

*Full Length Research Papers*

# **Maternal satisfaction with care during labour: A case study of the Mampong-Ashanti district hospital maternity unit in Ghana**

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Accepted 11 April, 2011

**This study was conducted to assess the care and satisfaction of expectant mothers during labour, birth and lying-in period in Ghana. Purposive sampling was employed to recruit participants, based on the needs of the study and on predetermined variables. Participants were second or third time mothers, who were admitted in the first stage of labour with a cervical dilatation of not more than 5 cm. They were those who had returned there for their two weeks post natal visits, who had no history of neonatal loss and who had normal vaginal deliveries, excluding forceps deliveries and vacuum extractions. Eight individual interviews were conducted with volunteering respondents within 48 h after delivery. This was followed by two focus group discussions two weeks after delivery. The groups were made up of three and four volunteering respondents. Data were inductively examined using content analysis, the process of first level coding, pattern coding and memoing. The respondents were between the ages of 22 and 37; they had limited educational backgrounds with the exception of two who were graduates from the university and teachers training college, respectively. All participants had two or three previous pregnancies and for at least one of these pregnancies, they have had experiences in the Mampong maternity hospital. The majority (seven) of them gave birth within 2 h of coming to the hospital. Findings from this study have established that: (a) multiple factors influence mothers' satisfaction with their care in labour, birth and the lying in period; (b) maternal satisfaction during this period is determined mostly by the attitude of care givers; (c) dissatisfaction with care leads to non-usage of the hospital in future or using the hospital only as a last resort. It is recommended that (1) staffs of the hospital have frequent continuing education on communication and interpersonal relationship, (2) The code of ethics of the nursing profession should be strictly enforced, (3) Care givers need to fully understand the expectations that patient have for their care, and provide care that is consistent with those expectations.**

**Key words:** Maternal, mothers, satisfaction, care, labour.

## **INTRODUCTION**

In Ghana, women and children form 70% of the population. Morbidity and mortality among this group accounts for a major proportion of all ill health and deaths in the country; making them the most vulnerable group (Reproductive and Child Health Unit Annual Report, 2002). Complications during pregnancy directly account

for about a third of all maternal deaths. The remaining deaths result from medical conditions that are aggravated by pregnancy, such as viral hepatitis, anaemia and cardiovascular disease (Herz and Measham, 1996). Many of these illnesses and deaths are preventable. While women are significant contributors to the nation's development efforts, children are a nation's important resource and their needs are a national priority. Reproductive and child health are crucial components of general health as they reflect health in childhood and set the stage for health even beyond the reproductive

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years for both men and women.

Reproductive and child health effects are in turn affected by; the broader context of peoples' lives, their economic circumstances, education, employment, living conditions, family environment, social and gender relationships, and the traditional and legal structures within which they live. Therefore, reproductive and child health mean more than bio-medical interventions. They involve a greater awareness of health by individuals so that they can promote and protect their own health.

There has been growing concern about falling standards of health care in recent times, coupled with an equally growing demand from the general public for improvement in the services provided in our health institutions. Patients/clients expect health workers to provide quality services with a high sense of friendliness when working. This is the goal of international and national programs, for a variety of compelling reasons (Reproductive and Child Health Unit Annual Report, 2002).

Vouri (1987) defines quality care as the degree of application of currently available scientifically based medical knowledge in patient care. This implies that when health care providers employ current medical knowledge in the management of patients' conditions, the care provided is most likely to be of a high quality, and this is very necessary in the delivery of maternity services. Lawrence et al. (1999) reported from their study of satisfaction with pregnancy and newborn care that "satisfaction with care is an important measure of quality of care". Patient satisfaction is considered to be an outcome of the delivery of health care services as well as a measure of its quality. In addition, a known relationship exists between satisfaction and the use of care (Handler et al., (1996).

Although a need for a theoretical basis for nursing care was recognized (Dickoff et al., 1968), too frequently the instruments that have been used to evaluate nursing care have been identified as lacking the necessary estimates of reliability and validity (Knapp, 1985; Giovannetti, 1986). Theoretical and methodological issues associated with most patient satisfaction studies have limited comparability and generalizability of the findings, because different definitions, tools and data analysis approaches have been used.

Client satisfaction research has been significant for a variety of reasons. Research has been conducted with the primary purpose of improving care. For example, Kirchoff (1976) was concerned with understanding aspects of care, which only the patient could assess, in order to improve care for intensive care patients. Bradley (1983) was concerned with improving care by increasing the accuracy between staff and patients perceptions of discomfort. Patient satisfaction research has been conducted to evaluate a change in facilities, for example, to compare types of services (Field et al., 1985), to compare organizational modes (Shaw, 1985), and to evaluate programmes (Moore and Aguiar, 1974). The World

Health Organization (WHO) estimated that over half a million women in developing countries die each year from causes related to pregnancy and childbirth, leaving at least one million children motherless (Bradley et al., 1983). One feasible way of reducing this mortality rate is to improve the quality of maternal services. Martey et al. (1994) in their study of maternal mortality and related factors in Ejisu district Ghana, observed that prenatal care alone is not sufficient to prevent some deaths and that the high mortality rate during delivery is a justification to improve the quality of care during delivery at all levels of the district health system.

This study focused on maternal satisfaction with care during labour, birth, and the lying-in period, and explores mother's views on the care they received during a recent labour, delivery and the immediate lying-in period.

## MATERIALS AND METHODS

### Study area

This study was carried out between February and August 2004 at the Mampong District Hospital Maternity Unit. It is one of the district hospitals in the Ashanti region of Ghana and is in the Sekyere-West district.

The district (Sekyere-west) is one of the 18 districts of the Ashanti region. It lies to the north of the region and the capital, Mampong, is about 57 km from Kumasi, the regional capital. The district shares boundaries with the Brong-Ahafo region to the north, Ejura-Sekyere Odumasi districts to the north-west, Afigya-Sekyere to the south and Sekyere- East to the east. The district has an area of 2,346 square kilometres.

### Sampling method

Purposive sampling was employed to recruit participants based on the needs of the study and on predetermined variables. Eight individual interviews were conducted with volunteering respondents within 48 h after delivery. This was followed by two focus group discussions two weeks after delivery. The groups were made up of three and four volunteering respondents respectively. Three of the participants who were interviewed individually also took part in the focus groups. The total sample size was twelve (12). Open-ended questions asking the participants to tell their birth stories were used at the initial interview and prompt questions were used when needed. The individual interviews were conducted in the hospital and as close to the respondents' discharge as possible. However, it was observed that respondents did not feel comfortable talking on the ward, so the focus group interviews were held in a separate office away from the hospital but close to the hospital premises.

Inclusion criteria were that: respondents could speak and understand either English or Twi, which were used during data collection. Participants were second or third time mothers, who were admitted in the first stage of labour with a cervical dilatation of not more than 5 cm and those who had returned there for their two weeks post natal visits, who had no history of neonatal loss and who had normal vaginal deliveries, excluding forceps deliveries and vacuum extractions. Any mother who met these criteria and was willing to participate by way of sharing her birth story was included. No exclusion criteria were used in relation to employment, education or marital status. Any woman who met the inclusion criteria and was willing to share her views on the care she received was eligible for the study.

Data were inductively examined using content analysis, the process of first level coding, pattern coding and memoing. The first level coding included descriptions of incidents that were reflected in the data and these were assigned a code, label or name. Finally, there were pattern-coding labels "grounded" in information. Example "the midwives should be a little patient with us", "I was shown the bed to lie on that was all", "they shouted at me, I was examined without being talked to" were coded as attitudes of caregivers. Whereas descriptions like; "I was reliably informed that if I came to the hospital early in labour, I would have too many vaginal examinations", "reasons for delivering at home are numerous mostly financial and to avoid caesarean section" These were labelled as client's perceptions of hospital delivery.

## RESULTS AND DISCUSSION

### Characteristics of respondents

The respondents were between the ages of 22 and 37 years. They had limited educational backgrounds with the exception of two who were graduates from the university and teacher training college, respectively. Of the remaining participants, two were primary school dropouts, two middle school dropouts and four junior secondary school dropouts. While the majority were Akans, two were Northerners and all the nine (9) respondents spoke Twi. Only two could speak English but both preferred to be interviewed in Twi. Their occupations included trading (4), dressmaking (3), teaching (1), and civil service (1).

All participants had two or three previous pregnancies and for at least one of these pregnancies, they had had experiences in the Mampong maternity hospital. They used the same facility during the index pregnancy and childbirth. Six of the respondents first attended antenatal clinics in their last trimester, whereas two started in their second trimester, and one in her first trimester. Of the three participants who had three children, one delivery each took place at home. All other respondents had all of their babies in a hospital. Majority (seven) of them gave birth within 2 h of coming to the hospital, while two gave birth within 6 to 12 h of coming to the hospital.

### Respondents' attitude and perception towards care givers

#### *Negative attitude and perception*

Caregiver attitude was identified as a major concern of clients and this in turn influenced their usage or non-usage of the hospital. Positive and negative attitudes were identified.

Negative attitudes tended to have a more powerful influence than the positive attitudes. This is because the negative attitudes hindered future use of the hospital for child birth. Respondents discussed characteristics of caregivers that left them feeling less satisfied.

Clients were dissatisfied with attitudes of caregivers when it led to negative behaviours such as not receiving explanation, being shouted at, and being ignored. The impact of negative attitudes had a more powerful influence than the impact of positive attitudes. If dissatisfaction was associated with staff attitudes, participants considered alternatives including non-usage of the facility in the future and/or late arrival at the hospital.

Another participant who also failed to report early to the hospital because of vaginal examinations attributed her reason to cost associated with each vaginal examination as follows:

1. Ineffective communication (impolite, frowning, whispering, not explaining procedures). These make client uncomfortable.
2. Neglect (not attending to clients promptly, not involving client in the care).
3. Unfriendliness (shouting, ignoring).
4. Financial factors (no explanation on hospital bills).

#### *Positive attitude and perception*

The findings of the study showed that maternal satisfaction with care during labour, birth and the post partum period is influenced by multiple factors such as care givers and client's interactions. The positive attitudes led to satisfaction and encouraged future usage of the hospital. Caregiver attitudes were perceived to be positive if the care giver did not shout at the client and if he/she was deemed to be kind and have a sense of humour. Issues relating to the competence of the staff and safety also influence satisfaction. Educational background was also found to influence participant's assessment of their care and care givers. Whereas the majority of participants with lower educational background made their assessment based on their interpersonal relationships with their care givers, the only participant with a university education based her assessment on the process of care, including procedures and information. Themes that were identified to influence client's satisfaction are therapeutic communication (listening, politeness, prompt relieve of pain, kindness, approachable, and smiling,) caring (attentive to needs, making clients feel accepted, and coax clients) and interpersonal skills of staff (staff confidence and competence).

## DISCUSSION

Behaviours that reflect positive attitudes towards clients/patients such as being patient with clients, politeness, not shouting at them and not belittling them, along with a good level of competence, are important to patient satisfaction. These findings agree with that found

by Jewkes et al. (1998) in a study on 'why do nurses abuse patients'. Their respondents reported that 'nice nurses' were those who explained procedures and did not shout at or speak rudely to women. Another factor that determined satisfaction with care was the characteristics of the setting, for example the availability of human and material resources.

Findings revealed that client's sources of dissatisfaction include negative behaviours of caregivers (ineffective communication, neglect and unfriendliness) such as shouting at them; ignoring them, frowning at them, belittling them, and whispering among caregivers that make clients uncomfortable. Other sources of dissatisfaction include characteristics of the hospital setting, which include the non-availability of human and material resources, such as infrastructure, staffing and financial problems. In addition, clients did not understand their hospital bills and this made them dissatisfied with the hospital because they felt they were being exploited. They were also dissatisfied with the hospital procedures such as vaginal examinations and assisted deliveries such as caesarean section.

Generally, respondents had no dissatisfactions in the post natal period because they had fewer expectations. This is congruent with an earlier study, that women are generally satisfied with the postnatal care they receive. Dowswell et al. (2001) argued that this could be because respondents were multiparous and did not need help as regards the care (breastfeeding) of the baby.

Clients felt they were influencing the process of care if they were involved in the caring process. Clients who had information during labour felt involved in their care and this contributed to their satisfaction with care. One respondent, who was not given information about her birth and was examined without being spoken to, felt uninvolved and said she felt like a piece of rock.

Respondents also perceived themselves as influencing the process of care if their requests were met. Two clients who requested that the nurses call in their relatives (for information) had their requests met and they felt part of the caring process. Two other respondents who requested to have intravenous infusions and were not given them perceived themselves as uninvolved in the care.

Findings showed that clients had various expectations about hospital delivery that influenced their perception of care. These expectations were based on their own past experiences in a hospital facility, experiences of friends and relations in a hospital facility, myths about procedures in the hospital and societal values and perception of an assisted delivery. For example, society perceives a client who delivers immediately she arrives in the hospital as very fortunate and blessed whereas a client who reports to the hospital early in labour, and therefore does not deliver immediately is considered as having a prolonged labour and less fortunate. As a result, if a client is expected to deliver immediately, and when she

got to the hospital, it happened, then she will be happy. Again, if she is expected to meet unfriendly and impatient nurses but met the friendly and patient one, then she will be happy. On the other hand, if she is expected a pleasant reception but had an unpleasant one, then she will be unhappy. These findings support those of Field (1982) that, in a community setting, lack of congruence between expectation of care and perception of care created dissatisfaction with care. Also, Singh et al. (1999) reported that consumers of primary health care services in most countries make judgements about quality by assessing factors they can appraise, such as courtesy, responsiveness, attentiveness and perceived competence. Patients indicated that they perceived the abuse they received to be an inseparable part of the procedures and methods of working on the midwives unit. Jewkes et al. (1998) reported from their study that most women expressed expectations that they would have problems delivering in the hospital setting again as they could be shouted at, beaten or neglected. These comments were largely based on previous personal experience, or that of friends.

The main factors identified as influencing satisfaction and dissatisfaction were, caregivers and clients interaction, the characteristics of the setting, the involvement of clients in the caring process, the nurses' perception of client characteristics, the outcome of labour for both mother and baby, the acceptability of alternative places for delivery, and the respondents' expectations and perceptions of hospital delivery. Of all these factors however, caregiver attitude was seen as the strongest factor in determining maternal satisfaction with care. All respondents mentioned that if the interpersonal relationships with their caregivers were good (politeness, kindness, and patience), then they were satisfied with their care even when other factors were not addressed. If a positive caregiver attitude was attained, the client found the hospital safe enough for future use. On the other hand, if the hospital was not found to be safe enough because of negative attitudes such as shouting, ignoring or whispering, this led to plans not to use the hospital in future. However, if the client did not find a safer alternative to hospital delivery (a live baby and mother), she then planned to use the hospital again as a last resort by reporting very close to second stage of labour. This would reduce the length of interaction with staff of the hospital, reduce the stay in hospital and consequently the need for intervention, and decrease cost to the woman. The results of this study are consistent with that of Mwaniki et al. (2002) who reported that delay in admission to a health facility once mothers report in labour, lack of satisfaction with quality of care given (shortage of drugs and essential supplies, unfriendly staff who were not committed to their work and lack of cleanliness in the health facility) are major demotivating factors in the use of health facilities for maternity services.

## Conclusions

In conclusion, client satisfaction issues are important factors for consideration in order to increase utilization of the hospital facility. Findings from this study have established that:

- (1) Multiple factors influence mothers' satisfaction with their care in labour.
- (2) Maternal satisfaction during this period is determined mostly by the attitude of caregivers.
- (3) Dissatisfaction with care leads to non-usage of the hospital in future or using the hospital only as a last resort.

## RECOMMENDATIONS

It is recommended that:

- (1) Staffs of the hospital have frequent continuing education on communication and interpersonal relationship.
- (2) The code of ethics of the nursing profession should be strictly enforced.
- (3) Caregivers need to fully understand the expectations that patient have for their care, and provide care that is consistent with those expectations.
- (4) The community members should be educated on hospital delivery and the need to report to the hospital early in labour.

## REFERENCES

- Bradley C, Brewin C, Duncan (1983). J. Perception of Labour: Discrepancies between midwives and patients' ratings. *British J. Obstetrics. Gynaecol.*, 90(12): 1176-1179.
- Dowswell T, Renfrew MJ, Gregson B, Hewison J (2001). A review of the literature on women's view on their maternity care in the community in the UK. *Midwifery.*, 17: 194-202.
- Dickoff J, James P, Wiedenbach E (1968). Theory in the practice discipline. *Nursing. Res.*, 14(1): 15-28.
- Field PA, Campbell I, Buchan J (1985). Parent satisfaction with maternity care in traditional and birthing room settings. University of Alberta, Edmonton.
- Field PA (1987). Client care seeking behaviours and sources of satisfaction with nursing care. *Nursing. Papers*, 14(1): 15-28.
- Giovannetti P (1986). Evaluative studies of primary nursing. In Werley J, Fitzpatrick, Taunton R (Eds). *Annual review of nursing research*. New York: Springer. pp. 127-151.
- Handler A, Raube K, Kelley MA, Giachello A (1996). Women's satisfaction with prenatal care settings: A focus group study. *Birth.*, 23(1): 31-37.
- Herz B, Measham AR (1996). The safe motherhood initiative: Proposal for action. *World Bank Discussion*. Washington D. C: World Bank. p. 9.
- Jewkes R, Abrahams N, Mvo Z (1998). Why do nurses abuse patients? Reflections from South African Obstetric services. *Soc. Sci. Med.*, 47(11): 1781-1795.
- Kirchhoff K (1976). Let's ask the patient: Consumer input can improve patient care. *J. Nurs. Adm.*, 6(10): 36-40.
- Knapp T (1985). Validity reliability. *Nursing. Res.*, 34(3): 189-192.
- Lawrence JM, Ershof D, Mendez C, Petitti DB (1999). Satisfaction with pregnancy and newborn care: development and results of a survey in a health maintenance organization. *Am. J. Manage. Care.*, 5(11): 1407-1413.
- Martey JO, Djan JO, Twum S, Browne NL, Opoku SA (1994). Maternal mortality and related factors in Ejisu District, Ghana. *East. Afri. Med. J.*, 71(10): 656-660.
- Moore Nunnally D, Aguiar M (1974). Patients' evaluation of their prenatal and delivery care. *Nursing. Res.*, 23(6): 469-474.
- Mwaniki PK, Kabiru EW, Mbugua GG (2002). Utilization of antenatal and maternity services by mothers seeking child welfare services. *East. Afr. Med. J.*, pp. 79-4.
- Reproductive and Child health Unit Annual Report, (2002). Ghana: Public Health Division, Ministry of Health.
- Shaw J (1985). Reactions to transfer out of a hospital birth center: A pilot study. *Birth*. 12(3): 147-150.
- Singh H, Hagg ED, Mustapha N (1999). Patients' perception and satisfaction with health care professionals at primary care facilities in Trinidad and Tobago. *The international Journal of public Health*, 77(4): 356-360.
- Vouri H (1987). Patient Satisfaction- An attribute or indicator of the quality of care? , *Qual. Rev. Bull.*, 13: 106-108.