ANTENATAL ASSESSMENT OF THE PSYCHOSOCIAL WELLBEING OF PREGNANT WOMEN: A CASE OF MPILO LOZIKEYI MATERNITY HOSPITAL, BULAWAYO, ZIMBABWE

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Abstract:

Introduction: Women have psychosocial challenges but perinatal interventions are not making much impact on their mental status hence the interventions need scaling up. This study involved measuring and analysing the extent to which levels of the psychosocial markers reflect effectiveness of the mental health interventions offered by midwives.

Methods: The study was conducted at Mpilo Central Hospital Maternity Bulawayo, for the main reason that it receives women referrals from 5 out of the 10 provinces in the country with a total catchment of almost 50% of the country's population. The maternity hospital has a full complement of all the five maternity units. A quantitative approach administrating a Quality-of-Life Enjoyment and Satisfaction Short form (Q-LES-SF) scale was used. The scale ranged from "very poor" to "very good" with "poor", "fair", "good" components in between was used to measure the psychosocial scores on a purposive sample of 300 women in the third trimester of pregnancy. The participants had attended at least three antenatal reviews where psychosocial interventions and mental health assessment, monitoring and evaluations are normally carried. The quantitative data was analysed using descriptive statistics on SPSS Version 23 package.

Results: The Q-LES-Q-SF psychosocial scale which was revealed that women had psychosocial challenges without adequate mental health interventions to ameliorate these challenges. The study demonstrated a bimodal sample with peaks at the "Good" and "Poor" set points. The relationships of the psychosocial and satisfaction scores along the scale continuum showed that "Poor" (33%) Q-LES-Q-SF was higher, followed by "Good" (29%), followed by "Fair" (25%), followed by "Very Poor" and "Very Poor" and "Very Good" being equal (6.5%) in a normal distribution pattern.

The likelihood of the demographic variables influencing the Q-LES-Q-F scale were not necessarily linked to the quality-of-life enjoyment and satisfaction of the expectant women during prenatal period. However, age, education level acquired and marital status showed a linearity towards the "Good" when individually rated against the Q-LES-Q-F.

Discussion: The psychosocial scores were generally both poor and good indicating that perinatal interventions are needed are needed to making much impact on the mental and social wellbeing of women in the third trimester of pregnancy. The good to very good Q-LES-Q-F scores are a requirement in expectant mothers as this has a strong bearing on the wellbeing of the foetus and mother post parturition. Apparently, the need for scaling up psychosocial support, monitoring, evaluation and interventions to third trimester pregnant women by midwives cannot be overemphasized.

Keywords: pregnant women, perinatal interventions, mental health, psychosocial wellbeing, midwife, Mpilo Central Hospital Maternity

1.0 Introduction

During the perinatal period the woman and her unborn and/or newborn are exposed to a greater danger of mental disturbance and disruptions in the "feeling" state of the woman which mostly becomes more prominent immediately or within the initial month after giving birth.[1] Evidence has shown that the provision of emotive, informational and noticeable support all the way through the stages of labour, fulfils the women's expectations about childbirth and can intensify their contentment with the birthing activity.[2] Moreover, prenatal and postnatal emotional, social and psychological has proven instructive in the wellbeing and positive outcomes of good motherhood.

1.1 Background to the study

Psychological instability of women results in deficient care during the antenatal period, underweight births, premature delivery, poor emotional attachment, inattentiveness and aggression on the new-born.[3] Emotional distress is clearly normative among perinatal women. However, women often do not receive psychosocial support during routine perinatal care. Evidence reveals that practical and cost-effective psychosocial interventions can reduce negative emotional outcomes and promote positive emotional outcomes.[4] Apparently, after childbirth the occurrence of depression ranges from 7% and 30% in poor, moderate and wealthy countries.[5] In 22 out of 28 poor and moderate wealth countries, the depression rates after childbirth were much more than those in wealthy countries, and Zimbabwe, with a prevalence rate of 33% was among the countries which rated highest[5]. Others with highest rates were Vietnam with a score of 33%, Guyana with a higher rate of 50%, whilst lowest prevalence rates were noted in Uganda with a score of 7.1% and Nepal which rated 4.9%.[6] Nyanyiwa[6] highlighted that Zimbabwe, alongside several other United Nations (UN) member states committed itself to attainment of Sustainable Development Goals (SDGs) 3. Four of the 17 SDGs are purposed at preventive and therapeutic strategies to reduce untimely deaths from non-communicable ailments by a third, and enforcing mental health promotion as a means of ascertaining the

attainment of well-being by year 2030. Studies revealed the Factors that contribute to the increased susceptibility to postnatal deaths (PND) in Zimbabwe as HIV, discrepancies in the socio-economic standing, gender-related harassment, and eminence of one's life.[7] In a study by Chibanda[8] on 264 adults, living with HIV, a greater frequency of probable common mental disorders (CMDs) (67.94%) was discovered and the prevalence of depression was found to be higher (68.5%), more than those without HIV.

The National Institute for Health and Care Excellence (NICE) 2014 Guideline[9] emphasises that perinatal mental instability has consequences on the growing foetus, on the new-born and on the mother too. Disappointingly, midwives, do not have skills, understanding, beliefs as well as attitudes to offer the mental aspect of midwifery care with some viewing it as not important.[1.0,11] Present-day training of health personnel does not sufficiently prepare nurses to manage emotional wellbeing nor are they equipped to manage the stress they experience in the professional setting, with little or no support available to them[11], let alone the pregnant

Systemic reviews by Alderdice and McNeill[12] openly revealed the paucity of scientific evaluations that buttressed the explicit role of the midwife in addressing the mental health concerns of expectant women, despite the realisation that midwives are the lynchpin for comprehensive exchange. McCann and Clark[10] showed that, apparently several midwives evade women who are mentally disturbed among a majority of participants with excess of 10 years midwifery experience. Ostensibly, in spite of having acquired this much practice, there were gross deficiencies pertaining to appreciation of obligation to evaluate the mental status of women during perinatal care. Mental health tends to be relegated to the responsibility of other disciplines, like social welfare officers or experts in mental health.

Similarly, there is clear deficiency in mental health knowledge and skills among the midwives in Zimbabwe. The Zimbabwe National Health Strategy (2009-2013)[13] only mention mental health briefly but does not anchor it to direct mental status assessments in general, let alone during pregnancy and after delivery. Effective midwifery interventions in mental health are essential for promoting a passionate rapport with women which is characterised by empathy, support, trust and empowerment which enables informed decision making.[14]

Alleviating mental health instability impacts positively on pregnancy outcomes, on mother-infant relationship, as well as the linkage with her significant others. McCauley, Elsom, Muir-Cochrane and Lyneham[15] note the accelerated need for inclusion of mental status examination and psychiatric assessment which are not currently included in many midwifery course curricula. Such inclusion would ensure that vulnerable women and their families have appropriate access to mental health and community support services. Effective midwifery interventions in mental health are essential for promoting a passionate rapport with women which is characterised by empathy, support, trust and empowerment which enables informed decision making[14]. McCann and Clark[10] conducted a study on students undertaking a bachelor's degree in midwifery to uncover their knowledge on the mental status of mothers with schizophrenia postpartum and findings revealed deficient knowledge which could be compared with that prevailing among untrained individuals.

Jolivet[14] noted the detrimental effects of poor mental interventions that range from comparatively elusive contempt in affording woman's independence and promoting self-worth to absolute exploitation; carnal attack, use of foul language, exclusion and rejection. However, studies clearly reveal that the midwives in practice have inadequate understanding and abilities, which demands urgent commitment towards uplifting their competencies. Higgins, Carroll and Sharek[16] reiterate that despite the fact that midwifes are exposed to practical situations that are fertile ground for exploring or even mediating on issues pertaining to women's mental wellbeing, it is unfortunate that they lack the ideal aptitude and may disregard or detach themselves from mental aspects of women's care.

Austin[17] contends that there are many opportunities for improving mental health so that women receive optimal care during the perinatal period. However, Kwee & McBride[4] realized that intercessions to promote mental stability in expectant women and adjustment after childbirth have trailed behind despite the advancing trends. Dennis and Dowswell[18] discovered that therapeutic mental protocols such as, interpersonal psychotherapy, home visits conducted by knowledgeable professionals, peer backup through telephone conversation meaningfully impact positively by decreasing the frequency of mental disruption following childbirth. McCauley et al[15] realised the importance of promoting improved specialist care by midwives through enhanced assimilation of mental assessments and provision of suitable attention to mental and community support service essentials to susceptible women and their families. Milgrom and Gemmill[19] reiterate the necessity for midwives to commit themselves towards incorporation of the women's psychological welfare as a rule at every encounter. Milgrom and Gemmil[19] concur that the role of midwifery services is ensuring strategies that advance the perinatal emotive welfare of women.

Despite the serious concern about the paucity of mandatory mental health screening in Zimbabwe,[20] an isolated survey in Harare, conducted by Chibanda et al,[21] based on the "Center for Epidemiological Studies-Depression Scale" showed prevalence of postpartum depression of 21.4%, suicidal ideation (21.6%) and attempted suicide (4%).[19] Milgrom and Gemmil[19] impressed on the need for comprehensive and multidimensional psychosocial assessment to evaluate every woman's circumstances, such as, support base, her relationships, life stressors, physical or sexual abuse as common practice during the antenatal period. This assessment would help in identifying those potentially exposed to a great danger but are not presently exhibiting features of mental disturbance such that circumvention measures would then be offered early.[17,19] Howard et al[22] reiterates the increased propensity towards psychosocial assessments in monitoring maternal mental wellbeing which would facilitate timely inception of perinatal mental interventions during admission through to care after discharge.

Authors identified several hindrances to proper psychosocial assessments. These were inclusive of being ill-equipped to initiate a conversation on delicate concerns of women, for instance sexual abuse, inability to tactfully educate women and their significant others,[23] deficient time, inadequate knowledge and deprived access to amenities for mental health.[24] Educating midwives and providing other operational

tools, like care protocols, are necessary in supporting provision of mental health care and collaboration interventions[23]. Incorporation of creative mental and social approaches into day to day perinatal activities, opens room for extensive accessibility to psychosocial assets for women and networking for attainment of optimum attention.[4]

Scientific evidence spells out the mechanisms of relieving these constraints singularly through devising creative methods of screening, educating women and following e-referral modalities[23,25] placed emphasis on alleviation of the hurdles by increasing awareness of societal resources, adherence to referral protocols, getting extra perinatal mental health education so as to enhance awareness, self-reliance, and use of evidence-based instruments for the mental screening, while using them as an antecedent to initiation of dialogue on mental issues.

Scrutinizing the woman's mental predisposition, as well as valuation of the psychological and social status should be urgently incorporated into midwifery programmes in order to ensure that midwives are educated on provision of optimal psychosocial comfort. A small number of respondents in an enquiry by McCann and Clark[10] alarmed at the conspicuous absence of any teaching on mental health and most of the times mental issues and mental expertise were visualised as unnecessary aspects of their services. Similarly, there is a clear deficiency in awareness and capacitation about mental aspects of care among midwives in Zimbabwe. Zimbabwean midwifery curricula in the various programmes, diplomas up to master's degrees are either silent or mention mental health briefly. Although, to a lesser extent, some midwifery programmes at tertiary level have realized the need to include the mental aspect of midwifery care, more still needs to be done because undoubtedly this is a crucial area.

McCann and Clark[10] denounce the lassitude in admitting the fact that mental health should be included in midwifery input and in the clinical areas. Further to this, the same authors argue against the notion of excluding mental health from the scope of midwifery practice, whilst endorsing that such ideas should no longer be accepted. Undeniably, midwives would definitely have varying levels of knowledge and capabilities which would make it improbable to train all the midwives such that they would catch-up with requisite knowledge acquisition for the national perinatal assessment.[10]

With the realization that Zimbabwe is among the African states which have maximal predominance of women who succumb to perinatal mental disorders, the country's health segment has consequently been summoned to pursue further scientific investigation pertaining to mental disorders in women.[6] WHO[26] reiterates that it is possible to treat mental ailments if active intermediations are done by health cadres who have attained the requisite competencies. There is a need to completely incorporate mental aspects of maternal care into the services package through routinely screening women during the prenatal period of pregnancy and in the postpartum periods as a means of ensuring that suitable, well timed interventions are employed[26]. However, the country lacks free-standing amenities which are dedicated to mental health in most areas such that psychological and mental health care in Zimbabwe is frequently incorporated into primary health services.[27,,28]

When mothers suffering from mental pathology are afforded the ideal support, it has been realized that there are undisputable merits on bonding and resultant behavior of the child.[29,30] There is, therefore, need for innovative styles of providing realistic perinatal mental health interventions that are tailored towards addressing the exceptionality of the needs of women in order to achieve optimal mental health outcomes.[3.1] Manley, Hills and Marriot[32] reiterate that providing some report back and monitoring; participation by woman, significant others and society; capacitating the personnel; advancement of functional governance; accessibility and persistent announcement of the strategic direction are essential aspects of care. Other important aspects are involving targeted boards and subdivisions dedicated to women-centred promotion initiatives; collaborative research; appropriate technology and structural support aspects which are not currently in place seeking modalities of implementation.

1.5 Scope of study

The study was conducted at one of the two tertiary maternity institutions in Bulawayo, which is one of the 10 Provinces in Zimbabwe. It lies in the southern region of the country and has an estimated population of 676,787 and a land area of approximately 1,707 square metres. According to the Zimbabwe Population Census CSO[33] (2012:3),[33] the Bulawayo population of child bearing women (15-49 years) is estimated at 56.2%, crude birth rate of 27.3, teenage marriages 9.4% and under five mortality rate at 955/1000births. Regarding maternal health data in Bulawayo, in 2015, the percentage of skilled birth delivery was 94.8%, antenatal coverage was 70.5%, total institutional deliveries was 90.3%, postnatal coverage was 69.1%.[34]

1.6 Limitations

The use of a psychosocial scale during quantitative data collection could not have provided all-inclusive evidence, however enhancement was afforded through performing retrospective data analysis and conducting comprehensive interviews with women, midwives and key informants. The study could have been further improved by direct observations of the woman-midwife interactions at the different phases of the perinatal period.

2.0 Materials and Methods:

2.1 Materials:

This study was the initial quantitative phase of a sequential explanatory design which takes place in two distinctive interactive phases, that start with the gathering and scrutinising of quantitative data followed by the subsequent assortment and analysis of qualitative data[35]. The descriptive study choice was necessitated by the need to quantify data from the psychosocial scale, women's documents followed by triangulation with women's, midwives' and key informant' perceptions. This entails initiation and then building on the quantitative results, by conducting a second qualitative phase to obtain deeper insights of some of the findings in the first phase and then interpreting the two results together[35]. The quantitative depiction concentrated on the predominance, occurrence, size, and quantifiable characteristics of phenomena.

2.2 Research Design

2.2.1 Descriptive Study

A descriptive tool was used for the study, namely, the psychosocial scale which measured the psychosocial wellbeing of women during the third trimester of the antenatal period. The psychological scale was then analysed using frequencies and percentages.

2.3 Population

The population for administering of the psychosocial scale comprised of 960 women in the third trimester of pregnancy during the two months of data collection.

2.4 Sample Size and Sampling Technique

Purposive sampling was used to select a sample of 300 women in the third trimester of pregnancy on whom the psychosocial scale was administered. These were women who had had at least three antenatal visits. The assumption was that these women would have benefited from the mental health interventions which would have been done prior to that particular visit.

2.5 Research Instruments

One descriptive tool was used for the study, namely, the psychosocial scale which measured the psychosocial wellbeing of women during the third trimester of the antenatal period. However, in-depth analysis was carried out using gatekeepers and key stakeholders interview guides as well.

2.6 Psychosocial survey

In this study, the researcher used the psychosocial scale to contact a large number of people which was relatively quick, efficient, and easy to code and interpret. Standardization of the scale was easy since respondents were commenting on exactly the same items which made the method reliable. Respondents were kept anonymous and completed the tool in privacy and it was easy to ascertain that the single page tool was filled in by the person to whom it was intended and clarification was provided instantly. The response rate was 100% since chances of attrition were minimal.

2.7 Methods

2.7.1 Development of a psychosocial Scale

Endicott[36] designed the Q-LES-Q-SF self-report instrument comprising of 16 items derived from the general activities scale of the original 93-item form. It consists of fourteen items assessing satisfaction with one's physical health, social relations, and ability to function in daily life, physical mobility, mood, family relations, sexual drive and interest, ability to perform hobbies, work, leisure activities, and household activities, economic status, living/housing situation, vision and overall well-being. Each of the 14 items is rated on a 5-point scale that indicates the degree of enjoyment or satisfaction experienced during the past week. The total score of all 14 items is computed (ranging from 14 to 70) and is expressed as a percentage (1–100) of the maximum total score. Higher scores on the Q-LES-Q-SF indicate greater contentment or satisfaction. The instrument also includes two additional items, measuring satisfaction with medication and overall life satisfaction that are not included in the overall score. As the French version of the Q-LES-Q-SF yielded valid

and reliable clinical assessments of self-reported health status, it was used in this study.

The draft psychosocial scale was discussed with the supervisor and then with a cross-section of 10 senior health professionals drawn from maternity administration, education and the hospital psychological services to determine its relevance, comprehensiveness, readability and applicability. Pretesting of the psychosocial tool was done on 10 participants who did not participate in the main study in order to make adjustments to the tool before final administration to the research participants. Adjustment of the wording was done to boost comprehension.

2.8 Validity and Reliability:

The validity and reliability of the psychosocial tool was already tested since it was adapted from The Quality-of-Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF) tool which was tested by many authors. Validity was also ascertained through consulting a panel of experts to review the wording and adjustment of the tool so as to allow better comprehension.

Reliability was ensured by documenting all procedures that were carried out in the development and conducting of the study so that future researchers could replicate it. Additionally, the research assistants were given a 2-day training to enable them to conduct the psychosocial scale in the same manner for all the participants. This was done as a means of standardising the processes to limit external sources of variations. The internal consistency reliability of the tool was $\alpha=0.83$.

2.9 Data collection process

Before collecting data, the researcher and the research assistants met the management of the hospital to brief them on the plan of work. The team then introduced themselves to the maternity unit administration and staff following which data were collected through use of a psychosocial scale which was administered to women who were in the third trimester (at least 36 weeks gestation) and had consented, they would be given the short tool to complete and return instantly with verification of aspects which needed clarification.

2.9.1 Data Presentation and Analysis

A data entry template with legal values was designed to capture psychosocial scale data using excel. This was followed by data cleaning and analysis using SPSS version 23 package. Descriptive statistics, which include means, standard deviations, and medians, were calculated for all continuous variables that were normally distributed and frequency tables were computed for all items and then presented as tables and graphs.

The scores were recorded such that positive responses with higher scores were compared with negative responses. Items that were amenable to scoring were grouped under the different dimensions and scores were assigned on a scale. The scores were recorded such that positive responses with higher scores were compared with negative responses. This was guided by referring to the chart with the calculations and interpretation of the computed scores. The psychosocial tool which is based on the Q-LES-Q(SF) has a total score which is derived by summing scores from the first 14 items, with each score on a response scale ranging from 1 (very poor) to 5 (very good). The raw total score, which can range from 14 to 70, was then

expressed as a percentage of the maximum (or % maximum) total score possible (ranging from 0–100) for ease of interpretation, with higher scores indicating greater enjoyment or satisfaction. The raw total score is transformed into a percentage maximum possible score using the following formula:

(Raw total score − minimum score)
(Maximum possible raw score − minimum score)

The data were then analysed using an SPSS Version 23 package. Descriptive statistics, which include means, standard deviations, and medians, were calculated for all continuous variables that were normally distributed and frequency tables were computed for all items and then presented as tables and graphs.

2.9.2 Ethical Considerations

It is generally accepted that all research should be carried out both ethically and with utmost integrity. Request for ethical approval for the whole study was obtained at two levels. Ethical clearance was sought from the Higher Degrees Committee of the University of South Africa (UNISA) [REC 012714-039 (NHERC)], the Medical Research Council of Zimbabwe (MRCZ) [MRCZ/A/2333] and the Institutional Review Board (IRB) of the Central Hospital, which is the study site. The ethical principles that were applied to this study are: consent, confidentiality and anonymity, beneficence and non-maleficence. Informed consent was obtained after explaining about the parameters of the study and how they would participate. The participants were free to withdraw at any time without prejudice and were assured of confidentiality, privacy and anonymity as codes were used instead of names.

3.0 RESULTS

The psychosocial scale was used to assess the extent to which perinatal interventions had impacted on the mental and social wellbeing of participants in the third trimester of pregnancy. These were women who would have had at least three (3) antenatal visits. The assumption was that these women would have benefited from the mental health interventions which would have been done prior to this particular visit. The Quality-of-Life Enjoyment and Satisfaction questionnaire (Q-LES-Q) was adopted for the study

The research question on analysing the extent to which the levels of the psychosocial markers reflected effectiveness of the mental health interventions was answered. Discussion entailed insights into issues directly relating to data presentation and analysis and articulation of concerns stemming from the data analysis with implications on the inclination of the guidelines.

3.1 Demographic Information and Psychosocial Score Distribution

A total of 300 women attending for Antenatal care at the Maternity Unit were subjected to a psychosocial scale, with an objective to assess the extent to which perinatal interventions impact on the mental and social wellbeing of participants in the third trimester. The perinatal interventions are a deliberate step taken to safe guard pregnant women from mental and social ills which tend to affect both mother

and child and the family at large if not managed properly. Pregnancy related stress has an untoward effect on the foetus in utero with effects manifesting as reduced developmental scores post parturition. These need to be avoided.

The median age in years among the study subjects was 26 (range: 15-43). The majority of the women, 215 (71.7%), were married and only 85 (28.3%) were single. The First-time women (Parity 0) constituted the largest proportion, 98 (32.7%), followed by the parity of one (30.3%) and the least proportion were those with a parity of four, seven (2.3%). The prevalence of medical conditions was very low, in this population. The majority of the women, 277 (92.3%), had secondary basic education and only 23 (7.7%) indicated that they had attended school up to primary education. Median satisfaction level in percent with life among this population was 53.6 (1.8-83).
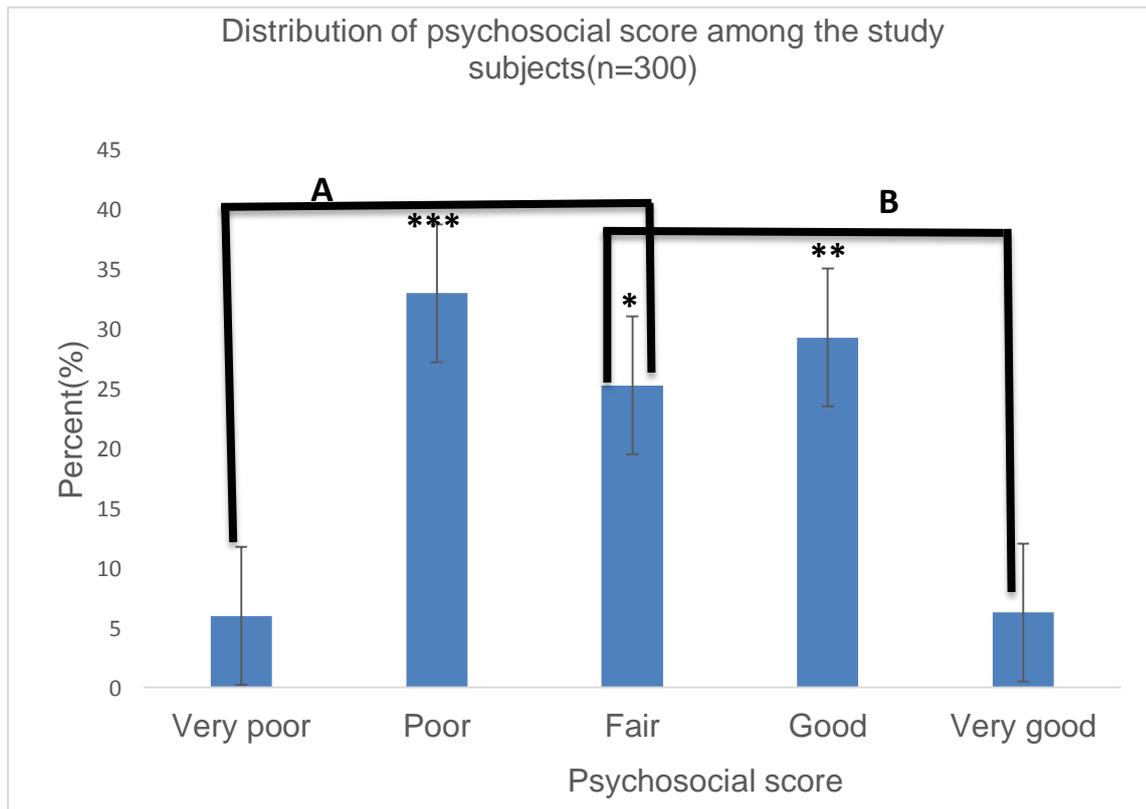
Figure 1: Percentage distributions of psychosocial scores in study

Key: The Q-LES-Q(SF) score interpretation as psychosocial score distribution poorness or goodness was variedly represented with statistically significant conspicuous centripetal peaks at "poor" and "good" on the continuum from very poor to very good [***$p<0.05$ poor vs very poor; ***$p<0.05$, poor vs fair; ***$p<0.05$, poor vs very good; **$p<0.05$, good<very good; **$p<0.05$, good vs very poor; *$p<0.05$, fair vs (very poor + very good)]. **(Figure 1).**

3.2 Percentage distributions of psychosocial scores

Psychosocial score is normally distributed in this population with the largest proportion (39.1%) on the poor and very poor side, whilst those under the fair category constituted 25.3% of the participants forming an equally distributed dichotomy or bimodal distribution around the "Poor" and "Good" psychosocial scores.

There are two distinct populations made up of those with poor psychosocial scores and those with good psychosocial scores in the bimodal distribution.

While a statistically significant difference could not be reached in the study, a comparative analysis between the combinations of **A** [Very poor + Poor + Fair] equalling 70.5% and **B** [Fair + Good + Very Good] equivalent to 60.8% in **Figure 1,** shows that the there is a preponderance towards poor psychosocial scores.

3.3 Psychosocial Scores Distribution Comparison by Demographics

The 300 women attending for antenatal care a maternity unit were assessed with a psychosocial scale, intending to find out the extent to which perinatal interventions impact on the mental and social wellbeing of participants in the third trimester. The median age in years among the study subjects was 26 (range: 15-43) with the older women overly represented in the categories of "Fair", "Good" and "Very Good" scales [***$p < 0.05$, Ages ≥ 35 years vs Ages ≤20 years; **$p < 0.05$, Ages ≥ 35 years vs Ages 21-30 years]. The majority of the women, 215 (71.7%), were married forming the majority in the Q-LES-Q-SF scale from "Poor" through "Fair" to "Good" [***$p < 0.05$, Married women vs Single women].

Surprisingly the single women, who only were 85 (28.3%), were overly represented in the "Very Good" category of the Q-LES-Q-SF scale showing a higher degree of satisfaction [***$p < 0.05$, Single women in "Very Good" scale (69%) + Single women in "Good" scale (22%) > Single women in "Poor" scale (7%) + "Fair" scale (2%)]. Most single women were also first-time pregnancy women (Parity 0) who constituted the largest proportion, 98 (32.7%).

The parity-of-one women (30.3%) were mostly married and had a "Fair" Score on the Q-LES-Q-SF scale showing fair psychosocial satisfaction with their pregnancy status and interventions they received. The four parity women were rare type in the sample 7 (2.3%) with a preponderance around the "Poor" to "Very Poor" psychosocial score despite their "experience" with motherhood. This category of women was all married and possibly not satisfied with the spouse support which may tend to affect the joyful outlook of a fifth child-birth.

The prevalence of medical conditions was very statistically significant high in this study population at 97.3% (n = 292) [***$p < 0.05$, Medical conditions vs no medical conditions]. The majority of the women, 277 (92.3%), had secondary basic education and had an almost equal representation in the whole Q-LES-Q-SF scale which was statistically significant [***$p < 0.05$, Secondary education vs primary education].

4.0 Discussion

The Q-LES-Q-SF psychosocial tool was used in the study was adopted and adapted from other studies with some significant modifications for use in prenatal care of pregnant women referred to the clinic from different clinics and hospitals in the region of Matebeleland Provinces and Bulawayo City Province.

Hope, Page and Hooke[38] have discovered attributes of substantial influence on the feeling of contentment with the value of life in patients with long-lasting ailments like nervousness, extreme sadness, learning, economic status, consecutive age and freedom of movement using the Q-LES-Q-SF tool. Stevanovic[39] noted that the "Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q)" and its "short form (Q-LES-Q-SF)", are aftermath valuation tools that are included amongst the most habitually used in psychic studies.

Its use in the psychometric evaluation on fifty-seven (57) grown-ups who were suffering from mental pathology, using "descriptive analysis, internal consistency, test-retest reliability, validity, sensitivity and responsiveness" was reported. The Q-LES-Q-SF scored 80% sensitivity on the receptiveness parameters, had a specific measure of 100%. Scrutiny of the Q-LES-Q-SF established reliable and valid scientific calculations of "quality of life"[40]. Observations have been made that the Q-LES-Q-SF questionnaire is fundamentally a rigorous depicter of health status in self-reported assessments on substance users.

Haynam, Wyrwich, Revicki, Locklear, & Endicott[41] immensely bank on the psychometric attributes of the Q-LES-Q-SF and presented further substantiation on adopting it as a "patient-reported outcome (PRO)" tool in patients with generalized anxiety (GAD).

In the study, reliability was unswervingly robust, with a high Cronbach's alpha at 0.88 or more at all intervals (baseline, at three and at six months). Given the impact of GAD, this post-hoc study showed that Q-LES-Q-SF comprises a trim and focused psychometrically sound PRO that supplements an assortment of outcome evaluations of features related to those searching for therapy for GAD.[41]

Raghuraman, Balasundaram, Sarkar, and Subramaniam[42] conducted a cross-sectional study on individuals attending preventive health services at a tertiary institution to assess mental pathology and the value of life. Findings revealed that psychiatric disorders were prevalent in one-fourth of the participants attending preventive health-care services. The existence of a mental ailment was connected with a considerably inferior quality of life (QOL) and therefore emphasis should be placed on mundane screening of the mental status as an invaluable exercise in such setups.

The psychosocial scale was completed by 300 women in the study whose objective was to determining the extent to which perinatal interventions by midwives and other variables impacted on the mental and social wellbeing of participants in their final trimester of pregnancy. The median age in years among the study participants was 26 and most of the women were married. The majority, were either first-time women (Parity 0) or had a parity of one. The majority of the participants had secondary

basic education. The median satisfaction level with life as a percentage of the study population was 53.6 (1.8-83) showing a satisfaction above half.

In the bimodal distribution (ranging very poor to very good) psychosocial scale displayed, increased evidence of poor psychosocial adjustment during pregnancy is a worrisome observation. This spells out possible poor to bad outputs and outcomes of a rather supposably a pleasant period (pregnancy) for women in general.

An important revelation was also that not all the demographic variables were necessarily linked to a "quality of life of enjoyment and satisfaction" for the expectant women. With a median age of 26 years, the study sample was generally young people and in the prime of child bearing which is usually expected to have a healthier outlook to life, much more during the act of bringing a life into existence.

A combination of being young and single exposed one to have a "Very Good" Q-LWS-Q-SF score which is unexpected seeing that both factors may be attributed to a situation of discomfort and loneliness. Pregnancy, when one is young and unmarried, may pose an ultimate stigma in a society that expects women to be married before getting pregnant. In such cases women may be expected to show and feel the awkwardness of their situation and also tend to live which may induce stress and anxiety. However, in this study sample, single para and single women seemed to show signs of satisfaction and a Q-LES-Q-SF scale score in the "Good" to "Very Good" section which is rather intriguing.

Most possibly, single women are attracting more attention from more than one man, thinking of the monogamous marriages in place, which may give psychosocial support and wellbeing. Also, the empathetic and goodwill of modern-day society leans more towards the under privileged and weak boosting their ego and stamina to survive. Pregnancy in society is now mostly viewed in the light of what it is, life-bringing-exercise, which may be more fulfilling than the attention other people may provide. This group may also receive more attention from the midwives during antennal clinic visits and reviews being known high risk populations and so be more content and satisfied, which is desirable, during the third trimester of pregnancy.

This, therefore calls for the midwives to pay more attention to the whole spectrum of women who consults them during antenatal visits. This is supported by the finding in the part of this study (data not published) that the documentation review process showed huge tracts of missing data in the participants' records.

Multiparous women, on the other hand, may be neglected and be given perfunctory attention by both the husbands, relatives, the clinics midwives and themselves too on the premise that they are "experienced" in childbirth. While this kind of perception is not only false, it is dangerously exposing the would-be-many-times mothers to a sense of self-pity and anxiety if one or more expected aspects or milestones of pregnancy turned out otherwise. This may affect the whole outlook and continuum of the pregnancy process giving "Poor" to "Very Poor" score in the Q-LES-Q-SF scale which was observed. The probability that this is a consequence of paucity of mental health interventions or the fact that the mental health interventions may not be

making enough impression on the mental status and social comfort of the women may not be discounted.

The need for scaling up or monitoring the psychosocial interventions,[37] particularly with the use of the (Q-LES-Q-SF) assessment tool cannot be over emphasized showing that the obtained result are a true reflection of what subsisted in the study population.

While the prevalence of medical conditions was very statistically and significantly high in this study population, this finding may put claim to the need of the Q-LES-Q-SF scale in the monitoring and evaluation of all pregnant women during the antenal period. It is a given that women suffer from other medical conditions that may impinge on the outcomes of pregnancy and may need adequate attention. Moreso, these women could have been at the maternal institution precisely on the basis of their known previous medical conditions having referred to the maternal institution for those reasons and expecting to received adequate interventions.

The site used for the study is a referral Maternal and Child Care institution expected to have all the up-to-date resources for antenatal good mother and child care. As alluded early, it is one of the provincial referral hospital adepts in safe deliveries with well-trained midwives and other health personnel. Therefore, the would-be-mothers would have been referred to the centre on the basis of their medical history requiring more than mere standard care which may not be available in other health institutions. In other words, the antenatal specialities given at the hospital is regarded as the best in the region and mainly carters for cases not optimally handled elsewhere.

For the study, the site was chosen for precisely that the women were going to receive adequate care enabling them to have favourable scores on the Q-LWS-Q-SF scale. However, this was not entirely met seeing there was a very high and statistically significant scoring by the would-be-mothers in the "Very Poor", "Poor" and "Fair" scores of contentment and satisfaction with life during pregnancy. This dissatisfaction is most likely to have continued into the postnatal period with possibility of affecting the mother-child bonding necessary for the natural wellbeing of the child.

Where the history of the mothers shows a tendency of having ill health of high risk for pregnancy complications, women are most likely to be referred to specialist institutions with competent midwives and obstetricians. Medical conditions that cause women to be referred for antenatal care may include previous births by caesarean section, hypertension in pregnancy, diabetes mellitus in pregnancy, proteinuria, twin pregnancy, first pregnancy and young age during pregnancy. These women, it is supposed, will receive adequate interventions for midwives and move their Q-LES-Q-SF scale scores towards the "Fair", "Good" and "Very Good" side of the scale so that they report a good satisfaction and mental psychosocial outlook in preparation of childbirth and child care.

The finding that the study sample had an age of 26 (range: 15-43) years is quite instructive in the sense that most of the participants were referred to the Central Hospital based on their young age during pregnancy which was, in most cases, a

first pregnancy. First pregnancies and young age are dual high risks for complications which are generally referred to specialist centres as standard practice. However, the finding that the majority had a "Fair", "Good" and "Very Good" score on the Q-LES-Q-SF scale is an encouraging finding although it does not tally with midwives' interventions being the cause of the satisfactory quality of life displayed.

There may have been some other factors like the quest for life seen in the young, the feeling of importance by being referred to a major central hospital and the anticipation of motherhood that may have given rise to the positive outlook to life in general. "Carrying a life inside one" and the general body changes that occur during the first pregnancy may be too exciting to over shadow any other misgiving one may experience or have. However, the missing records of entry in the mothers' documentation gives doubt to the midwives' interventions. Alternatively, the midwives may have done everything correctly but may have had no time to updated the record of the would-be-mothers, which is malpractice bent on jeopardizing the maternal clients' lives and wellbeing and lack of records is equivalent to no work done in clinical practice regardless of outputs and outcomes.

However, the referral policy that all would-be-mothers who have previous given birth by CS, have a first pregnancy at an early age, have known history of pregnancy-induced hypertension and or diabetes and other pregnancy-related need to be referred to the Central Hospital tends to put pressure on the limited resources available at these centres. This compromises the service delivery by well intending health practitioners who may tend to compromise record keeping at the expedience of saving mothers and their unborn children. None-the-less and somehow, midwives need keep all records of the antenatal mothers UpToDate as standard practice a fit that may not be able to achieve as has been shown in the study.

The finding that the majority of the women, 277 (92.3%), had secondary basic education and had an almost equal representation in the whole continuum of the Q-LES-Q-SF scale, showing that education was a vital motivator for psychosocial wellbeing during pregnancy. The fact that some educated women scored poorly in the Q-LES-Q-SF scale may mean that the dissatisfaction with quality of life may have been due to inadequate interventions during the antenatal visits. This could be due to psychosocial screening not being done thoroughly or not at all such that pregnant women end up using their own skills or get flustered by the demanding needs of pregnancy and social life. Effect of education and other demographics influence on childcare outputs and outcomes have been reported child nutrition and management of childhood diseases by health workers[43, 44].

Normally, inadequate interventions by midwives, who are the last port of call during pregnancy, has the greatest impact on maternal health outcomes and outputs. Usually, pregnancy reduces all women to the basic tenets of human creation as it disregards one's position in life, education level. Nothing is artificial about pregnancy and midwives not cognisant of this fact may fail to recognize the psychosocial needs to the affluent women during their pregnancy period through assumption that they will be knowing better.

Education status did not have had an influence on mental satisfaction during pregnancy without other factors coming into play. As such midwifery intervention during antenatal review visits is critical. Or education level did help reveal to the pregnant women areas of lack of care in themselves and by themselves. As a result, this knowledge may have raised the pregnant women's expectations for good management from the midwives. Failure to satiate their expectation, more so that they were referred to one of the highest quality healthcare delivery institutions in Zimbabwe, may have brought dissatisfaction towards the service rendered and received. The perceived or real lack of quality of service received during prenatal clinic visits may have triggered a sense of hopelessness and ultimately affecting psychosocial scores on the Q-LES-Q-SF scale. Actually, the reasoning behind antenatal clinic visits is to prepare would-be-mothers and their foetus for safe motherhood during and after childbirth regardless of educational status. In general, the median life satisfaction level as a percentage in the sample population was 53.6 (1.8-83) and may have been have been higher with thorough midwifery and other healthcare providers. This means an upgrading of the midwifes' intervention is critical at the institutions.

5.0 Conclusion

This study on assessment of the psychosocial wellbeing of pregnant women was conducted through utilisation of the Q-LES-Q-SF psychosocial scale revealed that woman definitely had psychosocial challenges as indicated by the psychosocial scores that showed bimodal peaks at the "Poor" and "Good" points of the scale. A comparison of the two distinct distributions showed that 70.5% of the study sample leaned towards the poor group (Very Poor + Poor + Fair) of psychosocial scores while 60.8% was represented in the good group (Fair + Good + Very Good). Salient findings were that the single women, para-gravida one and women of the younger age were more likely to have good psychosocial score in the Q-LES-Q-SF scale which could be ascribed to overly attention by the fathers of their unborn babies and relatives, overly attention from health practitioners seeing that they were a more vulnerable group or their sheer volition on life in general. The finding that some women had good psychosocial score while some had bad ones shows the perinatal interventions by midwives were needed to produce a noticeable influence on the mental and social welfare of participants by the third trimester of pregnancy. Despite the educational levels or other demographics, pregnancy outcomes and outputs are, however, squarely on the shoulders of the midwives who are given the responsibility to identify deviations from the good quality of life and judge the quality of life of their clients during prenatal clinic visits. Interventions need to be made to allow the reasons why clients are referred to specialized units for perinatal care are met. Apparently, the need for scaling up psychosocial assessments and interventions cannot be overemphasized.

Conflict of Interest: Authors declare no conflict of interest

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