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Women's perceptions of the quality of emergency obstetric care in a referral hospital in rural Tanzania

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Abstract

OBJECTIVES To assess perceptions of the quality of obstetric care of women who delivered in a rural Tanzanian referral hospital.

METHODS A descriptive-exploratory qualitative study, using semistructured in-depth interviews and participatory observation. Nineteen recently delivered women and 3 health workers were interviewed.

RESULTS Although most women held positive views about the care they received in hospital, several participants expressed major concerns about negative attitudes of healthcare workers. Lack of medical communication given by care providers constituted a major complaint.

CONCLUSIONS A more positive attitude by health workers and the provision of adequate medical information may promote a more positive hospital experience of women in need of obstetric care and enhance attendance.

keywords quality of obstetric care, health workers' attitude, patient perception

Introduction

Improving maternal health is one of the eight Millennium Development Goals, as formulated by the United Nations (UN) in 2000. The 47% decline in maternal mortality in 2012 indicates progress, but falls far short of the target of 75% reduction [1]. Half of all maternal deaths occur in sub-Saharan Africa [1]. Skilled birth attendance is widely recommended as an important intervention to reduce maternal mortality [2].

The time lapse before a decision is made to seek skilled care is the first of three 'phases of delay' commonly applied in the analysis of maternal mortality [3]. Exploring women's reasons regarding use of skilled birth attendants in hospital will help understand which factors impact on women's decisions to go to hospital [4]. It is known that sociocultural factors play an important role in care-seeking behaviour, but it is not well understood to what extent obstetric complications increase use of skilled attendance. Neither has the role of perceived benefit of care been extensively studied [5]. However, staff attitudes have considerable impact on perceptions of quality of obstetric care held by pregnant women and are likely to influence their healthcare-seeking behaviour [5, 6]. Poor quality and disrespectful maternal care may leave women feeling powerless and may prolong the first phase of delay [7]. Baral *et al.* [4] suggest that more qualitative research is necessary to understand the decision-making process in seeking health care.

The second phase of delay in maternal healthcare concerns the required time to reach an appropriate facility, and the third refers to facility-based delay until effective treatment is given. Perceived high quality of care, including accessibility, may enhance care utilisation and reduce the first phase of delay [8]. Continuous support during labour promotes better pregnancy outcome and prevents unnecessary obstetric interventions, but is frequently unavailable [9, 10]. Qualitative studies of patients' definitions of quality health care are scarce but essential [11]. Patients' feedback should form the basis for patient-centred health care [12].

Knowledge of what women perceive to be good and bad care may help to improve obstetric care and may enhance its uptake [6, 13]. To reduce substandard care in maternity services, research and documentation of those perceptions is much needed [13].

Improving the process of service delivery may increase both objective and perceived quality of care [12]. Therefore, the primary objective of this study was to examine the perceptions of quality of care held by women who attended obstetric services in a rural Tanzanian referral hospital. Secondary objectives were (i) to explore reasons

for women to come to hospital for delivery, (ii) assess their experiences during admission and delivery including perceptions of staff attitudes and (iii) to have women formulate suggestions for improvement.

Methods

Study design, setting and population

This qualitative study was conducted between September 2011 and March 2012 at Saint Francis Referral Hospital (SFRH) in Ifakara, Kilombero District, in Southeast Tanzania. The hospital offers comprehensive emergency obstetric care (CEmOC). In 2011, more than 5500 deliveries took place at the hospital, which has 371 beds and serves a population of 600 000 [14]. The study is part of a maternal and perinatal mortality and morbidity audit project in SFRH that aims to improve the obstetric outcomes in the region.

The study population was comprised of women who had delivered at SFRH and sustained severe pregnancy-related obstetric complications. By assessing their experiences, these women may be of great value in improving obstetric care [6]. As our focus was on hospital care, we chose to concentrate on women with complications, as they had spent more time at the hospital, and had seen a wider range of the care provided. These were women admitted into the maternity ward and recovered from one of the following complications: eclampsia, obstructed labour, post-partum haemorrhage or puerperal sepsis. By including women with a range of conditions, we believed that we would reach a diverse study population. In the morning meetings of the obstetric department, emergency cases were discussed and women suitable for an interview were chosen by convenience sampling in cooperation with the responsible clinician. If a woman was not found not to be able to participate due to poor physical or mental status, the interview was cancelled.

Data collection and analysis

Three qualitative methods were used for triangulation purposes: (i) participatory observation of obstetric care, (ii) 19 in-depth, semistructured interviews with women who sustained severe maternal morbidities and (iii) 3 interviews with healthcare workers from the obstetric department.

Fieldwork started with participatory observation by the principal researcher (KS) in her role of a medical student at the department of obstetrics and gynaecology at SFRH. The staff of SRFH is well acquainted with the concept of medical students doing clinical rotations.

Observation of care was carried out during regular working hours, weekend and night shifts. KS attended morning meetings, ward rounds and observed maternity care in delivery rooms and theatres. Attention was paid to daily work routine, staff workload, communication with and behaviour towards patients and perceived care improvements during the study period.

In-depth interviews were performed within 5 days after birth so as to prevent recall bias. Personal and confidential interviews allowed women to talk about sensitive topics concerning labour. A pilot interview was first conducted, using a topic list, which was based on subjects found in the literature. During the study, a semistructured questionnaire was developed from the topic list. Themes were (i) reasons for coming to hospital, (ii) experiences during admission and delivery and (iii) participants' ideas for service improvement. This questionnaire was edited in subsequent interviews to include new topics. A flexible and adaptive approach to the design of the questionnaire was taken so as to include the most relevant issues for the women.

Interviews were carried out by KS and PP, a medical doctor not employed in the obstetric department. He translated Kiswahili into English and vice versa. This same researcher interpreted during the entire study, to ensure continuity in translation. We applied the criterion of saturation, and continued data collection until no new properties emerged from continued coding and comparison [15]. After 17 interviews, saturation was reached. Another two women were included to ensure completeness.

Towards the end of the study, a senior assistant medical officer (AMO), a midwife and a theatre assistant were interviewed about the topics brought up by women to verify and achieve a complete approach for triangulation. Health workers were selected on the basis of relevant experience, aiming for those with several years of experience in gynaecology and obstetrics at this hospital. We started with an interview with the midwife treating the first included patients and snowballed from there.

Interviews were voice recorded, and all data were transcribed, using Express Scribe transcription software. Coding and analysis were performed following a grounded theory approach [16] and using the qualitative data analysis program Atlas.ti. We had made use of open coding due to the limited available literature of relevance. Codes and subcodes were formulated for all topics and organised in groups. Analysis was started at the beginning of the study to identify issues for further exploration. Quotes that substantiated study findings were extracted from (translated) answers.

Ethical considerations

Interviewees were informed about study goals and objectives and were asked for permission to tape-record. All 19 women and 3 health workers approved. It was guaranteed that information would be treated confidentially, anonymised before publication, and that quotes could not be traced back to individuals. This study was part of a larger study about perinatal and maternal morbidity and mortality, which included ethical approval [17].

Results

Age of the women varied between 18 and 37 years. Six had attended the minimum number of 4 required antenatal visits (Table 1). Sixteen women had given birth by emergency caesarean section. During 6 weeks of observation, we saw that, in general, patients did not ask questions and behaved in a humble manner. The midwives' behaviour varied from dedicated to impatient.

Midwives on the post-operative ward had more time for patients, which contributed to more positive staff–patient interactions. Women in pain were often ignored. It was observed 4 times that health workers hit patients to motivate them. In general, staff experienced high workload pressure.

A challenging group of patients that was regularly addressed in morning meetings were women with uterine scars from previous caesarean section with undocumented indications. Doctors described this as an obstacle to deciding about the mode of delivery. The obstetric history of patients should be available in the medical records, but unfortunately care providers did not take trouble to trace old files, which can be attributed to disorganisation in the records department, failure to acknowledge its importance and workload pressure.

Staff members tried to avoid informing mothers in case a child with a deteriorating clinical condition had to be admitted to the neonatal care unit. In one case, it was observed that a baby died within half an hour after delivery, and the mother was not informed until 5 hours later.

Table 1 Characteristics of interviewed women

Characteristic	*N* (*n* = 19)
Marital status	
Married	16
Not married	3
Education	
Less than primary school (unfinished)	13
Primary school	3
Secondary school	3
Occupation	
Farmer	14
Other	5
Parity	
1–2	9
3–4	7
5	2
Unknown	1
Antenatal care	
1–3 visits	13
4+ visits	6
Condition newborn at time of interview	
Alive	18
Alive, admitted neonatal ward	2
Died	1
Mode of delivery	
Caesarean section	16
Spontaneous vaginal delivery	2
Vacuum extraction	1

Reasons for seeking care at the hospital

The majority of women (15) delivered at the facility, because their local health centres referred them before labour started. Reasons were high-risk pregnancies including 'previous caesarean section', 'young primi- and grand multiparity' (over four deliveries), breech position, 'previous foetal wastage' and abnormalities detected during antenatal clinics. A general opinion among the interviewed women was that hospitals are more successful in dealing with complications than health centres or traditional birth attendants (TBAs). It was a common perception that women without problems can deliver in the local health centre (9 patients): 'Giving birth is a normal thing (. . .) if you have no problems, why should you go to the hospital?'

Twelve women never went to a TBA. The most common reason was lack of trust in their ability to handle complications correctly. For instance, one respondent who had her 4 caesarean section said 'I deliver through operations, what would they [TBAs] do?' During the start of her first labour, she attended a local health clinic and was referred to SFRH. The indication for her first caesarean section was reported to be cephalopelvic disproportion.

Staff–patient interactions

Almost all women (17) expressed themselves mainly positive about the staff members. Midwives in the labour ward were described as nice, friendly, helpful, trustworthy, charming, cooperative and/ or supportive: 'I think they were really concerned about my life and my baby's life.' Several women mentioned the example of the

anaesthesiologist at the theatre comforting them during operation as a very good experience: 'She was talking to me, telling me that I should not fear, (. . .) while she was touching my hair. It gave me courage.' Two women perceived harshness and even being hit by midwives as 'helpful', because they had 'failed' to push the baby. The attitude of the health worker had given them courage to continue. Two women emphasised their preference for the midwives on the post-operative ward over the labour ward midwives: 'These ones when they pass by and they see somebody with pain or if somebody calls for help, they will always come. But the ones at the labour ward (. . .) don't care.'

Approximately one-third of the interviewees gave examples of negative experiences with staff. Lack of emotional support and rudeness were mentioned several times: 'I was in so much pain, and I'm very sure the midwives understood that, but they didn't seem to care.' Some were told they would be left alone for a while and that they would get attention 'when the baby was coming.' In case of a proper explanation as to why they were left alone, those women were able to accept the situation. One woman reported that she felt terrible after being threatened by the staff; she would be neglected if she would not stop screaming of pain.

Hospital services were appreciated positively: a good bed, medication, operations and a clean and well-equipped labour ward. However, a recurrent problem in all phases of obstetric care seemed to be the lack of communication about medical conditions. Two-thirds of women complained about not being informed about their medical situation. These women expressed themselves more negatively about their admission. One woman had asked the staff several times for her baby, but was told – a day later – that the baby died: 'So the worst thing is not being told about my baby (. . .) about what happened.' Two other women were upset because they had not been informed on whether or not the requested tubal ligation was performed after caesarean section.

Relatives were not allowed to enter the labour ward, which was accepted by the majority of women with the general idea that the midwives would take care of them and family members would not be any help: 'Whatever is happening in the labour ward is for me, God and the midwives or doctors, my relatives would not add anything.' Two participants thought the absence of family members had a positive effect on their ability to act tough. Two women admitted they would have felt better if their mothers could have been there.

Privacy was not a topic spontaneously brought up by women, but when asked for their opinions, the majority expressed that the curtains between their beds gave them a feeling of privacy. Caesarean sections went well and were a relief for 14 women, but two patients experienced them as an extremely traumatic event due to failing anaesthetics, leading to 'awareness'. 'I felt like they were doing practice on my body and I didn't feel good about that.'

Half of the women expressed no ideas as to how to improve care: 'everything was okay.' However, a quarter of the patients suggested improvements focusing on the behaviour of midwives: '. . . the midwives in the labour ward need to be nicer, (. . .) it's very important for them to be good listeners to the patients.' It was suggested that the hospital management should communicate about the influence of negative attitudes and make clear that midwives should never hit patients.

The other quarter of the women mentioned more practical issues, such as a larger labour ward and more beds. Several women thought that the staffing level was too low, which had consequences for the patients: 'The midwives were more concerned with the ones who were about to deliver, and rarely with the ones who were not yet due.'

Health workers' perspective

The midwife confirmed the finding that most pregnant women go to the safer hospital for delivery instead of TBAs these days. This was attributed to increased health education in the community. In general, she thought that most complications arose because women arrived late.

According to the midwife, a good relation between patient and health worker is the most important factor in satisfying a patient. Comforting women is part of the job, agreed the theatre assistant. A woman can have wrong assumptions about the health workers' attitude. Sitting down and doing administrative work, too few staff or the protocol to do vaginal examination only every 4 h can be interpreted by patients as indifference, according to the AMO.

All interviewees disapproved of beating women during labour, but brought forward that this wrong practice does happen sometimes. Reasons for those beatings are uncooperative women who will lose their baby otherwise: 'When the baby is coming floppy or still birth, so the blame will come for the midwives'.

Staff members involved in this study were asked to add important topics they thought were important for obstetric care. The midwife spontaneously mentioned that most women do not know why a previous caesarean section was performed. The AMO suggested that satisfaction and involvement could be increased if communication with the patient, indicating what will happen during

delivery, is improved. 'You know they say, information is power.'

The AMO indicated that 'privacy is a problem in a teaching hospital, everybody wants to see everything.' It is also the reason why relatives are not allowed in the labour ward, although staff members admit that some women prefer this.

According to the AMO, only educated women will speak up if they feel pain, or if they are unhappy with a big group of (student) health workers around their beds, emphasising the importance of education.

There was a general agreement that extra training sessions for staff members to update knowledge and skills would be desirable, educative and would work as 'refreshing'. Health workers reported that they would like to learn more and become better in their jobs, which was also heard during observation of the obstetric skills training.

All mentioned the need for an increased number of midwives and doctors. The theatre assistant and assistant medical officer both said that the staff is 'over-exhausted most of the times', which may negatively impact on quality of care. Lack of equipment was also mentioned as an area for improvement; it contributed to delay and even complications. The theatre assistant mentioned the absence of catheters in the labour ward as a cause for delay in bringing the patient into theatre.

Finally, a larger obstetric facility was seen to be required to meet the needs of an increasing population, as all health workers agreed. There is a plan to build a bigger labour ward with only private labour rooms, so women can bring their relatives for support. The importance of having a meeting hall and offices for doctors was also emphasised. Morning meetings, presentations and lectures were convened in the corridor. But, 'money is a big, important problem', as the AMO underlined several times.

Discussion

Tanzanian women were generally satisfied with the obstetric care they had received. All participants acknowledged the importance of attending antenatal care (ANC), although the quality o this ANC is found substandard in rural Tanzania [18]. Women in this study came to hospital for delivery because they were referred by their health centres or ANC. It is known that women who regularly attend antenatal care are generally more satisfied with the quality of care they receive [12, 19].

Women also rate skilled birth attendance during labour as valuable. Women expressed that they felt safer in hospital than under TBA care. All women except one denied having had personal experiences with TBAs, although these traditional carers still play an important role and attend 55% of home deliveries in Tanzania [20]. Women expressed little trust in the skills of TBAs, which is in line with previously described dissatisfaction with home deliveries among women in Tanzania [20].

Lack of medical information, documentation and communication led to considerable anxiety among women and negatively impacted on their hospital experience. At the beginning of the interviews, the majority of women were mainly positive about their experiences with hospital staff. But when they were asked to formulate suggestions for improvement, one-quarter spontaneously mentioned detailed ideas to enhance friendliness of health workers towards patients. An important aspect of women's negative experiences was a lack of emotional support during labour. It was one of the key findings in this study. The perceptions of the Tanzanian women concerning the importance of staff attitudes and good communication and information resemble those of Ghanaian women in similar studies [6, 13]. A woman-friendly, respectful delivery should be a goal on its own, in addition to increasing patient satisfaction and care uptake [5]. The core of maternal health care, besides reaching the target of the MDGs, should be preserving the fundamental, country-independent human rights of every pregnant woman to deliver her baby under the best possible conditions. The importance of continuous support is an evidence-based intervention to improve birth outcomes and reduce unnecessary interventions in women during childbirth, especially in low-resource settings [9]. From the interviews, it can be concluded that the majority of women appreciate the presence of somebody supporting them through the whole process of birth, although they do not directly ask for this support.

Culturally based differences of the perception of health care between the studied population and the researchers were aimed to be prevented by applying triangulation, although this may be a bias in our study. A focus on women who experienced obstetric complications may provide insight into risk factors of maternal morbidity [6]. Although it was the intention to ensure a safe and open atmosphere during interviews, it is possible that women gave socially desirable answers. For example, two women indicated that health workers were hitting them and that they were right by doing so. Other women and staff members perceived hitting as malpractice. However, it is likely that women's answers provided a true reflection of their perceptions, as findings from interviews with women were confirmed by observation and in interviews with health workers. Although care providers were aware that care users needed information, physical and psychological support, all these were rarely provided. An ameliorated attitude of health workers could improve the

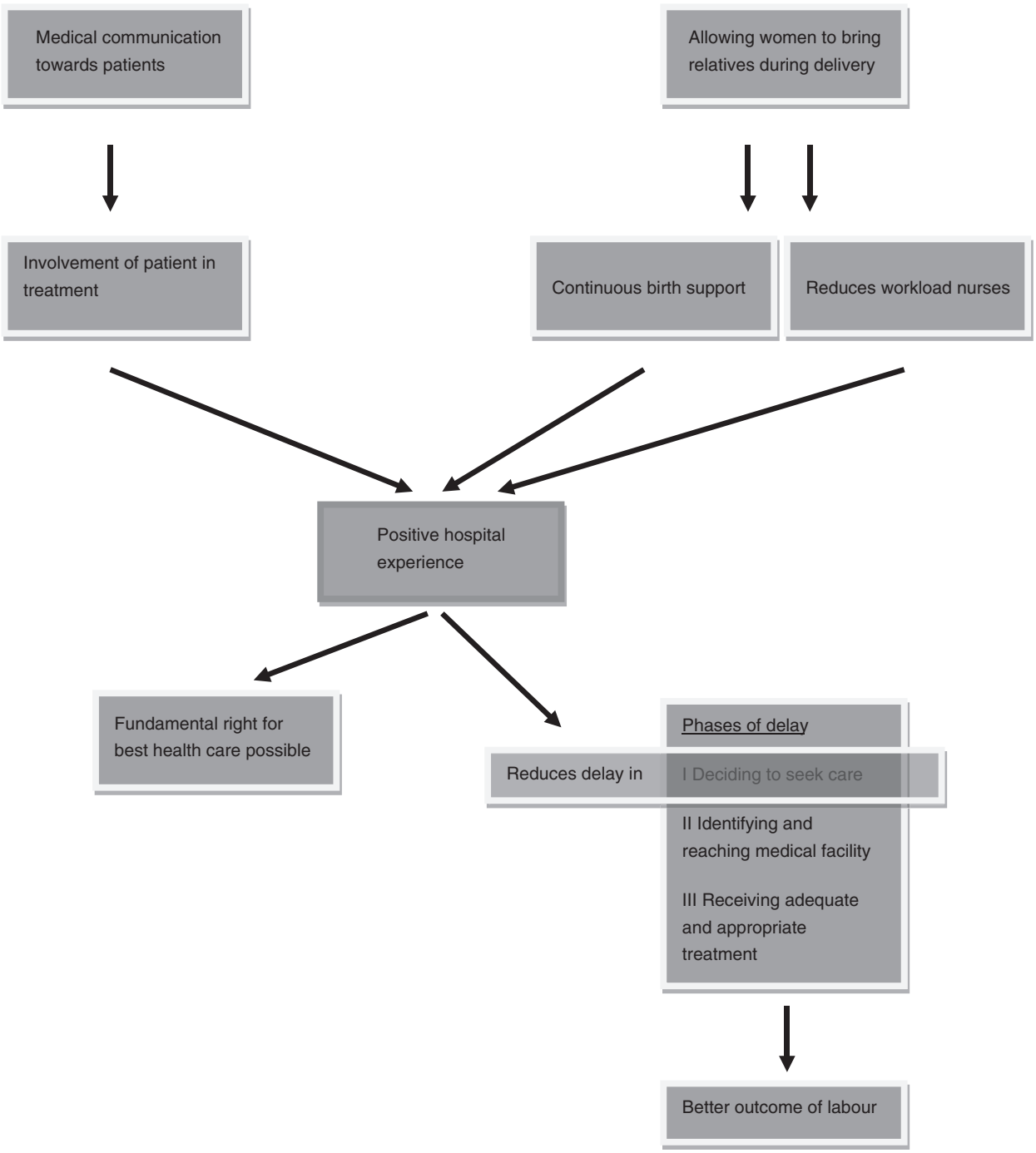

Figure 1 Overview of the influence and consequences of an informed patient and continuous birth support on the hospital experience (three delays model adapted from Thaddeus and Maine.

perception of care, as well as having indirect benefits. A study from this same setting found that insufficient commitment of staff was an obstacle to implement maternal audit [21], a method that is highly likely to improve the quality of obstetric care [22]. From interviews and observations, it may be concluded that staff are generally

motivated to learn and improve their skills. Therefore, we recommend including communication skills in obstetric training. Even when there is a high workload or a lack of instruments, attention should be devoted to the patients, as well as sufficient medical information. Further research may investigate the results of a more patient-involving treatment. Equally important, women should be able to bring their relatives for support during delivery to ensure continuous birth support (Figure 1).

We conclude that although women in this hospital were generally positive about their hospital experiences, a more positive and patient-centred attitude of health workers is likely to improve womens' experiences during birth and to enhance obstetric care attendance.

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