Health Annual Health Bulletin*, Ministry of Health, Colombo.

Fernando, D, Jayatilleka, A & Karunaratna, V 2003, 'Pregnancy-Reducing Maternal Deaths and Disability in Sri Lanka: National Strategies', in *British Medical Bulletin* 67:85-98 viewed on 2012 Oct 12, <http://bmb.oxfordjournals.org/cgi/reprint/67/1/85?eaf>

Hollen, C V, 2003, *Birth on the Threshold: Childbirth and Modernity in South India*, University of California Press, Berkeley.

Karel V, 1977, *A 30 year struggle*, The UNESCO Courier, Nov p-29.

Oakley, A, 1993, *Essays on Women, Medicine and Health*, Edinburgh University Press, Edinburgh.

Uragoda, C G, 1987, *A History of Medicine in Sri Lanka*, Sri Lanka Medical Association, Colombo.