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The complex challenge of providing patient-centred perinatal healthcare in rural Uganda: A qualitative enquiry

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ABSTRACT

Rationale: Increasing research and reflections on quality of healthcare across the perinatal period slowly propels the global community to lobby for improved standards of quality perinatal healthcare, especially in low- and middle-income countries.

Objective: The purpose of this qualitative study was to obtain a deeper understanding of how interpersonal dimensions of the quality of care relate to real-life experiences of perinatal care, in a resource-constrained local health system.

Methods: In total, 41 in-depth interviews and five focus group discussions ($N = 34$) were conducted with perinatal women and local health system health professionals living and working in rural Uganda. Data analysis used an emergent and partially inductive, thematic framework based on the grounded theory approach.

Results: The results indicated that interpersonal aspects of quality of perinatal care and service delivery are largely lacking in this low-resource setting. Thematic analysis showed three interrelated process aspects of quality of perinatal care: negative reported patient-provider interactions, the perceptions shaping patient-provider interactions, and emergent consequences arising out of these processes of care. Further reflections expose the central, yet often-unheeded, role of perinatal women's agency in their own health seeking behaviours and overall well-being, as well as that of underlying practical norms surrounding health worker attitudes and behaviours.

Conclusion: These findings highlight the complexity of patient-centred perinatal healthcare provision in rural Uganda and point to the relevance of linking the interpersonal dimensions of quality of care to the larger systemic and structural dimensions of perinatal healthcare.

1. Introduction

In the progress towards the sustainable development goals era, Quality of Care (QoC) is essential to ensure the strengthened capacity of all countries in health risk reduction and management (United Nations, 2016). Alongside this, with most countries not having reached the millennium development goals for maternal mortality and morbidity targets (Victora et al., 2016), there is a great impetus to ensure further progress on maternal health outcomes to validate it as a justified measure of sustainable development (Graham et al., 2016). Quality of care is a key dimension of service provision (Donabedian, 1966), but is oftentimes overlooked in low- and middle-income countries (LMICs) as contributing to health outcomes (Kruk et al., 2017). There is increasing evidence that poor QoC is a major barrier to progress in expected healthcare improvements in LMICs (Akachi and Kruk, 2017). As such, it is essential to successfully ensure that the six dimensions of QoC – namely, effectiveness, efficiency, equity, patient-centredness, safety, and timeliness (Institute of Medicine, 2001) – are effectively addressed in healthcare provision, policy, and research.

Combining the health and well-being sustainable development goals of improved QoC and maternal health outcomes, maternal healthcare should include care that is humane, respectful, dignified, and abides by the fundamental rights of women (Miller et al., 2016). While patient-centred care is an essential component of understanding QoC and ser-

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vice provision, especially the interpersonal dimensions of care, there is limited evidence concerning its implementation in sub-Saharan Africa, despite important repercussions in terms of patient outcomes (De Man et al., 2016). Most attempts at improving QoC in maternal health programmes focus on the technical and structural aspects of care (Van Lerberghe et al., 2014); strengthening the related interpersonal aspects – whether between patients and providers or between healthcare teams and personnel – is only recently being recognized as being vital to improving related outcomes (Akachi and Kruk, 2017; Srivastava et al., 2015).

Increasing research, recognition, and reflections regarding poor QoC across the perinatal period in sub-Saharan Africa highlights the prevalence with which the mistreatment, abuse, disrespect, and neglect of women at the words and hands of frontline health workers occurs (Bohren et al., 2015; Mannava et al., 2015). Studies in Nigeria, Ethiopia, Tanzania, and Kenya have shown 98%, 78%, 19%–28%, and 20% of women participants, respectively, reporting at least one or more categories of disrespectful and abusive care during their last childbirth (Abuya et al., 2015; Asefa and Bekele, 2015; Kruk et al., 2014; Okafor et al., 2015). A growing number of reviews showcase the various determinants and drivers of women's satisfaction with, and their use of, maternity care; health providers' interpersonal behaviour is often the most widely reported factor (Bohren et al., 2014, 2015; Bradley et al., 2016; Mannava et al., 2015; Moyer and Mustafa, 2013; Srivastava et al., 2015).

Anthropological evidence and analysis further suggest that the over-medicalisation of maternity care reinforces norms in which the *'mother's body disappears from* view'; that is, her body and her agency are not her own in the gendered power dynamics of maternal healthcare (Wendland, 2007). Meanwhile, health worker perspectives are lost and misunderstood without situating them in the everyday practice of practical norms and pragmatic contexts (De Herdt and de Sardan, 2015; Olivier de Sardan et al., 2017). The consequences impacting women's decision-making processes and changes in their maternal Health-Seeking Behaviour (HSB), such as forgoing facility-based delivery and decreased utilisation of skilled birth attendants, are increasingly being documented (Bohren et al., 2015; McMahon et al., 2014; Shifraw et al., 2016). Yet, the mechanisms underlying both maternal HSB-related negotiations as well as LHS health worker practices require further elaboration and enquiry, as does research regarding consequences for women's mental health and well-being during the perinatal period (Rahman et al., 2013).

This study focuses on the interpersonal dimension of QoC in perinatal healthcare within the public Local Health System (LHS) level in rural Uganda. In Uganda, home births and use of traditional birth attendants are often a common alternative (Anastasi et al., 2015) to public perinatal healthcare services that are characterized by poor attendance, poor counselling services, and poor patient-provider relations, with the QoC being worse in rural areas (Anastasi et al., 2015; Sacks et al., 2016; UBOS, 2007). Within this context, the aim of this qualitative enquiry is to obtain grounded understandings of the interpersonal processes relating to QoC as perceived by perinatal women and LHS health providers, and how these perceptions and their underlying mechanisms impact real-life choices, experiences, and provisions of perinatal care.

We highlight the data as related to reported patient-provider interactions, the perceptions shaping these interactions, and potential consequences. In our discussion, we reflect upon i) the interrelations between perceived QoC and the agency of perinatal women in their HSB, and ii) the role of underlying normative perspectives of LHS-level health professionals providing perinatal care, ultimately linking these back to the overriding impact on perinatal health outcomes and the global maternal health agenda.

2. Method

2.1. Study setting

The study took place in four rural villages and two health centre threes (HC IIIs) across two neighbouring districts in eastern Uganda (Busowobi and Kiboyo in Iganga district; and Buwaiswa and Kabayingire in Mayuge district), and Iganga District Hospital, from March 2016 to May 2016. The districts (locally reported to have higher rates of poverty and majority Muslim populations within Uganda) were purposively chosen as part of a larger overall study. The purposively selected study villages ensured that within each pair of villages per district, each village had access to the same HC III, which are public lower-level, frontline health facilities providing basic out-patient and maternal and infant health services. Total qualified clinical staff at each HC III ranged from three to eight, while daily on-duty staffing ranged from one to four. Iganga District Hospital is a level V general referral facility for the district. It currently serves a catchment population of over 1.5 million from seven neighbouring districts.

2.2. Study design

The outlined study is a qualitative enquiry based on 41 in-depth interviews (IDIs) and five focus group discussions (FGDs) with two groups of participants. 32 IDIs and four FGDs were conducted with perinatal women from rural Ugandan communities, alongside 9 IDIs and one FGD conducted with LHS health professionals staffed at the HC IIIs and the district hospital across the study period. These research activities were conducted as a part of a larger study on the challenge of equitable mental healthcare at LHS-level in low-resource, rural Ugandan settings (2015–2017).

2.3. Study population, sampling, and recruitment

The IDI participants ($N = 32$) included 16 pregnant women and 16 new mothers at the time of study. The four FGDs were mixed groups of pregnant women ($N = 12$) and new mothers ($N = 16$), with 28 participants in total. To rule out any perinatal-related natural processes of grief and mourning, any women who had had the adverse pregnancy outcomes of miscarriages and/or stillbirths within the preceding 12 months of the study were excluded from participation. The IDI health professionals ($N = 9$) included two clinical officers from the HC IIIs, and five nurses and two midwives from the district hospital. The health professionals in the FGD ($N = 6$) consisted of two nurses, three midwives, and one 'mentor mother' from the district hospital only. The perinatal women were from Busoga communities and spoke the local language of Lusoga. The majority of health professionals identified as Busoga; those who did not could still speak and communicate in Lusoga, as well as in English.

Purposive and snowball sampling strategies were utilized to enable maximum variation of identified participants through gradual selection processes. Perinatal women were recruited through the Iganga Mayuge Health and Demographic Surveillance Site, village local councils, and community health workers. Health professionals were recruited