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“Save My Baby”: The Lived Experience of Hospitalized Pregnant Women With a Threat of Preterm birth

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Abstract

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Keywords

Hospitalization, Jordan, Pregnancy, Preterm Birth, Qualitative Research, Women

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Activity restriction in hospital to prevent preterm birth (PTB) is widely used as the first step of treatment. It is associated with adverse physiological and psychological effects on maternal and fetal health that might persist years after birth. A sample of 10 pregnant women who were hospitalized for being at risk for PTB were purposively recruited to describe their lived experience via semi-structured in-depth interview. Five themes were identified, the maternal role establishment and suspending responsibilities, the women's perception of fear of uncertainty and finding support, dissatisfaction of care, the change of routine life and family relationships, and the cultural influence from the participants perspectives. Pregnant women with threat of PTB endure the physical and psychological suffering from being hospitalized to reach their ultimate goal of “having alive and healthy child via safe birth.” A nurse’s understanding of this experience is essential to provide a competent, compassionate and woman-centered care that can help women to cope and to establish maternal role. The study findings serve as a framework for improving services at health care facilities to be mother friendly to mitigate the negative effect of hospitalization during pregnancy on the women and their child health years after birth. Keywords: Hospitalization, Jordan, Pregnancy, Preterm Birth, Qualitative Research, Women

Introduction

Globally, the number of children who are born before 37 completed weeks of gestation is rising. Yearly, an estimated 15 million children are born preterm. Prematurity is the leading cause of death among children under 5 years of age, responsible for nearly 1 million deaths in 2015 (World Health Organization, 2018). In Jordan, the leading cause for hospitalizations during pregnancy was preterm delivery (20.4%; Batiha et al., 2013) and the most common cause of neonatal death was prematurity (72.5%; Batiha et al., 2016). Although there is no evidence either supporting or refuting bed rest or activity restriction at home or in hospital to prevent preterm birth (PTB) (Medley, Vogel, Care, & Alfirevic, 2018), it is widely used as the first step of treatment. Bed rest could have adverse effects on women and their families and increase the costs for the healthcare system (Sosa, Althabe, Belizán, & Bergel, 2015).

Hospitalization or restricted activities for high-risk pregnant women is associated with adverse psychological complications including depressive symptoms (anxiety, hostility, and dysphoria), increased stress, boredom, sense of being a prisoner, family stress and role alterations, financial difficulties, lack of control, concern for maternal and fetal wellbeing, worry about family at home, separation from family and paternal difficulties (Maloni, 2011; McCall, Grimes, & Lysterly, 2013). This condition involves high maternal distress which can hinder the development of an adequate maternal fetal attachment (Eswi & Khalil, 2012; Göbel, Stuhmann, Harder, Schulte-Markwort, & Mudra, 2018; Pisoni et al., 2014) and critically affect the infant's future mental health (Ashby, Scott, & Lakatos, 2016; Goodman, 2019), as well as

the emotional, behavioural, and physiologic functioning for the child years after birth (Boris & Renk, 2017).

Furthermore, hospitalization or restricted activities for high-risk pregnant women is associated with adverse physiological effects on maternal health that might persist through the postpartum period including fatigue, muscle atrophy, indigestion, sleep disturbance and bone loss especially in weight-bearing bones of the spine and hip. The prevalence of Deep vein thrombosis (DVT) increased among women who treated with bed rest to reach 15.6 per 1,000 women compared to 0.8 among those were not treated with bed rest (Maloni, 2011; McCall et al., 2013). Additionally, neonates who were born to hospitalized mothers on bed rest had lower birth weights and gestational age (GA) and were more likely to develop allergies, suffer from motion sickness, and require vigorous rocking to fall asleep (Bigelow & Stone, 2011).

In the previous studies women who were hospitalized during pregnancy due to threat of PTB expressed that they had a profound sense of personal responsibility for preventing PTB. Accordingly, they suspend their lives, endure the burden of activity restriction and cannot think of anything else, but they focus on their work of keeping the unborn baby safe and healthy (Lederman et al., 2013; MacKinnon, 2006; O'Brien, Quenby, & Lavender, 2010). They have a competing concern about their own health and the well-being of the unborn child. They want to prolong the pregnancy as much as possible and simultaneously, they wish to give birth immediately. They have a sense of loss and grief of normal childbirth experiences (Leichtentritt, Blumenthal, Elyassi, & Rotmensch, 2005) and search for meaning to help them make sense of their sudden and unexpected hospital admission and regain an element of control over their lives (Barlow, Hainsworth, & Thornton, 2007).

Hospitalized pregnant women on activity restriction fight a daily internal and external battle for the lives of their unborn children. Internally, these women fight a war within themselves by struggling with their daily fears, worries, conflicting emotions of sadness and hope and searching for spiritual meaning in their experience. Externally, these women face daily physical and mental battles to have a healthy baby as an outcome for their hospitalization. These women endure physical signs and symptoms because of their immobility and their fear of losing the pregnancy. They count down the weeks of pregnancy as each day increases their infant's chance for survival. Additionally, they endure the restrictions placed on their daily activity and described the restriction as being in prison (Lederman et al., 2013; Rubarth, Schoening, Cosimano, & Sandhurst, 2012).

Maternal hospitalization and activity restriction place different challenges on pregnant women including: lack of control over their daily activities (Bendix, Kjaergaard, & Zoffmann, 2014), loneliness and separation from their loved ones, lack of privacy (Kent, Yazbek, Heyns, & Coetzee, 2015), inadequate information about their condition and the likely outcome (Barlow et al., 2007; Richter, Parkes, & Chaw-Kant, 2007) and worries about their children and spouse at home (O'Brien et al., 2010). The women's faith and the involvement of family members and friends were reported by hospitalized pregnant women as a source of coping (Leichtentritt et al., 2005; Rubarth et al., 2012). Their relationship with their own mothers and their partners was intensified by supporting their effort to remain pregnant and collaborating with them for the unborn child's health (Lederman et al., 2013).

Existing studies provide a foundation for understanding the emotional, informational, and psychosocial requirements from the perspective of western high-risk pregnant women. However, there is no studies that examine the experience of Arab women who are anticipating the birth of a preterm infant. From the previous studies, women mentioned there need for more personalized and culturally sensitive care from health care providers especially nurses (Richter et al., 2007). Therefore, the purpose of this phenomenological study is to investigate the pregnant women's everyday experiences of living with the threat of PTB during hospitalization.

Methods

Design

To achieve the purpose of the current study, we used a phenomenological qualitative descriptive approach. This method explores the common meaning of people's everyday lived experiences of a phenomenon and reduces it into a description of the universal essence (Creswell, 2013). Essence is critical truths about reality that makes a phenomenon what it is and can be understood and grounded in people's lived experiences (Polit & Beck, 2013).

We established two bracketing conditions in this study: (a) engaging in bracketing interviews prior to, during, and following data collection with an outside colleague to uncover and bring into awareness preconceptions and biases (b) writing memos about cognitive process of the research and observational comments throughout data collection and analysis as a means of examining and reflecting upon the researcher's engagement with the data (Tufford & Newman, 2010).

Participants

A purposive sampling of 10 pregnant women with high risk for PTB were the study participants as saturation was achieved. Munhill (1993) reported that 2 to 10 participants are usually sufficient to achieve saturation of the data.

Participants were recruited by the principal investigator from a high-risk antepartum unit at a public hospital in Amman, Jordan. The women who were approached and met the following inclusion criteria: being pregnant between 22 and 37 weeks of gestation, hospitalized for at least 1 weeks and have any pregnancy complication that may lead to PTB accepted to participate and completed the interview.

Data Collection

The principal investigator conducted in-depth interviews utilizing a semi-structured interview guide developed by the researchers and validated by a team of experts from the school of nursing. The guide was based on previous literature addressing number of issues concerning hospitalized pregnant women who live with the threat of PTB. During the interview, the investigator asked the participants to describe, in detail, their experiences being hospitalized due to threat of PTB, and used probing questions to clarify the participants' perceptions. The interviews were conducted in a private room in the hospital, with only the presence of the participant and the principle investigator, from June–August 2018. The interviews were conducted in Arabic and audiotaped after obtaining verbal consent from participants. Each of the interviews took approximately 40 minutes to 90 minutes to complete. All interviews were transcribed verbatim, translated into English and back translated to ensure accuracy of the data by the study investigators.

Demographic data, including age, religion, education, employment status, income, admitting diagnosis, GA at admission and at the time of the interview, singleton or multiple pregnancy, parity, medical insurance, and presence of PTB history were collected at the beginning of the interview.

Data Analysis

We used descriptive statistics to analyse the participants' demographical data. For analysing qualitative data from the interviews, we used Colaizzi's phenomenological method.

Colaizzi's method follows the general guidelines of analysing data for significant statements, developing meanings, and organizing them into clusters of themes, then presenting an exhaustive description of the phenomenon (Creswell, 2013). We read the transcripts several times to obtain the overall feeling about the women's' experience of living with the threat of PTB. Then, significant words, statements, or phrases related to women's' experience of living with the threat of PTB were identified and coded. After that the categorizing codes were clustered into themes and the obtained themes were integrated into an in-depth description of the phenomenon "How pregnant women live with the threat of PTB." Analysis was done simultaneously with the data collection.

The rigor and trustworthiness of this study were established by using various methods guided by Creswell and Miller's validation strategies including: (a) triangulation by analysing the data from each team member and the findings were compared to reach a consensus; (b) prolonged engagement and persistent observation in the field to build a trust-relationship with the participants and to gain better understanding of the phenomenon; (c) member checking by using the participants' feedback to check if the study findings reflect their true experience in two steps: post-interview and post-analysis; (d) a rich and thick description was used when writing the themes to ensure the transferability of the study findings; (e) and reflexivity by keeping a diary about researchers' personal experiences and reactions during interview and observations to prevent biases (Creswell, 2013); (f) auditing the data obtained from five randomly selected cases by an external researcher (Cohen & Crabtree, 2008).

Researcher Reflexivity

The first author had a professional experience through working as a teacher at the Maternal and Child Health Nursing Department at a school of nursing in which she trains nursing students how to provide care to pregnant women, newborns and their families. The study participants were known to author one only as a researcher when she contacted them to participate in the current study. As the first Author had the experience of caring for high risk pregnant women, yet she used bracketing to isolate her preconceptions, previous knowledge and experiences regarding the phenomenon through writing down her own preconceived ideas before data collection and did journaling and reflection.

One of the research members collected a field notes throughout the data collection process to capture reflections on the interviews. Author one discussed the primary analysis with the other researcher who then jointly worked on the final data analysis. In this way the researcher was able to remain truthful to the participants' experiences.

Ethical Considerations

Prior to conducting the study, we obtained ethical approval from the institutional review board (1925-107). The principal investigator informed each pregnant woman in this study of the purpose and procedure of the study, about her rights to voluntary participation, confidentiality, and the right to decline or withdraw from the study without consequential penalty. She informed them that no harm will be inflicted on them and consequently invited them to sign a consent form and gave each woman a copy of this form that includes the research team contact numbers for future reference. Audiotapes were erased after transcription.

Results

Participant Characteristics

The participants were between 23 and 35 years of age with a mean of 28 (4.16) years. More than half of the participants had less than high school education. All of them were unemployed. Their family monthly income ranged from 250 to 1000 Jordanian Dinar (JOD) with a mean of 455(235.05); 1 JOD = 1.4 US Dollar. One participant was primigravida and the majority of them had at least one alive child. The gestational age of their pregnancies at the time of interview ranged from 26 to 36 weeks with a mean of 31(3.03). The period of hospitalization ranged from 7 to 14 days with a mean of 8.4 (2.95). Two of the women were pregnant with twins by invitro fertilization (IVF). Four women describe their pregnancy as unplanned or unwanted. Four of them had recurrent admission to the hospital in the current pregnancy and three of them had a history of hospitalization in their previous pregnancy. Almost all of them did not have medical insurance and had a special one that was given to the pregnant women for an amount of 50 JOD in governmental hospital only. The participants in this study had several comorbidities and / or symptoms that increased the risk for them for having premature birth in addition to their preterm labor pains. Two participants had twin pregnancy using IVF after more than 6 years of infertility, one of them had a Preterm Premature Rupture of Membrane (PPROM). Three women had vaginal bleeding due to placenta previa, one of them had five previous cesarean sections, and intrauterine growth restriction. One participant had partial placental abruption. One participant had a history of habitual abortion with PPRM. A participant had a history of having two Collodion babies out of three children. One participant had a history of asthma with four previous cesarean sections and one participant was complaining of anemia.

Five themes were derived from the data. The maternal role establishment and suspending responsibilities, fear of uncertainty and finding support, dissatisfaction of care, the change of routine life and family relationships, and the perceived cultural influence.

Maternal Role Establishment and Suspending Responsibilities

Upon discovery of pregnancy, the women started to establish their role as mothers, the following subthemes were identified, bonding with their unborn child, striving for baby survival (my baby comes first), and seeking safe passage for self and unborn child.

Bonding with their unborn child. All women who have pregnancy after infertility or previous pregnancy loss considered the long-desired pregnancy as a joyous experience they have dreamed. They expressed longing and love for their unborn child. All of them indicated that all what they want is to complete their pregnancy and to give birth for alive and healthy child. One of the women who is pregnant with twins considered the threat of PTB as a response from God to her feelings of longing to see her children: “God feels and knows that I longed to see my children. God is accelerating my giving birth to hasten the fulfilment of my hope” (Salma).

All women who had unplanned pregnancies admitted they were unhappy and angry upon discovery and tried to terminate pregnancy through legal or traditional methods. Nearly half of them considered the threat of PTB as a punishment from God because they used family planning methods to avoid pregnancy or as consequence of for trying to abort: “I was angry when I knew that I was pregnant, I tried to abort the baby by drinking a cup of cinnamon, nothing happened but being at risk for preterm birth now is a result of doing that” (Rana).

Eventually, all of the women who had unplanned pregnancies accepted being pregnant and felt attached to their unborn children:

At the beginning I refused being pregnant and I had intention to abort the child because I was afraid to have another Collodion child. Now I love this pregnancy and I want to see my child even if the child is Collodion (Mariam).

Striving for baby survival “My baby comes first”. The majority of the women considered the hospital as a safe place for themselves and their unborn child. They felt safe as they were under regular clinical supervision with prompt access to care during any emergency that may affect their health and their unborn child. Half of the women felt better and more comfortable in the hospital because they were relieved of household chores and their responsibilities toward their spouses and children: “I feel more comfortable at hospital. At home, I always have pain in my back and legs. Now, I feel better and more comfortable because of bed rest” (Hala).

Few women preferred being at their home because they consider it more comfortable, but they accepted to be at the hospital because it is a safe place to protect their life and their unborn children:

I want them to save my children. If I have the choice, I will choose to stay at my home. I am forced to be at the hospital because I am afraid that something bad will happen to me suddenly and my home is far from hospital (Eman).

The majority of the women was in bed rest and limited their activity as they were advised by their health care providers to prevent PTB. Their fear from losing their unborn children due to premature birth prevented them from doing many activities that they like to do such as moving, walking, shopping, visiting their family and friends, managing their household tasks like cleaning, cooking, and laundry on their own: “Previously I had unsuccessful IVF cycle due to my work, so I decide to leave my work and to stay at home. My pregnancy prevents me from movement; I want to protect my unborn children” (Salma).

The majority of the women suffered from preterm labour symptoms such as painful uterine contraction, vaginal bleeding or spotting, and/ or leaking of amniotic fluid: “The most annoying thing is the painful contraction. Some time I cannot breathe. During that time, I feel that I will die... Severe pain... Some time I syncope from pain” (Mariam).

The majority of the women had negative emotions due to bed rest and activity restriction including feelings of being isolated, bored, tired, stressed, anxious, fatigued, sad, afraid, unable to maintain their independent life, desperate and frustrated: “I don’t know why things got so bad?! I feel tired during hospitalization. I am bored and frustrated, I left my home and my children, and I did not get better” (Zahra).

Seeking safe passage for self and unborn child. All of the women main concern was having a healthy child by safe birth and to go back to their homes. A woman described the day of giving birth and leaving the hospital like “Eid”:

InshAllah I will get birth safely and in good health. No matter the gender of the baby the most important thing is to have an alive child... I want to leave the hospital. I wait for the day of operation like I am waiting the “Eid”. I am waiting to get rid of this situation. I and other high-risk pregnant women in my room pray to Allah and compete to deliver first (Fatima).

Fear of Uncertainty and Finding Support

The women in this study discussed issues related to the fear of uncertainty and need for support, this theme included four subthemes: being afraid; seeking reassurance, not being alone, women strengthen each other, and attachment to Allah and faith.

Being afraid. Nearly all of the women reflected fear about their unborn children survival, health and wellness. The majority of them were worried about admitting their children to neonatal intensive care unit (NICU) and not having the appropriate care they need or giving birth prematurely without having place for their children in NICU. Half of them were afraid about having child with birth defect:

I am afraid that my child will need to be admitted to NICU and there is no place for him. I am worried because he was very small, and his weight did not reach one kilogram. If I get birth at this time my child will die soon. I am afraid that my child is abnormal, and the doctors are hiding the truth (Rana).

Half of the women were worried about giving birth by cesarean section, giving birth alone, having complications or suffering from too much pain, a participant commented: "I am scared to lose my uterus. I am still young, and the uterus comforts my body through menstruation" (Fatima).

Seeking reassurance. While half of the women considered their unborn children's movements and pulse as a reassuring sign that their unborn children in a good health:

The most important thing for me is to hear my unborn child's pulse and to feel her movements. When she does not move, I asked Allah to let her move even a light one to make sure that my daughter is alive. Every movement is a source of Serenity for me (Hiba).

Few of them considered having antenatal steroids for fetal lung maturity and fetal ultrasound as reassuring:

I had two steroid injections that help my unborn child's lungs to develop more quickly. I feel psychologically comfortable that the child's lung will be fully developed and if she gets born at seven months' gestation, she will have better chance to survive (Farah)

Half of the women found that it is very reassuring to know that they are not alone and there are other women with same diagnosis or to hear from other mothers who had same diagnosis and they had a healthy child by safe birth:

The woman who is sharing my room was admitted to the hospital at the sixth month of her pregnancy because of preterm labour pain. Now she is at the ninth month of her pregnancy. I learned to be patient from her experience (Hala).

Not being alone. While some women described their spouses as the most supportive during hospitalization, the majority reported that they received the greatest support from their close female relatives especially their mothers and sisters. Those women reported that their spouses are preoccupied with work and are unable to provide the soul-depth companionship

that they crave for. One of the women described her spouse as being conservative with no compassion to prove his virility for his family. Two third of them used their phone when they remain alone in the hospital to seek support by talking with their family members and friends. They mentioned having financial assistance, food, and help in providing care for their children at home as well as psychological and emotional support from their families:

My mother is the most supportive during hospitalization. My spouse works in a shop for curtain, and he is not able to be with me in a hospital because he will lose his wage that day. I want him to console me even by holding my hands only (Fatima).

Women strengthen each other. The majority of the women motivate others who have the same high-risk conditions to protect themselves and their unborn child by being comfortable, limit their physical activity, go to hospital when needed, practice exercise and eat balanced food:

Drink lemon juice and eat cucumber it helps to prevent preterm labour pain. When you have vaginal bleeding, do not get tired by working or moving only limit your movement to bathroom until the bleeding stops (Nora).

More than half of the women encourage those with same condition to get rid of nervousness, trust themselves, be courageous, be patient, have faith and strong personality and have hope even when they themselves were experiencing medical or psychological complications during hospitalization: "I always give hope to women with same diagnosis even if I was the one who experienced the worst during pregnancy. I do not want them to be afraid and feel despair" (Salma).

Attachment to Allah and faith. The majority of the women reported being engaged in spiritual practices such as prayer, praising "Allah", reading Qur'an, charity, and asking for forgiveness to seek proximity to "Allah" as a safe haven wherein they soothed and comforted in their times of distress. They try to have close relation with Allah to alleviate their anxiety, stress and to seek protection for themselves and their unborn children:

The 'Roqia' (Islamic Healing) enhance my health. When I feel decrease in my baby movements, I put my hand on my abdomen and I read Qur'anic verses to protect my baby. Shortly after that I feel response from my baby (Salma).

Half of the women placed their trust and faith in "Allah". They indicated resign themselves to destiny because they know that "Allah" has created all things within destiny, and that what befalls them does so solely because "Allah" so wishes:

My faith in Allah is above anything in this life. All praise is due to Allah, the Lord of the Worlds. I pray and fast to Allah. I have the fear of Allah. I have faith in my destiny. Whatever happens to me is destined. At the end whatever I do, I cannot go beyond Allah's wishes (Fatima).

Being Dissatisfied with Care

The study participants discussed the different challenges related to the health care provided to them during hospitalization. The following subthemes were identified; hospital

environment is not mother-friendly, seeking being informed, absence of empathy and compassion, being verbally abused, mere unsatisfactory physical care, and suffering until admission.

Hospital environment is not mother-friendly. All women reported that hospitals environment did not help them to satisfy their personal care needs such as bathing, showering and toileting due to lack of adequate water, sanitation and hygiene. The majority of them complained of lack of cleanliness of their rooms especially toilets and lack of clean and warm water for bathing:

There is no cleanliness at all, my room's cleanliness is not appropriate, and my toilet smell is so bad. I used to clean my room and toilet for a while, but I stopped because I was so tired from doing that (Nora).

Almost one third of the women found that the food and nutrition services in the hospital did not meet their needs for a good quality, safe and hygienic food: “I don’t like the hospital food. The chicken and meat are undercooked” (Farah). “There is no clean drinking water in hospital” (Zahra).

Not getting enough sleep and rest during hospitalization was a distressing problem for almost half of the women. They spoke about many factors affecting their ability to get enough sleep including noise from other patients and visitors, uncomfortable environmental temperature, pain, uncomfortable beds, annoying mosquitos’ bites, medical and nursing procedures, and worries about their children at home: “I could not get enough sleep because of needle insertion, numbness in my hand and feet and I am worries about my children at home” (Farah).

Some women stressed the need for better and flexible visiting hours. They explained that they felt restricted and separated from loved ones by not being able to contact their family and friends or choose when to do so:

My spouse could not come to see me during hospital visiting hours because of his work. When he came at night the hospital regulations prevented him from entering the ward and prevented me to come out at the door to see him. I am frustrated, I feel like being in a prison (Fatima).

In addition, some women in multi-bedrooms complained from noise, being afraid and stress from sharing the same room with critical cases and worrying of catching any infections, many of the women recommended that patients with same diagnosis must be admitted in the same room:

Different cases admitted to my room with different health problems during pregnancy and all of them died. One of them due to bleeding, and the others from uterine rupture or heart disease. I lived negative experience only... Now, I limited my interaction with new admitted cases to decrease my fear (Nora).

Few women described poor quality of hospital services during night shifts and weekends: “The night shifts staff did not provide care for anyone. The hospital services at Thursday and Friday were very poor. It seems as there is no staff... The hospital is like a waste dump” (Fatima).

Field note: almost all the women in this study brought their supplies such as blankets, pillow, fan, drinking water, thermos to keep cold water, and food. One woman brought cleaning supplies and she was cleaning her room daily.

Seeking being informed. All women reflected a need to know everything concerning their diagnosis, treatment, and prognosis to reassure their heart. They wanted information to be communicated to them in simple and clear terms that they can understand. The health care providers' explanations of diagnoses and treatments were confusing to most women because they speak rapidly using English medical jargon. Few women justified the inadequate explanation for health care providers by being busy. Because of being uninformed, all of the women described their fear, anxiety and uncertainty about any possible threat in future:

The physicians did not explain for me my health condition. I have blood accumulation around my child's placenta. They did not explain for me the causes and prognosis. I am confused. I always ask myself what is the end results of my hospitalization? Is it a preterm birth at 7 months by Cesarean section or discharge? No one explains to me in a clear way. All of them use English terms and I am afraid to ask because I feel they are always in a rush (Farah).

Few women said that their health care providers explain their condition in scary way and exaggerate complications to convince them to perform medical procedures or to stay hospitalized at bed rest:

The physicians exaggerate my diagnosis complications. They use so horrible words to convince me about the seriousness of my condition and in their medical management. They made me depressed and die inside. They took my consent to remove my uterus, part of my bladder and intestine during Cesarean section. In addition, they inform me that I may bleed to death (Fatima).

Absence of empathy and compassion. The majority of the women sadly reflected that the physicians and nurses have lost their ability to understand and respond to their physical and psychological needs. They complained from lack of empathetic and caring behaviors

No one knows how the family feels. Child loss is a normal situation for them. They see many cases every day. They know that I must move slowly because my membrane was broken but they urge me to walk quickly to ultrasound room. They are careless and without feelings (Eman).

Two thirds of the women thought that physicians are more concerned and compassionate than nurses because they provide information intended to reassure them about their health condition: "The nurse does not listen to me when I feel upset. She only notifies my physician when I'm tired. My physician reassures me about my health condition and advises me to continue in treatment" (Zahra).

Being verbally abused. Half of the women reported that they encounter verbal assault from physicians and nurses including being shouted at and humiliated: "When the physician palpated my abdomen, I yelled from pain. He did not complete the exam and shouted at me" (Farah).

A woman reported that she encountered an annoying sexual statement: "I complained from the long waiting time to the physician in the emergency room and I asked her why she examined others women before me even though I arrived before them she respond to me 'no one told you to open your legs for coitus'" (Mariam).

Mere unsatisfactory physical care. Few of the women describe nursing care as routine-based that focus on their physical needs and the physicians' instructions. They unanimously agreed that nurses disregard their psychological, spiritual, emotional and social needs a participant reported:

Nurses only measure my temperature and blood pressure without paying attention to me. They do not help me when I feel too tired to walk to the bathroom. Their response to my concerns is always “we cannot do any things except following the doctors' orders. They do not listen to my psychological distress or tell me something to give me hope. I feel helpless day after day (Zahra).

Two thirds of the women complained that nurses perform skills such as vital signs, needles insertion, fetal heart rate assessment, intravenous medication administration or blood transfusion either incorrectly or with dishonesty: “The nurses document my vital signs without measuring them for me” (Eman). “The nurse inserted the intravenous line for me incorrectly. She gave me a blood through it. My hand became swollen and bruised. I suffered a lot” (Nora).

Suffering until admission. Half of the women described their experience in emergency room as unsatisfactory. They mentioned different issues including: long waiting times, delays in being moved between different departments, performing medical procedure without their informed consent, lack of compassion and empathy:

When the physician in emergency room inserted long instrument inside my vagina, the amount of amniotic fluid that came out increased, I felt scared and I closed my legs... I sat on a chair for long time and the amniotic fluid kept coming out. The staff did nothing for me and did not admit me until my family brought the blood units for me (Eman).

The health care providers communicate the diagnostic and prognostic aspects of their health problem using unclear, hopeless and distressing approach: “Emergency staff were uncaring no one listened to me or considered my feelings. Suddenly, the nurse shocked me when she said that my placenta is low, and my uterus will be removed due to bleeding” (Nora).

Few women claimed that they were coerced into a treatment against their will. Their health care providers refused to complete their treatment unless they obey their instructions. For instance, few of them complained from performance of pelvic examinations without purpose or consent: “When I refused the pelvic exam, my physician withheld treatment unless I submit to pelvic exam. I entreated him a lot to do the pelvic exam and to complete my treatment after many hours of negligence” (Fatima).

Change of Routine Life and Family Relationships

The study participants reported that their family life was disturbed as consequences of their hospitalization, the following subtheme were found; being worry about their children at home, changing relationship with their spouses, and being a burden.

Being worried about their children at home. Nearly all of women expressed their feelings of longing, distress frustration, and worries about their children at home, many women indicated that their spouses and children are suffering from their frequent hospitalization, a woman said: “My mother is diabetic and if she sleeps, she cannot wake up easily. My boys

may burn the home. I feel like I was torturing my spouse and my children when I was admitted to hospital” (Fatima).

Changing relationship with their spouse. Half of the women either were discouraged from having sexual activity due to their high-risk status or their spouses abstain from sex because they were afraid of hurting them and their unborn children. However, more than half of the women reported that their emotional relationship is more powerful than ever. Half of them were satisfied because their spouses helped them in performing household chores such as cleaning, cooking, providing care for children at home, one woman said: “My spouse became more compassionate after I was hospitalized. He takes care of me, pampers me, brings my needs and call me frequently forsake of reassurance... I nearly abstained from sex during pregnancy especially after I have vaginal spotting and back pain” (Farah). On the other hand, few women reported that their emotional relationship becomes strained:

My spouse became nervous and mad when I got pregnant. I have tragic feelings when I have cramping, and he responds in mockery way” go to hospital are used to that”. We are facing an emotional distance. He is used to the idea that I am not at home. Yesterday, I left hospital to see him and I imagined that he will be with me. Unfortunately, he reacted as I am not home (Fatima).

Being a burden. The majority of the women have high economic burden associated with their hospitalization: “My family has financial hardship because I was hospitalized unexpectedly, and I do not have medical insurance” (Farah). Being a burden to their families, especially mothers, because of symptoms and needs of being at risk for PTB and/or recurrent hospitalization was the concern of the majority of the women.

My children live with my mother one week and the next week with my mother in law and so on. This is because my mother is tired and my mother in law has spinal disc. I feel I am a burden to my family (Nora).

Some participant indicated that family members started to be annoyed with their condition. One woman reflected: “The most difficult moment in this hospitalization when my father in law said to me "I get extremely exhausted from your recurrent hospitalization” (Mariam).

Being Influenced by Cultural Issues

Two thirds of the women were being distressed from other people interfere in their own affairs a participant indicated: “Everyone calls you and gives advices such as, “why you did not do so and so” ... People only give a lot of unsolicited advices but did not offer actual help” (Eman).

Some of the women believe in Proverb “A child born at seven months of pregnancy can survive but a child born at eight months of pregnancy will die”. They asked physicians to initiate their birth at seventh month of pregnancy or to stop the preterm labor pain until they can reach the nine months of pregnancy:

The eight months unborn babies begin to renew their lungs again so they will not be mature. At seven months of pregnancy the lungs are mature, and the babies can survive. I prefer to get birth at seven months of pregnancy and not at eight months (Farah).

Few of the women are afraid from the harm inflicted from envy “Hassad” on their unborn child health: “My spouse did not want me to go outside the home. The ‘Sheikh’ told him that what happened with me and why my children are born Collodion is a result of envy” (Mariam).

Few of the women are afraid from passion by Jinn “Tab’e’a” In love with those women, the Jinni may cause complication of pregnancy and the death of their unborn children to alienate them from their spouses: “I made Amulets with special Qur’anic verses written into it. I wear it seek protection for my baby” (Hiba).

Discussion

The study findings provided in- depth understanding of the women’s perspectives related to their experiences with a threat of preterm birth. The expectant mothers developed feelings of attachment for their unborn child despite their pregnancy condition. They strive and suffer a lot to protect their unborn child. They suspended their life and their responsibilities, accepted being hospitalized in a very low-quality healthcare facility, endured physical, mental and psychological burden of being at risk of preterm birth, and endured being separated from their families and loved ones. This result is consistent with previous studies that women do whatever takes to ensure safe passage for their unborn child (Lederman et al., 2013; MacKinnon, 2006; O’Brien et al., 2010; Rubarth et al., 2012). This result can be explained by Rubin theory of maternal role attainment. The theory identifies four specific tasks that a pregnant woman must progressively achieve to learn the maternal role: seeking safe passage for herself and her child through pregnancy, labour and delivery; ensuring that the unborn child is accepted by significant others; binding -in; and giving of herself (Brandon, Pitts, Denton, Stringer, & Evans, 2009). Additionally, Condon (1993) described that the pregnant woman develops emotional tie or bond with her unborn child in which the pregnant woman tries to know, be with, avoid separation or loss, protect, and identify and satisfy the needs of her unborn child.

Consistent with previous studies (Lederman et al., 2013; Leichtentritt et al., 2005; O’Brien et al., 2010; Rubarth et al., 2012), women in this study described their fears regarding their own health, and their fetus wellbeing and survival. In consistent with Linde et al. (2016) found that fetal movements give mothers information about their unborn child wellbeing. Women in this study sought contentment about their unborn child wellbeing mainly through counting their unborn child movements and/or listening to their fetal heart rate sound. Sometime when their fetal movements decreased, they were trying to provoke movement by triggering the fetus through reading a Qur’anic verses on their abdomen, talking to their unborn child or prying to Allah to make their unborn child move.

All women in this study try to avoid being afraid and worried by seeking proximity to Allah and by relying on their faith in destiny. Usually, people at the time of crisis perceive God as an attachment figure and to be a safe haven at that time (Bonab, Miner, & Proctor, 2013). Additionally, attachment to God uniquely fosters the individual psychological health and wellbeing (Keefer & Brown, 2018; Leman, Hunter, Fergus, & Rowatt, 2018).

The majority of the expectant mothers received the greatest support from a close female relative during hospitalization. Unfortunately, in this study some expectant mothers reported being restricted and separated from family and close friends because hospital regulations did not offer flexible visiting hours. Social support is basic human need and has a direct beneficial effect on physical and mental health (Thoits, 2011). Social support decreases stress processes and increases coping skills during prolonged hospitalization (Kent et al., 2015).

Almost all women in this study were not satisfied about the quality of health care services. They experienced mistreatment from health care providers by having incompetent, uncompassionate and disrespectful care. This finding is consistent with previous studies in

Jordan that mothers in maternity settings received dehumanized health care services in an inappropriate childbirth environment. They reported being neglected, verbally abused, not treated with empathy and respect, and being dissatisfied with the information they received leading them to a feeling of insecurity (Alzyoud, Khoshnood, Alnatour, & Oweis, 2018; Hatamleh, Shaban, & Homer, 2013).

Nearly all women in this study complained of lack of cleanliness of their rooms and toilet, lack of clean and warm water for bathing, poor quality of food and nutritional services, being in multi-bed rooms with critical cases, uncomfortable environment temperature and poor ventilation, uncomfortable beds, noisy environment for sleeping and poor services at night and weekends shift. This finding is supported with previous Jordanian study findings that mothers were unsatisfied with the physical environment in the maternity units primarily because they are unable to sleep or rest, being in multi bedroom, poor nutrition services, poor cleanliness and being alone (Hatamleh et al., 2013). Florence Nightingale in her Environmental theory believed that environment in its type physical, psychological and social had a strong influence in maintaining health and wellbeing and promoting recovery. She encouraged health care providers to engage patients in various activity to keep their minds active such as manual work and to communicate with them in a therapeutic, soothing and unhurried manner (Hegge, 2013).

Previous studies found that hospitalized high-risk pregnant women lose their ability to perform daily activities, and their families face financial burden during their hospitalization, this leads to their feeling of being a burden to their families (Richter et al., 2007; Rubarth et al., 2012). Similarly, in this study the majority of women had a feeling of being burden on their families. Their children at home went to live with their grandparents, whom some time because of their health condition will not be able to provide the needed care for those children. Their spouses were helping them in performing the household chores such as cleaning, cooking, and providing care for other children, and their hospitalization adds a high financial burden on their family.

Social and cultural believes such as Evil eye, and possession by Jinn and its associated risk; the seven months gestation baby lived if borne while the eight months gestation will not, and people meddling in others affairs increase the women distress and affect their health care decision during their experience of being at risk of PTB. These findings are supported by previous studies that socio-cultural interpretations of threats to pregnancy increased women's anxieties, driving them to seek multiple sources of care (Dako-Gyeke et al., 2013; Kilshaw et al., 2017).

As all women were from the same public hospital in Jordan, further research is needed on a more diverse population and in various settings, to see how these experiences relate to women from different backgrounds. While the interviews were recorded, the respondents seemed worried about their confidentiality and about how their health care services will be affected by their interviews. Their worries may cause them to conceal some relevant and important information.

Conclusion

The expectant mothers in this study were attached to their unborn child whether they want the pregnancy or not. During hospitalization, they suffered from physiological symptoms of preterm birth and from poor quality of health care. They had negative emotions toward health, wellness and survival for themselves and their unborn children. Additionally, they had worries about their children at home. Their culture over impose their experience by increasing their worries. All of these concerns urge the expectant mothers to strive for seeking a safe passage for themselves and for their unborn children. Their family and social network in addition to fetal movement and fetal pulse give these mothers the energy to keep striving to

reach their ultimate goal the “alive and healthy child”. The role of health care providers specially nurses should be emphasized specifically in the area of providing culturally sensitive information, explanations, and offering caring and emotional support to expectant mothers, is extremely important.

Relevance to Clinical Practice

The current study results can serve as a framework for improving the health care services especially nursing care provided to hospitalized women at risk for preterm birth. Interventions that promote safe passage for mothers and their unborn child must be included in their care. Improving the physical environment by enhancing the cleanliness services, and redesigning the room, view and furniture to satisfy the women basic needs during hospitalization are recommended. Providing flexible visiting hours that allows the expectant mothers to spend time with their families and friends to decrease their fears and stressors.

Health care providers especially nurses should provide compassionate, competent and woman- centered care. They should allow women to verbalize their fears, stressors and concerns. They should use simple and reassuring language as much as possible to keep the expectant mothers informed about their health condition and prognosis. They should pay a special attention to women's spirituality because of its positive effect on women's health and well-being during hospitalization. Efforts need to be placed on building the capacity of the health care providers especially nurses who work on obstetric emergency room to keep mother safe through providing high quality health care as well as to be able to provide psychological and emotional support for those mothers. The study findings can inform policy makers, nurse administrators, and nurse educators on strategies to enhance nursing care to mitigate the negative effect of hospitalization on expectant mothers and their children years after birth.

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