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'I thought they were going to handle me like a queen but they didn't': A qualitative study exploring the quality of care provided to women at the time of birth

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ABSTRACT

Objective: To explore experiences of care during labour and birth from the perspectives of both the healthcare provider and women receiving care, to inform recommendations for how the quality of care can be improved and monitored, and, to identify the main aspects of care that are important to women.
Design: A descriptive phenomenological approach. 53 interviews and 10KII as per table 1 took place including in-depth interviews (IDI), focus group discussions (FGD) and key informant interviews (KII) conducted with women, healthcare providers, managers and policy makers. Following verbatim transcription thematic framework analysis was used to describe the lived experience of those interviewed.
Setting: 11 public healthcare facilities providing maternity care in urban Tshwane District, Gauteng Province ($n = 4$) and rural Waterberg District, Limpopo Province ($n = 7$), South Africa.
Participants: Women who had given birth in the preceding 12 weeks (49 women, 7 FGD and 23 IDI); healthcare providers working in the labour wards (33 healthcare providers; nurses, midwives, medical staff, 5 FGD, 18 IDI; managers and policy makers (10 KII).
Findings: Both women and healthcare providers largely feel alone and unsupported. There is mutual distrust between women and healthcare providers exacerbated by word of mouth and the media. A lack of belief in women's ability to make appropriate choices negates principles of choice and consent. Procedure- rather than patient-centred care is prioritised by healthcare providers. Although healthcare providers know the principles of good quality care, this was not reflected in the care women described as having received. Beliefs and attitudes as well as structural and organisational problems make it difficult to provide good quality care. Caring behaviour and environment as well as companionship are the most important needs highlighted by women. Professional hierarchy is rarely seen as supportive by healthcare providers but when present, good leadership changes the culture and experience of women and care providers. The use of mobile phones to provide feedback regarding care was positively viewed by women.
Conclusion: Clarity regarding what a healthcare facility can (or cannot provide) is important in order to separate practice issues from structural and organisational constraints. Improvements in quality that focus on caring as well as competence should be prioritised. Increased dialogue between healthcare providers and users should be encouraged and prioritised.
Implications for practice: A renewed focus is needed to ensure companionship during labour and birth is facilitated. Training in respectful maternity care needs to prioritise caring behaviour and supportive leadership.

Introduction

A focus on 'technically competent care', while essential, will not in itself have enough impact in improving the quality of care and health outcomes (de Souza et al., 2014; van den Broek and Graham, 2009). Globally, there is a move towards a more person-centred approach. An approach that ignores the relationships and culture central to care provision is fundamentally flawed. However, this is in real-life terms a

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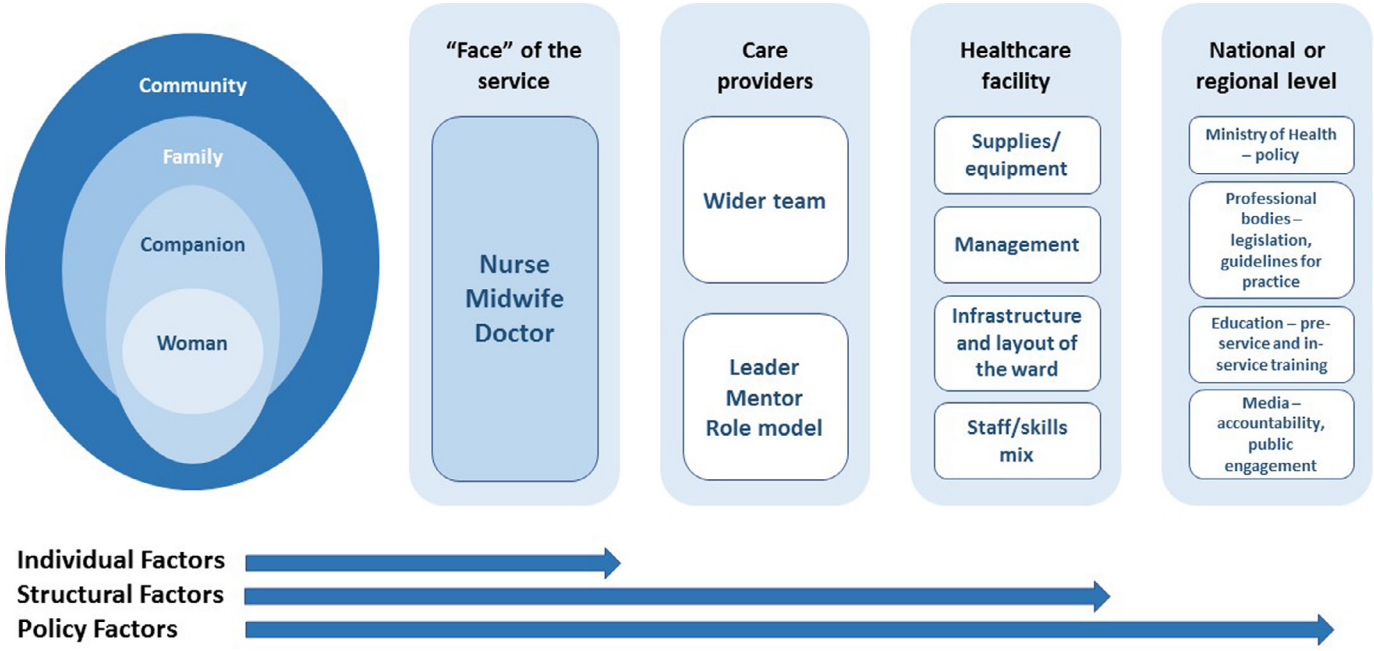

Fig. 1. Factors impacting on experience of care for the individual, structural and policy level.

complex relationship that can be difficult to map out, monitor and, can be challenging to influence (Freedman and Kruk, 2014; Chadwick et al., 2014; Bohren et al., 2015).

It is understood that it is too simplistic to attribute poor quality of care, including mistreatment and lack of respectful care, solely to the healthcare provider (Bowser and Hill, 2010; Bohren et al., 2015). The social, economic and health system barriers healthcare providers experience in their daily working lives can be significant (WHO, 2016; Freedman and Kruk, 2014; O' Donnell et al., 2014). It could be hypothesised that what has most frequently been measured or described, is the absence of quality, rather than quality itself, or, the type of care women would like to receive. Exploring the barriers and opportunities to providing care that is perceived as being of good quality from the perspective of both those providing and those receiving care is essential if meaningful recommendations for monitoring, and, improving the quality of care are to be developed (Raven et al., 2012).

The importance of a person-centred approach is highlighted by recent models that provide process measures for monitoring the different aspects of care quality (Freedman and Kruk 2014; Raven et al., 2012). Although Freedman and Kruk's (2014) model primarily addresses disrespect and abuse, their approach also highlights the interrelationships between the personal experiences of care and the health system. This supports a contextual approach to quality of care with the focus starting with the woman's perception and experience of quality of care. This is seen as a central rather than a peripheral component of the quality of care. The model of quality of care then extends outwards from the personal to the wider health systems perspective rather than a model that moves from the health system to the personal level (Fig. 1).

In South Africa, with 94.3% of births attended by a skilled birth attendant, predominantly at healthcare facility level, improving the quality of care is seen as a priority (Pattinson, 2014). In addition to improved access to care, it is important that the quality of the care provided is such that care received leads to improved outcomes and also experience of care (de Souza et al., 2014; van den Broek and Graham, 2009). How South Africa addresses this may influence progress in other countries in the process of moving from stage one to stage two in the obstetric transition model. In South Africa, there is a proactive approach to improving the quality of care and addressing mistreatment. Mistreatment of women who have accessed care has long been identified as a serious matter that required attention (Jewkes et al., 1998). Unfortunately, verbal abuse and lack of respect in maternity care is still experienced by women as reported in more recent studies (Chadwick et al., 2014). South Africa has successfully implemented a text-based system 'MoMConnect' for both women accessing care, and, nurse-midwives providing care, which has the potential for use to obtain feedback on quality of care (RSA DoH, 2017).

Wenzel and Jabbal (2016) identify that obtaining feedback from users of healthcare services is only of benefit if linked to an action plan for improvement. Feedback is important in order to be able to identify what needs to change and where to direct resources (Beattie et al., 2014). Tools and methods used to obtain feedback must be easy to use, relevant and provide actionable data. Studies reporting on experiences of maternity care illustrate that often the tools or questionnaires to assess care are lengthy, administered by healthcare providers themselves (which could introduce bias) A mixed-methods approach appears to be the most comprehensive one. For example, using a short, anonymous and easily administered feedback questionnaire and system, enhanced by qualitative studies for triangulation (Wenzel and Jabbal, 2016; LaVela and Gallan, 2014). It is important to identify whether it is experience or satisfaction (or both) that is being measured as these are different aspects of care and require different approaches to measurement.

Furthermore, currently many tools in use are study specific rather than generic (D'Ambruoso et al., 2005; McMahon et al., 2014). Moreover, a trained assessor in the context for example of a research study or an audit, can usually only obtain information from a limited number of women. While this will provide important information about individual women's experiences, it does not necessarily provide information in a way that can guide change and policy development more widely. There are also limitations associated with this approach in terms of continuous monitoring and quality improvement. To encourage and facilitate monitoring and assessment of quality of care as experienced by women, a set of simple but relevant questions that are easy to use as often as possible and can be self-administered by women would be useful (Finlayson and Downe, 2013; LaVela and Gallan, 2014; Vogel et al., 2015).

There is a complex interrelationship between the factors that determine why a woman may receive care that is not acceptable to and/or not valued by her (Jewkes et al., 1998; Freedman et al., 2014). The aim of this study was to explore the lived experience of maternity care providers as well as women who had received care at the time of birth