Original Articles/นิพนธ์ต้นฉบับ

Thai Women's Belief on Roles of Nurse-midwives Working with Pregnant Women in Antenatal, Intranatal and Postnatal Units.

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Abstract

The purposes of this study were to explore women's belief on roles of nurse-midwives working with pregnant women in antenatal, intranatal and postnatal units, and to examine differences in beliefs of women accessing care at different types of health care settings. The samples recruited in the study were 323 primigravid women firstly booking at primary to tertiary health settings (Bang-Yai Health center, Oothong Community hospital, Rachaburi provincial hospital, Maternal and Child hospital (Health promotion centre), and Ramathibodi university hospital). A questionnaire was chosen as a tool to collect data. Descriptive statistic was used to analyze demographic data and womens beliefs, while Odd ratio with 95% confident interval to examine differences in beliefs. It was found that not all roles defined by the Thai Nursing and Midwifery Council were not perceived by Thai pregnant women as midwife' roles. Differences in beliefs also existed amongst women visiting different types of settings. Women booking care at Bang-Yai Health center, community, Provincial hospital, and Maternal and Child hospital believed more numbers of procedures as midwife's roles than those visiting at university hospital. Thai midwifery practice thus is not well recognized by pregnant women. The findings from this study can be used as fundamental data for developing midwifery practice and its profession in Thailand by firstly enhancing public recognition of care provided by midwives.

Key words: Thai women's belief, roles of nurse-midwives.

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Introduction

It has been world-wide accepted that midwifery practice includes care throughout pregnancy covering family planning and counseling to support both physical and psychological aspects for the childbearing woman and her family.[1] Similarly, the Thai Nursing Council and Midwifery (TNCM) has defined midwifery as a care for pregnant women enhancing the health status of both the mother and the baby.[2] Thai nurse-midwives thus are expected to provide care and to perform practice as defined by the TNCM.

Nevertheless, it is found that Thai nurse-midwives are not the main care providers for normal pregnancy as defined by the TNCM and WHO. As seen in the study of exploring midwifery practice in Thailand; nurse-midwives (working with pregnant women) randomly selected from all levels of various health care setting across the country do not play a full range of practice as defined by the TNCM and WHO. Instead, the scope of Thai midwifery practice is shaped by the governmental structure rather than the scoped depicted by the TNCM. Some midwifery procedures were not performed by nurse-midwives as officially defined. In the antenatal clinic, for example midwifery practice mainly focuses on documentations rather than examinations.[3]

To develop midwifery practice and its profession, understanding the existing roles and perceptions of nurse-midwives is not an only one component. Midwifery is a profession which has a body of knowledge (a valuable attribute of the profession) and requiring a long and intensive preparation for specific training to be skillful and expertise.[4-7] One main criteria of the profession is that the member of a profession must be recognized by the community - they are ones who know best what needs to be done, why and how to do it.[7-10] From this point of view, women's recognition on what nurse-midwives do is also an important factor to develop midwifery profession and also to enhance professional status.

Furthermore, one significant accountability of members of the profession is the responsibility to the profession. Once midwifery has been accepted as a profession, it is midwives' responsibility to securely maintain the unique characteristics and image of the profession. Failure to maintain and promote midwifery practice may inhibit public recognition of the profession. Women and society may not automatically realize what benefits they should receive from midwifery care. Women or public unrecognition on midwifery practice certainly devalues the professional status and its profession. Thus it is midwives' responsibility to promote what midwifery care is and what care midwives provide to women and their families.

To maintain and develop midwifery profession, understanding women's recognition thus is inevitably essential. If women do not recognize what nurse-midwives do or have incorrect beliefs about midwifery care, it may be inferred that midwifery profession in Thailand is not in the secure position and may be easily disappeared.

Women's belief on midwifery practice and midwives' roles thus is important information for professional status enhancement and profession development in Thailand. Research relevant to this issue has little been conducted. Women's belief on roles of nurse-midwives working with pregnant women in antenatal, intranatal and postnatal units has never been reported.

The purposes of this research study are to:

1. explore pregnant women's belief on roles of nurse-midwives working with pregnant women in antenatal, intranatal and postnatal units
2. examine differences in beliefs of women accessing care at different types of health settings ranging from primary to tertiary health settings

Material and Method

- **Research design:** descriptive study
- **Study site:** Antenatal clinics at

1. Saothonghin Health Centre, Bang-Yai, Nonthaburi province

2. Oothong community hospital, Suphanburi province

3. Rachburi provincial hospital, Rachaburi province

4. Maternal and Child hospital (Health promotion centre), Rachburi province

5. Ramathibodi hospital, Mahidol university hospital, Bangkok

- **Sample population:** inclusion criteria are primigravida women who:
  - firstly visit antenatal clinic at the study site
  - are willing to participate the research study
  - understand, and are able to write in and read Thai
- **Sample size:** 300 pregnant women (60 per each site)
- **Procedures as roles of a midwife:** the procedures recognized nurse-midwives' roles defined by the TNC are listed in Table 1.

Table 1 Roles of nurse-midwives

Roles			
Antenatal	**Intranatal**		**Postnatal**
1. Taking history	1. Performing vagina examination	13. Conducting vagina delivery	1. Assessing uterine & lochia
2. Providing health education of self care during pregnancy	2. Performing Abdominal palpation	14. Cord cutting	2. Caring C/S wound
3. Providing health education of newborn care	3. Diagnosing true labor pain	15. Performing placenta delivery	3. Assessing C/S & episiotomy wound
4. Give immunisation	4. Assessing women's weight gain	16. Encuraging pushing	4. Assessing postpartum blood loss
5. Counseling	5. Assessing laboring women's VS	17. Assessing blood loss	5. Assessing maternal urine & feces
6. Performing auscultation & assessing FHR	6. Assessing women's urine analysis	18. Providing eye prophylaxis	6. Assessing maternal VS
7. Assessing women's weight gain	7. Screening risks	19. Assessing newborn temperature	7. Assessing newborn VS
8. Assessing women's urine analysis	8. Performing auscultation & assessing FHR	20. Performing newborn health examination	8. Assessing newborn urine & feces
9. Assessing women's laboratory test results	9. Assessing labor progress	21. Assisting newborn resuscitation	9. Giving newborn immunisation
10. Providing health education of abnormal signs in pregnancy	10. Assessing fetal position	22. Giving newborn vaccination	10. Providing health education of newborn care
11. Providing health education of laboring signs	11. Infiltrating	23. Assessing newborn urine & feces	11. Assisting breastfeeding initiation
12. Assessing women's VS	12. Performing episiotomy	24. Recording delivery	12. Providing family planning
			13. Providing health education of self care

Data collection: Questionnaire will be used as a tool. Construction of the questionnaire was based on two rationalities. Firstly, it was necessary that the questionnaire should be able to elicit responses that addressed the area being studied. The practice listed in the questionnaire thus need to include all practice giving clients (women and fetus/newborns) at the antenatal, intranatal, and postnatal units, regardless who do.

Secondly, all of the practices listed in the questionnaire were developed based on the currently accepted definitions of midwifery practice. Thus the official documents of definitions, regulations, and standards of practice as defined by the TNCM were used as a framework. The practice listed questionnaire therefore was also constructed within the TNCM documents.

Once the questionnaire was developed, it was then piloted with primigravid pregnant women booking at Ramathibodi hospital. Twenty pregnant women were asked to participate in the pilot study by completing the questionnaire. The purpose of this pilot study was to test for errors and/or misunderstands, and to establish whether the questionnaire was effectively addressing the underlying issues on interest. It was also to examine validity and reliability of the questionnaire and to ensure that the questions and the lists of practice were understandable and conveyed similar meaning to all respondents. The participants in this pilot study were also asked to provide feedbacks in the form of written comments on any confusion they experienced in completing the questionnaire.

Data analysis

1. Descriptive statistic was used to explain women's belief on roles of nurse-midwives working with pregnant women in antenatal, intranatal and postnatal units

2. Odds ratio with 95% confident interval was used to analyze differences in beliefs amongst women firstly visiting at health care settings. Beliefs of the women having antenatal visit at University hospital (tertiary level care) was designated as the reference on the expectation that all aspects of midwifery roles should be completely attained.

Ethical approval for the study:

The study project was ethical approved by Human Ethic Committee from Faculty of Medicine, Ramathibodi hospital and also permissions from the administrators of all five levels of health care sites.

Findings

Three hundred twenty three pregnant women were included in the study. The majority of the women were between 15-20 as well as 21-25 (n=97, 30% each). Most of them had held a primary school qualification (n=159, 49%), and were employees (n=169, 52%). Details of their characteristics are shown in Table 2.

Regarding antenatal practice, more than half of pregnant women perceive roles listed in the questionnaire as those of nurse-midwives defined by the TCNM. Amongst these, almost all of them (82-92%) agreed that nurse-midwives had responsibilities on taking history, providing education of self care during pregnancy, of newborn, and of abnormal signs in pregnancy, and counseling. More than 70% of them belief that nurse-midwives had roles of assessing women's vital signs, urine analysis, weight gain, fetal heart rate, and gave immunizations (Table 3).

In terms of intranatal responsibilities, less numbers of pregnant women believed the roles presented in the questionnaire as those of nurse-midwives. As seen, 50-70% of women belief that nurse-midwives had responsibilities on providing care for childbearing women including conducting normal vaginal delivery. Less than half of them (44-49%) perceived that nurse-midwives had roles on infiltrating, performing episiotomy, and assessing women's blood loss and newborn temperature (Table 3).

Similar to intranatal roles, less numbers of pregnant women believed that nurse-midwives had

Table 2 Demographic data

Data	Number (n)	Percentage	Total (N)
Settings where the women visit			
Health centre	67	20.7	
Oothong community hospital	57	17.6	
Rachburi provincial hospital	67	20.7	323
Maternal and Child hospital	69	21.4	
Ramathibodi hospital	63	19.5	
Age (year)			
15-20	97	30.0	
21-25	97	30.0	
26-30	81	25.1	323
31-35	34	10.5	
36-40	14	4.3	
Education			
Primary school	159	49.2	
Secondary school	84	26.0	
College	24	7.4	323
Bachelor degree	51	15.8	
Master's degree	5	1.5	
Occupation			
House wife	97	30.0	
Employee	169	52.3	323
Government officer	14	4.3	
Business own	43	13.3	

responsibilities on providing care for postnatal women and newborns. Approximately, 50-70% of women considered that nurse-midwives perform care listed in the questionnaire as their roles. Less than half of them (48-49%) believed on assessing maternal urine-feces, and caesarean section or episiotomy wound as nurse-midwives' roles (Table 3).

When looked at differences between women's belief and types of settings they visited, there were statistically significant differences in beliefs of women visiting between University Hospital and other settings. Compared to University Hospital as a reference, more roles were believed as those of nurse-midwives by the women visiting at other health care settings. To what extend, women accessing pregnancy care at Health centre, Community, General, and Maternal and Child Hospital, belief that nurse-midwives had more roles and responsibilities than those visiting at University Hospital. As seen in Table 3, women visiting at Maternal and Child Hospital believed that nurse-midwives had roles 64 times (OR= 64, 95% CI 8.16 to 501.92) more than those visiting at University Hospital. Women visiting at General Hospital believed that nurse-midwives had roles about 2 times (OR= 2.1, 95% CI 0.94 to 4.72) more than those visiting University Hospitals. Women visiting at Community Hospital believed that nurse-midwives had roles about 5 times (OR= 4.6, 95% CI 1.91 to 11.08) more than those visiting University Hospitals. Finally, women visiting at Health Center believed that nurse-midwives had roles about 2 times (OR = 1.93, 95% CI 0.87 to 4.32) more than those visiting University Hospitals.

As shown in Table 4, sources of their beliefs

Table 3 The percentage of the respondents indicating beliefs for roles of nurse-midwife in caring for pregnant women

Antenatal		Intranatal				Postnatal	
Roles	n (%)	Roles	n (%)	Roles	n (%)	Roles	n (%)
1. Taking history	299 (92.6)	1. Performing vagina examination	210 (65)	13. Conducting delivery	189 (58.5)	1. Assessing uterine & lochia	195 (60.4)
2. Providing education of self care during pregnancy	287 (88.9)	2. Performing Abdominal palpation	220 (68.1)	14. Cord cutting	199 (61.6)	2. Caring C/S wound	210 (65)
3. Providing health education of newborn care	286 (88.5)	3. Diagnosing true labor pain	224 (69.3)	15. Performing placenta delivery	163 (50.5)	3. Assessing C/S & episiotomy wound	161 (49.8)
4. Give immunisation	241 (74.6)	4. Assessing women's weight gain	183 (56.7)	16. Encuraging pushing	237 (73.4)	4. Assessing postpartum blood loss	172 (53.3)
5. Counseling	265 (82)	5. Assessing laboring women's VS	194 (60.1)	17. Assessing blood loss	140 (43.3)	5. Assessing maternal urine & feces	158 (48.9)
6. Auscultation & assessing FHR	250 (77.4)	6. Assessing women's urine analysis	163 (50.5)	18. Providing eye prophylaxis	184 (57)	6. Assessing maternal VS	188 (58.2)
7. Assessing women's weight gain	233 (72.1)	7. Screening risks	166 (51.4)	19. Assessing newborn temperature	160 (49.5)	7. Assessing newborn VS	185 (57.3)
8. Assessing women's urine analysis	227 (74)	8. Performing auscultation & assessing FHR	197 (61)	20. Performing newborn health examination	215 (66.6)	8. Assessing newborn urine & feces	166 (51.4)
9. Assessing women's laboratory test results	227 (70.3)	9. Assessing labor progress	196 (60.7)	21. Assisting newborn resuscitation	51.5 (51.5)	9. Giving newborn immunisation	226 (70)
10. Providing education of abnormal signs in pregnancy	265 (82)	10. Assessing fetal position	181 (56.0)	22. Giving newborn vaccination	184 (57)	10. Providing education of newborn care	255 (70)
11. Providing education of laboring signs	257 (79.6)	11. Infiltrating	156 (48.3)	23. Assessing newborn urine & feces	163 (50.5)	11. Assisting breastfeeding initiation	214 (66.3)
12. Assessing women's VS	225 (69.7)	12.Performing episiotomy	142 (44)	24. Recording delivery	225 (69.7)	12. Providing family planning	230 (71.2)
						13. Providing education of self care	254 (78.6)

Table 4 The percentage of the sources of women's beliefs

Sources of beliefs	Numbers (n)	Percentage (%)
Own's belief	292	90.4
Friends	2	0.6
Books	4	1.2
Family	23	7.1
Colleagues	2	0.6
Total	**323**	**100.0**

Table 5 Differences in belief of women visiting at different types of health setting university hospital (reference)

Belief	University Hospital OR	Maternal & Child Hospitals OR (CI)	General Hospital OR (CI)	Community Hospitals OR (CI)	Health centre OR (CI)
Roles	1.00	64 (8.16 - 501.92)*	2.11 (0.94 - 4.72)	4.61 (1.91 - 11.08)*	1.93 (0.87 - 4.32)

* significant at P= 0.05

mainly come from the women themselves (90%) while little from family (7%).

Discussion

As seen, not all roles are not perceived by Thai pregnant women as a midwife' common responsibility. High percentage of up to 90% of pregnant women identified their belief as nurse-midwive' roles on antenatal care procedures. Lower percentages of at least 40% of them recognize midwives' roles on intranatal and postnatal responsibilities. Varied percentage of the women in the study identified the procedures they belief as nurse-midwives' roles can be pointed out that the scope of midwifery practice is not fully recognized by the public.

Concerns remain misbelieve in some officially defined roles can be a sign of less recognition of the women as the public or community. As seen in Table 3, of all 49 roles throughout pregnancy care listed in the questionnaire, only six of them were believed as midwives' roles by most women (more than 75%). Those include taking history, providing health education of self care during pregnancy, of self care during postpartum periods, of abnormal signs in pregnancy, of newborn care, and counseling. Only around half and less belief that midwives provide other care listed such as assessment of women and newborn health conditions and conducting normal deliveries. The findings suggest that roles of a Thai midwife recognised by the respondents fall into giving health education and support rather than assessing information/health and performing procedures.

In countries where midwifery practice and its profession are far more developed, midwifery practice and services are well promoted. Recognition of women and societies on midwifery practice can be viewed as indicator of successful development. Women can identify what midwifery is and what midwives do. In England, for example, majority of women are clear about the role of the midwife and the scope of midwifery practice[11], and have positive experiences finding midwives with good knowledge, skills, and abilities.[12] Midwives in this instance are able to run maternity clinics and also work independently in the community.

In New Zealand, "most women and their

families (over 75%) choose a midwife as their Lead Maternity Carer (LMC) to provide care from early pregnancy right through until four to six weeks after the baby's birth".[13] In addition to women and their families, the New Zealand societies and the government also recognise midwives as main providers for normal pregnancy and childbirth as it appears that "this care is free and is available to all women throughout New Zealand who meet the Ministry of Health eligibility criteria".[13]

From previous mentioned, it can be inferred that as long as women correctly belief or well recognize on roles of midwives, midwifery practice and its profession can be promoted and developed. Women have a clear picture of what midwifery is, and who they should access to care when they get pregnant. In turn, a lack of a clear image of midwifery by women and their families can be easily viewed as a barrier for midwifery profession development.[14] To further state, accomplishing professional status and profession recognition is not achieved simply through education and being practical but is basically a public acceptance and a political concerns.[15,16]

If this is true, one obstacle to develop midwifery profession in Thailand thus exists. As reported, more than 75% of the respondents in this study belief that nurse-midwives roles focus mostly on giving health education and support rather than extending to performing childbearing procedures. This means in their belief midwives are responsible to provide information probably in terms of prenatal/postnatal classes, while assessment and management of birth are given by other health professionals.

Not only midwifery practice in Thailand is not fully recognized, differences in belief also exist amongst women visiting five different types of settings. This probably means roles of nurse-midwives in women's views differ according to where they visit.

In Thadakant et al's study,[3] it was found that there were statistically significant differences in practices of nurse-midwives working with pregnant women between Health Centres, Community Hospitals, General Hospitals, Maternal & Child Hospitals and University Hospitals. As identified by nurse-midwives' samples, nurse-midwives from University Hospitals had less involvement in normal pregnancy than those from other settings. They generally gave less advice and less frequently in fewer areas of practice and performed fewer examinations.[3]

Surprisingly, roles of nurse-midwives are not confusing only in Thai nurse-midwives themselves[3], but also in women. In this current study, women visiting at University Hospital had beliefs in roles of nurse-midwives less than those at Health Center, Community Hospital, General Hospital, and Maternal and Child Hospital.

Beliefs may also be influenced by educational levels. Almost all women in the study identified a source of their belief from their own mind. All of them are primigravid, thus never having pregnancy and birthing experiences. What they belief are not confounded by either knowledge from documented books/journals or by people surrounding them. Although an association between sources of belief and educational levels are not examined, it is noticeable that most women have hold primary school degree and midwives' roles come from their own belief. It may be also inferred from the study that Thai women with lower education have an information deficit as well as recognition about midwifery practice.

To promote midwifery practice and to enhance women's recognition, it may be difficult to improve educational level as this is an issue involving with various aspects. However, to change belief, it is midwives' responsibility to consider how their actual roles are appropriately recognized. The finding of self's belief may be reflected that women have no opportunity to receive information regarding midwifery practice and a midwife's roles from any sources. Finding other ways out of classrooms perhaps is an

interesting issue for Thai nurse-midwives to enhance women's as well as publics' recognition.

Conclusion

It is reasonable to conclude that roles of nurse-midwives are not fully recognized by Thai women. They do not understand roles of nurse-midwives on providing care for low risk pregnancy, particularly those accessing care at university hospitals. The findings can be implemented as fundamental data for developing midwifery in Thailand as they will contribute to the understanding of pregnant women's beliefs on the roles of nurse-midwives. They can also further assist nurse-midwives in developing public recognition of midwifery care, professional status, and the profession by providing background information for nurse-midwives administrators and policy makers in developing midwifery profession, constructing a strong foundation for midwifery services, and contributing to the future development of midwifery education.

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Original Articles/นิพนธ์ต้นฉบับ

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บทคัดย่อ

การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อสำรวจความเชื่อของสตรีไทยต่อบทบาทของพยาบาลผดุงครรภ์ที่ให้การดูแลสตรีตั้งครรภ์ในระยะตั้งครรภ์ ระยะคลอด และหลังคลอด และเพื่อศึกษาเปรียบเทียบความแตกต่างของความเชื่อของสตรีที่ฝากครรภ์ ณ สถานพยาบาลปฐมภูมิ ทุติยภูมิ และ ตติยภูมิ (สถานีอนามัยบางใหญ่ โรงพยาบาลชุมชนอู่ทอง โรงพยาบาลประจำจังหวัด โรงพยาบาลแม่และเด็ก และโรงพยาบาลรามาธิบดี) กลุ่มตัวอย่างประกอบด้วยสตรีตั้งครรภ์แรกไปรับการฝากครรภ์ครั้งแรกที่คลินิกฝากครรภ์ของสถานพยาบาลทั้ง 5 แห่ง จำนวนทั้งสิ้น 323 คน เก็บข้อมูลโดยใช้แบบสอบถามที่ประกอบด้วยบทบาทของผดุงครรภ์ทั้งหมดที่ภาพยาบาลและผดุงครรภ์แห่งประเทศไทยกำหนด วิเคราะห์ข้อมูลการสำรวจความเชื่อของสตรีตั้งครรภ์โดยใช้สถิติเชิงพรรณนา และเปรียบเทียบความเชื่อของสตรีที่ไปฝากครรภ์ต่างสถานพยาบาล โดยใช้ Odd ratio ที่ค่าความเชื่อมั่นร้อยละ 95 ผลการศึกษาพบว่าสตรีตั้งครรภ์มีความเชื่อเกี่ยวกับบทบาท ของผดุงครรภ์แตกต่างกันไป โดยเชื่อว่าบางบทบาทที่เป็นบทบาทของผดุงครรภ์ไม่ได้เป็นกิจกรรมการดูแลที่อยู่ภายใต้บทบาทของของผดุงครรภ์ นอกจากนี้สตรีตั้งครรภ์ที่ฝากครรภ์ที่ฝากครรภ์ที่สถานีอนามัย โรงพยาบาลอู่ทอง โรงพยาบาลประจำจังหวัด โรงพยาบาลแม่และเด็ก ระบุบทบาทที่เชื่อว่าเป็นบทบาทของผดุงครรภ์จำนวนมากกว่าสตรีที่ไปรับการฝากครรภ์ที่โรงพยาบาลสังกัดมหาวิทยาลัย ดังนั้น จึงอาจกล่าวได้ว่าบทบาทของผดุงครรภ์ในการให้การดูแลสตรีตั้งครรภ์ตลอดการตั้งครรภ์ยังไม่เป็นที่ยอมรับของสตรีไทย ผลที่ได้จากการศึกษาสามารถนำมาใช้ในการพัฒนาวิชาชีพผดุงครรภ์ได้ในอนาคต เนื่องจากในการพัฒนาวิชาชีพ การทำให้เกิดการยอมรับจากผู้รับบริการเป็นตัวแปรที่สำคัญตัวแปรหนึ่ง ดังนั้นเพื่อพัฒนาวิชาชีพผดุงครรภ์ การส่งเสริมความเข้าใจของสังคมเกี่ยวกับบทบาทผดุงครรภ์ที่แท้จริงให้แก่สตรีไทยจึงน่าจะเป็นสิ่งที่ควรกระทำ

คำสำคัญ: ความเชื่อของสตรีไทย บทบาทพยาบาลผดุงครรภ์