



‘Without ultrasound you can’t reach the best decision’ – Midwives’ experiences and views of the role of ultrasound in maternity care in Dar Es Salaam, Tanzania

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ABSTRACT

Objective: To explore Tanzanian midwives’ experiences and views of the role of obstetric ultrasound in relation to clinical management of pregnancy, and in situations where maternal and fetal health interests conflict.

Method: In 2015, five focus group discussions were conducted with midwives (N = 31) at three public referral hospitals in the Dar es Salaam region as part of the CROSS Country Ultrasound Study (CROCUS).

Results: Ultrasound was described as decisive for proper management of pregnancy complications. Midwives noted an increasing interest in ultrasound among pregnant women. However, concerns were expressed about the lack of ultrasound equipment and staff capable of skilful operation. Further, counselling regarding medical management was perceived as difficult due to low levels of education among pregnant women.

Conclusion: Ultrasound has an important role in management of pregnancy complications. However, lack of equipment and shortage of skilled healthcare professionals seem to hamper use of obstetric ultrasound in this particular low-resource setting. Increased availability of obstetric ultrasound seems warranted, but further investments need to be balanced with advanced clinical skills’ training as barriers, including power outages and lack of functioning equipment, are likely to continue to limit the provision of pregnancy ultrasound in this setting.

Introduction

Ultrasound is suggested to be one of the most important advances in obstetric emergency care [1], and clinical trials have shown that ultrasound can improve management of pregnancies with high risk of obstetric complications also in the developing world [2]. In Western countries ultrasound has been a routine part of antenatal care (ANC) for many years, and while portable, relatively affordable ultrasound devices have been introduced in several sub-Saharan African countries, the use of ultrasound in pregnancy management in this region is still limited [3]. Although women in some settings might be afraid that ultrasound can harm the fetus [4], there is generally a positive attitude towards ultrasound examinations among pregnant women in low-income countries (LICs) [5,6]. The need to enhance use of ANC services in

LICs has been strongly emphasised [7], and in 2014 50% of pregnant women in the sub-Saharan region attended at least four ANC visits as recommended by the World Health Organization (WHO) [8]. Integration of ultrasound scanning as a part of routine ANC in LICs is still limited although its use in the sub-Saharan region has been shown to result in increased visits for antenatal check-ups, and has motivated pregnant women to deliver at healthcare facilities [9,10]. It has also been recognised that women in LICs now might request ultrasound for non-medical reasons such as viewing the fetus and sex determination [5].

To promote pregnant women’s utilisation of healthcare a user fee exemption for ANC services was introduced by the Tanzanian government in the 1990s [11]. In accordance with the WHO recommendations for routine ANC services in the developing world [8], Tanzania also

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allocates large resources to ANC for universal prevention and treatment of infections such as HIV and malaria [12]. National statistics show that 80% of the ANC services are provided by nurses and midwives, and 96% of pregnant women received ANC by skilled health care providers at least once during pregnancy, although only 43% attended the four or more visits recommended [8]. Further, it has been reported that there can be major deficiencies in ANC due to insufficient application of the user fee exemption for ANC [13] and shortage of skilled health care professionals, especially in the rural areas of Tanzania [14]. The number of nurses and midwives in 2008–2014 were 0.4/1000 people in the country, while the average across the world was reported to be 3.3/1000 [15]. The corresponding figure for high income countries was 8.6 [15]. Even though the workforce is heavily concentrated in urban areas [16] a shortage of health care professionals is also a problem in the urban Dar es Salam region [12]. Further, both private and public health facilities operate with significant deficiencies in trained health staff, drugs and medical equipment [17].

Aim

The aim of this study was to explore Tanzanian midwives' experiences and views of the role of obstetric ultrasound in clinical management of pregnancy, and in situations where maternal and fetal health interests conflict.

Methods

Study design

This study was conducted as part of the multi-national CROSS-Country Ultrasound Study (CROCUS) [18,19]. A qualitative study design was applied, and data were collected through focus group discussions (FGDs).

Setting

To capture a broad picture of midwives' experiences and views on the role of ultrasound, the study was performed at three purposively selected public hospitals in the Dar es Salam region, where pregnancy ultrasound services were provided. FGDs were performed with midwives at one tertiary referral hospital, and at two regional hospitals, representing different levels of care, number of deliveries and staffing (Table 1). Ultrasound examinations were provided free of charge for public patients but the possibility for pregnant women to undergo an ultrasound examination was limited, as only a few professionals, mainly sonographers, were proficient in using the ultrasound machines. Further, sonographers were commonly off duty during night time and weekends, and only a small number of doctors and nurses in the maternity ward were qualified to do ultrasound examinations. Additionally, there was limited access to functioning ultrasound machines. Although patients could be referred for an ultrasound examination to a private practitioner in the government-owned hospitals, this entailed a cost of 12–28 USD, equivalent to about 12–24% of the minimum monthly salary, and in the private health care sector the fee could be double this (personal communication).

Table 1
Hospital maternity ward characteristics (data reported in January 2015).

Hospital/level of health care	Deliveries per year	Number of beds	Number of staff			Catchment areas
			Physicians	Nurses	Midwives	
National Referral hospital	10,330	160	30*	–	161	All districts for complicated cases and nearby regions
Regional Referral Hospital	21,561	63	21	32	37	Nearby districts
Regional Referral Hospital	12,792	30	9	12	8	Nearby districts

* Consultants, specialists, residents and registrars.

Participant recruitment

The heads of the three selected hospitals were contacted and agreed to assist with recruitment of participants. Midwives working in the maternity ward on the day scheduled for the FGDs were invited to participate in the study. All eligible participants approached agreed to participate and a total of 31 midwives participated in the study. Eighteen midwives were recruited for three FGDs at the tertiary referral hospital (FGD.A: n = 7, FGD.B: n = 6 and FGD.E: n = 5). Another 13 participants were recruited for FGDs at two regional referral hospitals, with seven and six participants respectively (FGD.C: n = 7 and FGD.D: n = 6).

Participant characteristics

All participants were women, ranging in age from 28–51 years (mean 38 years), having 1–26 years' (mean 9 years') experience working in antenatal or intrapartum care, intensive care, delivery ward, or in radiology. Twenty-seven of the participants were nurse midwives of whom one had a bachelor degree in midwifery. Two participants were nurse officers with diplomas in diagnostic ultrasound, and their main role was to perform obstetric ultrasound examinations.

Data collection

The thematic interview guide was developed by the research team for use across all countries participating in the CROCUS project, and had been pilot tested in a previous study [19]. The key domains in the interview guide are presented in Table 2. Data collection was conducted during one week in 2015 by authors KE, MN and AÅ. The coordinating researcher MN recruited participants for each of the five FGDs in the morning on the days when the FGDs were scheduled. The FGDs were held in a quiet room at each hospital. Before the start of each FGD, participants completed a questionnaire including information on age, gender, professional qualifications and number of years working as a professional in obstetric care. First the main interviewer (KE) posed the question in English, then a second interviewer (MN) translated the question into Swahili. Participants were encouraged to respond in English, but were informed that they could speak Swahili if they felt more comfortable with that. Responses given in Swahili were directly translated into English by MN to enable the English speaking interviewer to participate fully in the FGDs.

Data analysis

The FGDs were transcribed verbatim, and the parts of the transcripts that were in Swahili were translated into English. Data were analysed using qualitative content analysis [20]. First, AÅ and IM read the transcripts to get a sense of the whole, after which preliminary core topics in the FGDs were identified. The data addressing the aims of this study were then coded by AÅ and sorted into main categories and sub-categories. Then IM, HLK, and MN reviewed the identified main categories and sub-categories. The results were then reviewed by KE and RS resulting in some additional clarifications of the descriptions of the categories and sub-categories.

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