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"If really we are committed things can change, starting from us": Healthcare providers' perceptions of postpartum care and its potential for improvement in low-income suburbs in Dar es Salaam, Tanzania

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ABSTRACT

Objective: To explore healthcare providers' perceptions of the current postpartum care (PPC) practice and its potential for improvement at governmental health institutions in low-resource suburbs in Dar es Salaam, Tanzania.
Design: Qualitative design, using focus group discussions (8) and qualitative content analysis.
Setting: Healthcare institutions (8) at three levels of governmental healthcare in Ilala and Temeke suburbs, Dar es Salaam.
Participants: Registered, enrolled and trained nurse-midwives (42); and medical and clinical officers (13).
Results: The healthcare providers perceived that PPC was suboptimal and that they could have prevented maternal deaths. PPC was fragmented at understaffed institutions, lacked guidelines and was organized in a top-down structure of leadership. The participants called for improvement of: organization of space, time, resources, communication and referral system; providers' knowledge; and supervision and feedback. Their motivation to enhance PPC quality was high.
Key conclusions: The HCP awareness of the suboptimal quality of PPC, its potential for promoting health and their willingness to engage in improving care are promising for the implementation of interventions to improve quality of care. Provision of guidelines, sensitization of providers to innovate and maximize utilization of existing resources, and supportive supervision and feedback are likely to contribute to the sustainability of any improvement.

Introduction

This paper reports healthcare providers' (HCP) perceptions of current postpartum care (PPC) practice and its potential for improvement in governmental health institutions in low-resource suburbs in Dar es Salaam, Tanzania.

Globally, PPC is the weakest link in the continuum of healthcare for mothers/newborns [1] despite its known health benefits [2] and that about half of maternal/newborn deaths occur during the first weeks after childbirth. Mothers' low levels of attendance for PPC at health institutions furthermore contribute to risks such as: infection, hemorrhage, poor nutrition, reduced duration of breastfeeding, unmet family planning needs [3], unidentified mental health disorders [4], and infant morbidity and mortality [5].

In Tanzania, it is remarkable that only 30% of mothers attend PPC within two days after childbirth, while the immunization coverage at Reproductive and Child Health (RCH) units at the same health institutions is over 75% [5]. The PPC attendance is not higher in the low-resource suburbs of Dar es Salaam despite the fact that institutional deliveries and attendance at under-five clinics are next to universal [5]. The quality of the PPC in the Tanzanian health institutions is reported to be low and is comparably inferior to the care in Uganda and Ethiopia [6]. Midwives [7], parents [3,8] and community members [9] in Dar es Salaam are concerned about the shortcomings of PPC and have called for quality improvement.

The Tanzanian strategic plan has a target of reaching 80% PPC attendance in 2020 [10]. The national PPC guidelines [11] from 2011 aim at promoting high quality, integrated maternal/newborn healthcare to increase their physical and mental health. After discharge from the maternity ward, healthy mothers are recommended to make PPC visits within 7, 28 and 42 days postpartum, each with their specific content.

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Successful implementation of PPC guidelines, policies and evidence-based care requires consideration of the organization of work, and individuals' motivation and performance [12]. These are overlooked in many settings [13], sharing characteristics with the Tanzanian healthcare system, such as: shortage of human resources (about 50% available); high absenteeism (about 40%); and low levels of productivity, performance, skills, knowledge and motivation [13]. Supervision at healthcare institutions is described as infrequent, unfriendly and unsupportive [13]. No general performance management system is in place [10].

Rationale and study aim

The low levels of PPC attendance and quality are recognized as problematic and improvement is needed [6] in Tanzania and elsewhere [1]. Internationally, few intervention studies are reported in this field and innovations are called for [14]. Before designing interventions in health systems with multiple problems it is essential to carefully consider the contextual situation [15]. HCP engaged in daily PPC have a potential to contribute with such circumstantial knowledge. Therefore, we designed the present study aimed at exploring HCP perceptions of current PPC practice and its potential for improvement in governmental health institutions in low-resource suburbs in Dar es Salaam, Tanzania. The results will contribute to the limited international body of knowledge about PPC practices and development in low-resource settings and will inform an intervention for the improvement of PPC in the study area.

The conceptual framework

The "Promoting Action on Research Implementation in Health Services" (PARIHS) framework [15] contributes to this study with a conceptual understanding of what is important when preparing an intervention to implement evidence-based knowledge. The framework delineates the interplay of three core elements: the nature of the evidence, context, and method in which the process is facilitated [15].

Methods

A qualitative design, using focus group discussions (FGD) [16], was chosen to enable detailed descriptions of the HCP perceptions of PPC. FGD allow interactions between participants and elicit multiple views that help gain insight into their shared and divergent understandings [16].

Study setting

This study was conducted at three levels of healthcare institutions in Ilala and Temeke, which are two out of three districts of Dar es Salaam, Tanzania, an East African low-income country where 28% of the population lives below the national poverty line [17]. Dar es Salaam is rapidly growing and is the largest city of Tanzania with about 4.4 million inhabitants; 1.2 residing in Ilala, and 1.4 in Temeke [18]. Here, as in many global urban settings, people have moved from rural areas to the mushrooming squatter settlements. They often face unemployment, poverty, poor sanitation, transport problems and ill-health [18].

Health services in Tanzania are delivered in the form of referrals from dispensaries and through health centers, at both district and regional levels, to referral/consultant hospitals. Ilala district has two hospitals (one referral), one health center and twenty-eight dispensaries. Temeke district has two hospitals (one referral), one health center and twenty-six dispensaries. Governmental health services for mothers/newborns (ANC, HIV, under-five care, family planning, vaccinations, PPC) are provided at RCH units at all levels of health institutions. At RCH units the mothers/newborns are first seen by a Registered Nurse Midwife (RNM) who has three years of training, an Enrolled Nurse Midwife (ENM) who has two years of training, or a Maternal and Child health Aider (MCHA) who has one year of training. If they identify health problems they refer the client to a Medical Officer (MO) or a Clinical Officer (CO), who have five and three years of training, respectively.

Ethical approval

Ethical approval was granted by the Ethics Review Committee at the National Institute of Medical Research in Tanzania. Permission to conduct the study was obtained from the Municipal Councils and health institutions management in Ilala and Temeke districts. Prior to data collection, the first author (EP) met with all HCP to explain orally and in writing and respond to questions relating to the study, its objectives and procedures, issues of confidentiality, the importance of voluntary participation, and the need for individual informed consent. All participants signed a consent form.

Participants

A purposive sampling technique was adopted to identify participants who could provide rich answers to the research questions. Participants from diverse professions who work together at the same institution were opted for to maximize the exploration of different perspectives and to invite joint reflections of differing views on incidents occurring and contradictions in their setting [19]. The heads of the institutions were informed about the study and they helped to identify prospective participants. The recruitment was conducted by EP. The majority of the participants were women, aged 25–55 years old and further details are given in Table 1.

Focus group discussions

Eight FGD, one at each institution, were conducted at all hospitals, health centers and at two dispensaries (one from each district) where providers were numerous enough to formulate a group and views from different levels of institutions could be obtained (Table 1). Those HCP from the selected institutions who occupy various roles in PPC were invited to participate, all of whom ($n = 55$ out of a total 200 in the districts) agreed. All the participants signed informed consent forms prior to taking part in the FGD. Prior to the discussions, a convenient date, venue and meeting time were agreed. Discussions were conducted after working hours to avoid interrupting clinical work. The participants were compensated for transport costs as they had prolonged their stay at the workplace and had to seek alternative transport home.

Each group comprised 6–8 participants working with PPC at the same institution. The first author moderated the FGD assisted by the second author (CKM). An FGD guide with four topics was used: current PPC practices, the need for improvement of PPC, barriers for improvement, and providers' readiness for improving PPC. The moderator was aware of the possibility of power dynamics in groups; for example, MO/CO are perceived to be more superior than nurse midwives, MO/CO and RNM are more educated and powerful than ENM/MCHA, and men are seen as superior to women. All participants were encouraged to take active participation in the discussions. The interaction was intense and vivid experiences from a variety of perspectives were revealed. The FGD were between 40–60 minutes long, held in the national language of Kiswahili and audio-recorded. Data collection and preliminary analyses were conducted concurrently [20]. Thus, information from one FGD influenced the probing in subsequent discussions.