

**DEVELOPMENT OF GUIDELINES TO IMPROVE CLIENT-CENTRED CHILDBIRTH
SERVICES IN GHANA**

by

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DECLARATION

I hereby declare that this research report on development of guidelines to improve client-centred childbirth services in Ghana that I submit for the degree of Doctor of Literature and Philosophy at the University of South Africa is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Signature 

Date 14-09-15

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DEVELOPMENT OF GUIDELINES TO IMPROVE CLIENT-CENTRED CHILDBIRTH SERVICES IN GHANA

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ABSTRACT

This study was carried out as part of efforts to better understand the factors that impinge on childbirth service delivery and to develop guidelines to help improve the quality and safety of childbirth services in Ghana. The objectives were to: assess the factors that influence client-centredness; explore women's and health professional's views of and experiences with client-centred childbirth services; and develop guidelines to assist improve client-centred childbirth services in hospitals.

The fixed mixed methods design comprising both quantitative and qualitative methods was employed. Structured questionnaire and exit interviews were used to gather data from 754 women who delivered in the hospitals. Furthermore, in-depth interviews were used to examine the experiences of women, doctors and midwives. STATA MP Version 13 was used to analyse the data by generating frequencies, chi-square and binary logistic regression results. Qualitative data analysis was analysed through data reduction, data display and generation of themes and categories. The process of developing the guidelines comprised: drafting based on the findings of the study and additional literature review, and a number of reviews by senior health professionals to build consensus on the content.

With a response rate of 97.8%, the results indicated average performance. A number of the items examined under demographic characteristics, ante-natal, labour and postnatal care were significantly associated with the experience of excellent client-centred care. These included: number of weeks pregnant before delivery; health professional who assisted with delivery; mode of delivery; labour pain management; and length of stay after delivery.

On the whole, the findings of the quantitative study were supported by that of the structured interviews. Most of the themes from in-depth interviews with women were related to the relationship between health care provider and clients. Issues of support during childbirth; decision-making and informed choice; and continuity were raised. Themes deduced from the doctors' and midwives' interviews demonstrated a fair understanding of principles of client-centred care and delineated relational as well as client, health care worker and organisational factors that facilitate or limit effective implementation of client-centred care. The findings of the studies were used to develop guidelines to help improve services. It is recommended that the Ministry of Health, Ghana adopt the guidelines and provide the enabling environment for its effective implementation.

KEY WORDS:

Childbirth; childbirth services; client; client-centred care; doctors; experience; guidelines; health professionals; health worker; midwives; patient; woman.

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Dedication

This research report is dedicated to my husband Kofi Agbo and my children Yayra, Akpene and Kofi.

TABLE OF CONTENT

	PAGE
CHAPTER 1	1
OVERVIEW OF THE RESEARCH	1
1.1 INTRODUCTION	1
1.2 BACKGROUND TO THE PROBLEM.....	2
1.3 STATEMENT OF THE PROBLEM.....	3
1.4 PURPOSE OF THE RESEARCH	4
1.5 OBJECTIVE OF THE RESEARCH	4
1.6 RESEARCH QUESTIONS	4
1.7 SIGNIFICANCE OF THE STUDY	5
1.8 DEFINITION OF TERMS	5
1.8.1 Conceptual definitions.....	5
1.8.1.1 Client.....	5
1.8.1.2 Client-centred care.....	6
1.8.1.3 Guidelines	6
1.8.1.4 Patient-centred care.....	6
1.8.1.5 Person-centred care	6
1.8.1.6 Woman-centred care	6
1.8.1.7 Maternal mortality ratio	7
1.8.1.8 Health care worker.....	7
1.8.2 Operational definitions	7
1.8.2.1 Clients.....	7
1.8.2.2 Women.....	7
1.8.2.3 Doctor	7
1.8.2.4 Experience	7
1.8.2.5 Guidelines	8
1.8.2.6 Midwife.....	8
1.8.2.7 Health professionals	8
1.8.2.8 Childbirth services.....	8
1.9 DETERMINING THE THEORETICAL GROUNDING OF THE RESEARCH	8
1.9.1 Innovation attributes.....	9
1.9.2 Individual adopter's factors	10
1.9.3 The inner organisational contextual factors	10
1.9.4 The external contextual factors	11
1.9.5 The implementation and routinisation process factors.....	11
1.10 RATIONALE FOR USE OF THEORETICAL MODEL	12
1.11 RESEARCH DESIGN AND METHODOLOGY	13
1.11.1 Setting.....	13

1.11.2	Study design	13
1.11.3	Phase 1: Questionnaire study to assess the factors that influence client-centeredness of the care given to women from ante-natal to immediate post-natal period.....	14
1.11.3.1	Design.....	14
1.11.3.2	Population, sampling technique and sample.....	14
1.11.3.3	Data collection	15
1.11.3.4	Data analysis	15
1.11.4	Phase 2: In-depth interview with women on their views and experiences with childbirth.....	16
1.11.4.1	Design.....	16
1.11.4.2	Population, sampling technique and sample.....	17
1.11.4.3	Field work.....	17
1.11.4.4	Data analysis	17
1.11.5	Phase 3: In-depth interview with doctors and midwives views and experiences with implementation of childbirth services	18
1.11.5.1	Design.....	18
1.11.5.2	Population, sampling technique and sample.....	18
1.11.5.3	Field work.....	18
1.11.5.4	Data analysis	19
1.11.6	Phase 4: Development of guidelines on client-centred childbirth.....	19
1.12	SCIENTIFIC RIGOUR.....	20
1.12.1	Qualitative study	20
1.12.1.1	Credibility	20
1.12.1.2	Transferability	21
1.12.1.3	Dependability and confirmability	21
1.12.2	Quantitative study	21
1.12.2.1	Reliability.....	21
1.12.2.2	Validity	22
1.13	ETHICAL CONSIDERATIONS.....	22
1.14	STRUCTURE OF THE THESIS.....	23
1.15	CONCLUSION	24
CHAPTER 2	25
CONCEPTUAL FRAMEWORK	25
2.1	DIFFUSION OF INNOVATIONS THEORY AS IT APPLIES TO HEALTH CARE AND CLIENT-CENTRED CHILDBIRTH	25
2.1.1	Definition and attributes of an innovation	25
2.1.2	The innovation attributes.....	26
2.1.2.1	The relative advantage	26
2.1.2.2	Compatibility	26
2.1.2.3	Complexity	26
2.1.2.4	Trialability.....	27
2.1.2.5	Observability	27
2.1.2.6	Re-inventability	27

2.1.3	Adoption by individuals	29
2.1.4	Assimilation or adoption at the organisational level, and the contextual antecedents for innovation readiness	31
2.1.5	The external contextual factors that influence adoption of innovations.....	35
2.1.6	The implementation and routinisation (sustainability) process.....	36
2.1.7	Description of the proposed conceptual framework for the study	37
2.2	ADOPTION OF INNOVATIONS IN HEALTH CARE	39
2.3	CONCLUSION	42
CHAPTER 3.....		43
LITERATURE REVIEW		43
3.1	INTRODUCTION	43
3.2	THE CONCEPT OF QUALITY IN HEALTH CARE	43
3.3	QUALITY OF CHILDBIRTH CARE	45
3.4	MATERNAL HEALTH CARE IN GHANA	47
3.5	CONCEPTUALISATION OF PATIENT/CLIENT-CENTRED CARE	49
3.6	PATIENT/CLIENT-CENTRED CARE AND HEALTH OUTCOMES	52
3.7	FACTORS THAT INFLUENCE CLIENT-CENTRED HEALTH CARE PRACTICE.....	53
3.8	FACTORS THAT INFLUENCE CLIENT-CENTREDNESS OF CHILDBIRTH SERVICES.....	54
3.8.1	Socio-demographic factors that affect women’s experience and client-centredness of childbirth services.....	54
3.8.2	Accessibility and reception.....	55
3.8.2.1	Availability, location and accommodation	55
3.8.2.2	Affordability factors	57
3.8.2.3	Socio-demographic factors that influence access.....	58
3.8.3	Reception and waiting.....	59
3.8.4	Respect and dignity in childbirth	59
3.8.5	Respect for women’s preferences and needs.....	61
3.8.5.1	Control, decision-making and choice	62
3.8.5.2	Place of birth and birth attendant	64
3.8.5.3	Mode of birth and birth position.....	66
3.8.5.4	Support during childbirth and comfort	67
3.8.5.5	Labour pain management	69
3.8.5.6	Length of stay	70
3.8.5.7	Socio-cultural, psychological and emotional needs.....	70
3.8.5.8	Psychological and emotional needs influencing childbirth	72
3.8.6	Communication and information giving in childbirth.....	73
3.8.7	Integration and coordination of care.....	75
3.8.8	Safety of care.....	79
3.8.9	Continuity of care	80
3.8.10	Empowering and engagement of patients, families and community	83
3.8.11	Built environment	86

3.9	MEASURING CLIENT-CENTRED CARE OR SERVICE	87
3.10	CONCLUSION	88
CHAPTER 4.....		91
METHODOLOGY		91
4.1	INTRODUCTION	91
4.2	STUDY DESIGN	91
4.2.1	Descriptive study.....	93
4.2.2	Exploratory study	94
4.2.3	Philosophical context of the study.....	95
4.3	SETTING	96
4.3.1	Characteristic of Ghana health system	96
4.3.2	The demographic characteristics of the study region.....	97
4.3.3	Site sampling technique.....	98
4.3.3.1	Selection of hospitals	99
4.3.3.2	Characteristics of the selected hospitals.....	99
4.3.4	Consent from hospitals	101
4.4	PHASE 1: FACTORS THAT INFLUENCE CLIENT-CENTEREDNESS OF CHILDBIRTH SERVICES.....	102
4.4.1	Design.....	102
4.4.2	Development of the questionnaire	102
4.4.3	Population, sampling technique and sample.....	104
4.4.4	Preparation for data collection (questionnaire)	104
4.4.5	Field work: Administration of questionnaires.....	105
4.4.6	Quantitative data analysis.....	105
4.4.7	Statistical analysis.....	107
4.5	PHASE 2: IN-DEPTH INTERVIEWS WITH WOMEN ON THEIR VIEWS AND EXPERIENCES WITH CHILDBIRTH	107
4.5.1	Design.....	107
4.5.2	Pre-testing of the process	108
4.5.3	Population, sampling technique and sample.....	108
4.5.4	Field work: Interview with women	109
4.5.5	Field notes	111
4.5.6	Data analysis	111
4.5.6.1	Preparations for data analysis.....	112
4.5.6.2	Reading and data reduction/coding	112
4.5.6.3	Data display	113
4.5.6.4	Conclusion and verification	113
4.6	PHASE 3: IN-DEPTH INTERVIEWS WITH DOCTORS AND MIDWIVES: THEIR VIEWS AND EXPERIENCES WITH IMPLEMENTING CHILDBIRTH SERVICES	113
4.6.1	Design.....	113
4.6.2	Pre-testing of process	114
4.6.3	Population, sampling technique and sample.....	114

4.6.4	Field work: Interview with health professionals	116
4.6.5	Field notes	117
4.6.6	Data analysis	118
4.6.6.1	Preparation for data analysis	118
4.6.6.2	Reading and data reduction/coding	119
4.6.6.3	Data display	119
4.6.6.4	Conclusion and verification	120
4.7	RELIABILITY AND VALIDITY OF QUESTIONNAIRE STUDY	120
4.7.1	Validity	120
4.7.2	Reliability.....	121
4.8	TRUSTWORTHINESS OF QUALITATIVE STUDY	121
4.8.1	Credibility	122
4.8.2	Transferability	122
4.8.3	Dependability	123
4.8.4	Confirmability	123
4.9	PHASE 4: DEVELOPMENT OF GUIDELINES ON CLIENT-CENTRED CHILDBIRTH	124
4.10	ETHICAL CONSIDERATIONS.....	124
4.10.1	Consent.....	124
4.10.2	Confidentiality and anonymity	125
4.10.3	Beneficence and non-maleficence.....	125
4.11	CONCLUSION	126
	CHAPTER 5.....	127
	RESULTS AND DISCUSSION OF THE QUANTITATIVE STUDY ON THE CLIENT-CENTREDNESS OF CHILDBIRTH SERVICES.....	127
5.1	INTRODUCTION	127
5.2	PART 1: RESULTS OF STUDY ON FACTORS THAT INFLUENCE CLIENT-CENTRED CHILDBIRTH SERVICES	127
5.2.1	Demographic characteristics.....	127
5.2.2	General information on baby.....	128
5.2.3	Arrival and reception during labour	128
5.2.4	Ante-natal care experience	131
5.2.5	Labour experience	137
5.2.6	Postnatal experience	143
5.2.6.1	Care in hospital after delivery.....	143
5.2.6.2	Feeding your baby	144
5.2.6.3	Information on care at home after delivery.....	145
5.2.7	Hospital environment	145
5.2.8	Findings on dimensions for client-centred care experience with childbirth.....	147
5.2.9	Findings on socio-demographic and other general variables correlates of excellent client-centred care experienced with childbirth using chi-square test of independence	150
5.2.10	Overall assessments.....	152
5.2.11	Comparing excellent client-centred care experienced with childbirth among three facilities.....	153

5.2.12	Multivariable analysis of factors associated with excellent client-centred care experienced with child birth based on the binary logistic regression.....	154
5.2.13	Comments from participants	156
5.3	PART 2: DISCUSSION OF FINDING ON FACTORS THAT INFLUENCE CLIENT-CENTRED CHILDBIRTH SERVICES	158
5.3.1	Introduction	158
5.3.2	Demographic characteristics.....	158
5.3.2.1	Socio- demographic characteristics of study participants	159
5.3.2.2	Information on baby	161
5.3.2.3	Payment of hospital fees.....	162
5.3.3	Arrival and reception during labour	163
5.3.4	Dignity, respect, courtesy and privacy	164
5.3.5	Decision-making, control and informed choice	165
5.3.6	Communication and education.....	166
5.3.7	Place of birth	167
5.3.8	Birth attendant.....	169
5.3.9	Mode of delivery.....	170
5.3.10	Position during birth	171
5.3.11	Support in labour and immediately after birth	172
5.3.12	Labour pain relief	173
5.3.13	Continuity of care	174
5.3.14	Length of stay after delivery	175
5.3.15	Built environment	176
5.3.16	Overall assessments.....	178
5.4	CONCLUSION	179
	CHAPTER 6.....	180
	FINDINGS AND DISCUSSION OF IN-DEPTH INTERVIEWS WITH WOMEN ON THEIR VIEWS AND EXPERIENCES WITH CHILDBIRTH	180
6.1	INTRODUCTION	180
6.2	DEMOGRAPHIC CHARACTERISTICS	180
6.3	RELATIONSHIP WITH HEALTH CARE WORKERS	183
6.3.1	Respect, courtesy and privacy (N=15).....	183
6.3.2	Communication and information giving (N=15).....	187
6.4	SUPPORT DURING CHILDBIRTH	195
6.4.1	Socio-cultural and spiritual support (N=15).....	195
6.4.2	Psychological and emotional support (N=7).....	197
6.4.3	Physical support (N=15).....	200
6.5	DECISION-MAKING, CONTROL AND INFORMED CHOICE	204
6.5.1	Health professional as decision-making (N=10).....	204
6.5.2	Views on and experiences with informed choice in childbirth	206
6.5.2.1	Women's view on and experiences with choice of place of birth	208
6.5.2.2	Women's views on and experiences with choice of birth attendant	210

6.5.2.3	Women's views on and experiences with choice of mode of birth	211
6.5.2.4	Women's views on and experiences with choice of birth position and mobility.....	213
6.5.2.5	Women's views on and experiences with choice of pain	215
6.5.2.6	Women's views on and experiences with choice of length of stay after delivery	219
6.6	CONTINUITY OF CARE	221
6.6.1	Knowing your staff (N=15)	222
6.7	OVERALL ASSESSMENT BY WOMEN	225
6.7.1	Satisfaction with care	225
6.8	BARRIERS IDENTIFIED BY WOMEN.....	228
6.8.1	Too many clients (N=13).....	228
6.8.2	Inadequate staff (N=5)	230
6.8.3	Non-availability of some services (N=15).....	231
6.8.4	Unacceptable staff attitude (N=6)	232
6.8.5	Lack of cooperation from other clients (N=7)	233
6.9	RECOMMENDATIONS FROM WOMEN	234
6.9.1	Health workers to have patience (N=15).....	234
6.9.2	Need for open communication (N=7)	235
6.9.3	Friendliness and good relationship (N=10)	236
6.9.4	Health workers to be attentive (N=5).....	237
6.9.5	Re-organisation of services (N=14)	238
6.10	CONCLUSION	239
CHAPTER 7		240
FINDINGS AND DISCUSSION OF IN-DEPTH INTERVIEWS WITH DOCTORS AND MIDWIVES.....		240
7.1	INTRODUCTION	240
7.2	DEMOGRAPHIC AND BACKGROUND CHARACTERISTICS.....	240
7.3	THE MEANING AND UNDERSTANDING OF CLIENT-CENTRED CARE	243
7.3.1	Focused individualised care (N=19).....	243
7.3.2	Involving clients and families in care (N=8).....	245
7.3.3	Open communication and education (N=10).....	248
7.3.4	Personal and interpersonal relationship with care provider (N=19).....	253
7.3.5	Continuity (N=11)	256
7.3.6	Dignity, respect and privacy (N=17)	260
7.4	QUALITIES AND CHARACTERISTICS OF HEALTH PROFESSIONALS.....	263
7.4.1	Patience (N=13).....	264
7.4.2	Tolerance (N=6)	264
7.4.3	Empathy (N=10).....	266
7.4.4	Nice and friendly (N=12)	267
7.4.5	Confidentiality (N=10)	268
7.5	ORGANISATIONAL FACTORS THAT INFLUENCE IMPLEMENTATION OF CLIENT-CENTRED CARE.....	270

7.5.1	Leadership influence (N=17).....	271
7.5.2	Training (N=19).....	273
7.5.3	Guidelines on client-centred care (N=19).....	274
7.5.4	Provision of resources (N=8).....	276
7.5.5	Monitoring and feedback (N=16).....	277
7.6	CONTROL OVER DECISION-MAKING AND INFORMED CHOICE ON KEY ATTRIBUTES OF CLIENT-CENTRED CHILDBIRTH.....	279
7.6.1	Shared decision-making (N=19).....	280
7.6.2	Decision must be taken with husband or family (N=5).....	282
7.6.3	Health professional dominance in certain situations (N=11).....	283
7.6.3.1	Views on choice of place of birth.....	284
7.6.3.2	Views on choice of birth attendant.....	286
7.6.3.3	Views on choice of mode of birth.....	287
7.6.3.4	Views on choice of birth position.....	289
7.6.3.5	Views on choice of labour support person or companion.....	290
7.6.3.6	Views on choice of labour pain relief.....	292
7.6.3.7	Views on choice of length of stay after delivery.....	294
7.7	BARRIERS TO EFFECTIVE IMPLEMENTATION OF CLIENT-CENTRED CARE.....	296
7.7.1	Client factors that limit implementation of client-centred care.....	296
7.7.1.1	Client lack of knowledge (N=7).....	296
7.7.1.2	Client cultural and spiritual issues (N=10).....	297
7.7.1.3	Lack of cooperation from clients (N=8).....	299
7.7.1.4	Client financial challenges (N=5).....	299
7.7.2	Health care worker factors that limited implementation of client-centred care.....	300
7.7.2.1	Inadequate knowledge and skills on some delivery options (N=15).....	300
7.7.2.2	Poor staff attitude (N=5).....	301
7.7.3	Organisational barriers that limit implementation of client-centred care.....	303
7.7.3.1	Facility rules and routines (N=18).....	304
7.7.3.2	Lack of equipment and logistics (N=17).....	305
7.7.3.3	Infrastructure and space (N=19).....	306
7.7.3.4	Inadequate staff (N=19).....	307
7.7.3.5	Organisation of services (N=19).....	309
7.7.3.6	High workload (N=18).....	310
7.8	RECOMMENDATIONS BY DOCTORS AND NURSES.....	311
7.8.1	Training of staff on client-centred care (N=17).....	311
7.8.2	Recruitment of or provision of additional staff (N=19).....	313
7.8.3	Provision of equipment and logistics (N=16).....	314
7.8.4	Improve infrastructure (N=19).....	315
7.8.5	Re-organisation of services (N=10).....	316
7.8.6	Improve communication and education of mothers and the public (N=15).....	317
7.9	CONCLUSION.....	318

CHAPTER 8	319
GUIDELINES ON CLIENT-CENTRED CHILDBIRTH	319
8.1 INTRODUCTION	319
8.2 SUMMARY OF FINDINGS FROM THE THREE STUDIES	320
8.2.1 Focusing individualised care.....	322
8.2.2 Dignity, respect, courtesy and privacy	322
8.2.3 Involving and explaining issues to clients and family in health care.....	323
8.2.4 Communication and education.....	324
8.2.5 Interpersonal relationship.....	324
8.2.6 Decision-making and control, and informed choice.....	325
8.2.7 Support in childbirth	326
8.2.8 Continuity of care	326
8.2.9 Overall assessment by women	327
8.2.10 Organisational factors that influence client-centred childbirth.....	327
8.2.11 Factors that hindered client-centred care.....	328
8.2.11.1 Client factors that hindered client-centred care.....	329
8.2.11.2 Health care worker factors that hindered client-centred care.....	329
8.2.11.3 Organisational barriers that limit implementation of client-centred care.....	330
8.2.11.4 Facility rules and routines	330
8.2.11.5 Lack of equipment and logistics	330
8.2.11.6 Infrastructure and space (built environment).....	330
8.2.11.7 Inadequate staff	331
8.2.11.8 Inappropriate work organisation.....	331
8.2.11.9 Non-availability of some services.....	331
8.2.11.10 High workload or patient numbers	331
8.2.11.11 Language barrier.....	332
8.2.12 Recommendations from participants.....	332
8.3 GUIDELINES TO IMPROVE CLIENT-CENTREDNESS OF CHILDBIRTH SERVICES IN HEALTH CARE SETTINGS IN GHANA.....	333
8.3.1 Introduction	333
8.4 SECTION 1: INTRODUCTION TO GUIDELINES	334
8.4.1 Process of guidelines development	334
8.4.2 Scope of application of guidelines.....	336
8.4.3 Purpose of the guidelines.....	336
8.4.4 Objectives of the guidelines	336
8.4.5 Guiding principles of client-centred childbirth.....	336
8.4.6 Definition and meaning of client-centred childbirth.....	336
8.4.7 Components or attributes of client-centred childbirth.....	338
8.5 SECTION 2: TECHNICAL GUIDELINES ON CLIENT-CENTRED CHILDBIRTH	340
8.5.1 Providing individualised care.....	340
8.5.2 Dignity, respect, courtesy and privacy	341

8.5.3	Ensuring effective communication and education	342
8.5.4	Personal and interpersonal relationship	344
8.5.5	Decision-making and informed choice	344
8.5.5.1	Informed choice	346
8.5.6	Involving women and family in care	347
8.5.6.1	Role of the woman and family	347
8.5.7	Support in pregnancy and birth	348
8.5.7.1	Socio-cultural and spirituality support	348
8.5.7.2	Psychological and emotional support	349
8.5.7.3	Physical support	349
8.5.8	Continuity of care	350
8.5.8.1	Ante-natal continuity of care	350
8.5.8.2	Intrapartum continuity of care	351
8.5.8.3	Intrapartum – postnatal continuity of care	351
8.5.9	Organisational factors that promote implementation of client-centred childbirth	352
8.5.9.1	Leadership	352
8.5.9.2	Staffing	353
8.5.9.3	Education, training and staff development	353
8.5.9.4	Equipment and supplies	354
8.5.9.5	Infrastructure and environment	355
8.5.9.6	Re-organisation of services	355
8.5.9.7	Integration and coordination of care	356
8.5.9.8	Staff health and welfare	357
8.5.9.9	Monitoring and feedback	357
8.6	CONCLUSION	358
CHAPTER 9		359
CONCLUSION AND RECOMMENDATIONS OF THE STUDY		359
9.1	INTRODUCTION	359
9.2	CONCLUSIONS	359
9.3	RECOMMENDATIONS	361
9.3.1	Leadership and organisation for client-centred care	361
9.3.2	Health care worker education and training	362
9.3.3	Reorganisation of services	362
9.3.4	Staffing	363
9.3.5	Infrastructure and resources	363
9.3.6	Provision of resources	363
9.3.7	Communication and patient engagement	363
9.3.8	Monitoring and evaluation	364
9.4	FURTHER RESEARCH	365
9.5	CONTRIBUTION OF THE STUDY	365
9.6	LIMITATIONS	366

LIST OF REFERENCES	367
ANNEXES	413
Annex 1: Questionnaire- women experiences with childbirth services.....	413
Annex 2: Sample participant informed consent (qualitative study).....	422
Annex 3: Schedule of work for field work and report writing.....	423
Annex 4: Sample letter to the Regional Director of Health Services	424
Annex 5: Items and scoring scheme for client-centered care dimensions	426
Annex 6: Items and scoring scheme for antenatal, labour and post-natal experience	435
Annex 7: Interview guide for women	442
Annex 8: Sample interview transcript from a woman	443
Annex 9: Interview guide for doctors and midwives	454
Annex 10: Sample transcript form interview with doctors and midwives	455
Annex 11: Ethical clearance from Ghana Health Service ethics committee.....	466
Annex 12: Ethical clearance from University of South Africa	467
Annex 13: Letter of the statistician	468
Annex 14: Letter from the editor.....	469

LIST OF TABLES

No	Title	Page
5.1	Frequency and percent frequency distribution of socio-demographic characteristics	129
5.2	Frequency and percent frequency distribution on arrival and reception during labour	130
5.3	Frequency and percent frequency distribution on general information on ante-natal experience	132
5.4	Frequency and percent frequency distribution on provision on information on choices available regarding labour pain relief, birth attendant, birth position, labour companion or support, mode of delivery and choice of where to go for antenatal check-up	134
5.5	Frequency and percent frequency on additional items on ante-natal experience	135
5.6	Frequency and percent frequency distribution on choice of birth position, type of pain relief method women planned to use, type of pain relief method used	138
5.7	Frequency and percent frequency distribution on variables on labour experience	142
5.8	Frequency and percent frequency distribution on the feeding of the baby after delivery	144
5.9	Frequency distribution of dimensions for client experienced with childbirth	148
5.10	The overall mean rating on dimensions for client-centred care experienced with childbirth...	149
5.11	Bivariate analysis of socio-demographic characteristics and other general variables and excellent client-centred care experienced with childbirth	150
5.12	Multivariable analysis of factors associated excellent client-centred care experienced with childbirth	155
5.13	Comments and suggestions from participants	157
6.1	Frequency and percent frequency distribution of demographic characteristics of women	181
6.2	Categories and themes of finding of interviews with women	182
7.1	Categories and themes of finding of interviews with health professionals	241
7.2	Presentation of demographic characteristics of health professionals	243
8.1	Significant socio-demographic and obstetric characteristics associated with excellent client-centred care	321
8.2	Components or attributes of client-centred childbirth and their explanations	338

LIST OF FIGURES

No.	Title	Page
2.1	Rogers (2003) category of adopters	31
2.2	Conceptual framework for evaluating client-centred childbirth.....	38
5.1	Findings on provision of information from midwife or doctor to help women decide where to have their baby	131
5.2	Findings on number of ante-natal check-up that women had	133
5.3	Findings on overall rating of care received during the ante-natal period by women	137
5.4	Finding on being able to move around during labour.....	137
5.5	Findings on giving of pain relief during labour	139
5.6	Findings on types of delivery that women had.....	139
5.7	Findings on position the women assumed during delivery.....	140
5.8	Results on women who had skin-to-skin contact with their baby shortly after delivery	141
5.9	Findings on overall rating on labour/delivery experience by women.....	143
5.10	Findings on overall rating of postnatal care experience by women.....	145
5.11	Finding on type of accommodation used during and after delivery and the type of accommodation preferred by women.....	146
5.12	Findings on cleanliness of wards, washrooms and bedsheets	146
5.13	Comparative analysis of excellent client experience with care and location of facility	154
8.1	Framework for developing guidelines on client-centred childbirth.....	335

LIST OF ABBREVIATIONS

AHRQ	Agency for Health Care Research and Quality
ANC	Ante-natal Care
AWHONN	Association of Women's Health, Obstetric and Neonatal Nurses
BMC	Biomed Central
DDNS	Deputy Director of Nursing Services
GHS	Ghana Health Service
IAPO	International Alliance of Patient Organisations
IOM	Institute of Medicine
MDGs	Millenium Development Goals
MOH	Ministry of Health
NICE	National Institute for Health and Care Excellence
OMA	Ontario Medical Association
RNAO	Registered Nurses Association of Ontario
SVD	Spontaneous Vaginal Delivery
UK	United Kingdom
WHO	World Health Organization

CHAPTER 1

OVERVIEW OF THE RESEARCH

1.1 INTRODUCTION

Patient or client-centred care has gained tremendous recognition globally as an important health care delivery strategy that helps to improve the safety and quality of care (IOM 2001:40; Kenyon, Ullman, Mori & Whittle 2007:667-668; Silow-Carroll, Alteras, & Stepnick 2006:5). Client-centred care has been associated with positive outcomes in health status and efficiency of care such as, reduced hospitalisation, diagnostic test and referral, and lower medical charges (Bertakis & Azari 2011:236). It has also been linked to improved knowledge, adherence to treatment regimens and, high levels of self-care and satisfaction with care (Poochikian-Sarkissian, Sidani, Ferguson-Pare & Doran 2010:19). Ferrante, Balasubramanian, Hudson and Crabtree (2010:113-115) state that there is high correlation between patient-centred and receipt of preventive service. In a study on quality of maternity care services as experienced by women, that is, 1,248 pregnant clients, Wieggers (2009:[6-8]) found that women who received a more client-centred care during labour and birth reported higher quality of care scores. Patient-centred care is thus seen as an important quality and safety strategy that should be integrated into the culture of health institutions.

Like many developing countries, Ghana is constantly looking for ways to improve the quality of childbirth services. The World Health Report (2008:44-45) notes that though technical and safety parameters are key determinants of the outcomes of health care, how services deal with people is also vital. The client-centred approach encompasses qualities of compassion, empathy, and responsiveness to the needs, values and expressed preferences of the individual patient (IOM 2001:48-51). It also offers an opportunity that could help transform the quality of services. Some aspects of the principles of client-centred services can be found in the Ghana National Safe Motherhood Protocol (Ministry of Health 2008a) but there has been very limited research evaluating the understanding of the principles and its impact on outcomes. This study seeks to address this gap by examining the client-centredness of childbirth services in health facilities. The chapter outlines: the background to the problem; statement of the problem; the purpose and objectives; significance of the study;

definition of terms; theoretical underpinning; overview of the methodology; ethical considerations and structure of the thesis.

1.2 BACKGROUND TO THE PROBLEM

In Ghana, huge investments and innovative programmes and approaches to providing care in the last two decades have helped to improve maternal and child health indicators, but there are still great concern about the quality of maternal and child health services (Osei, Garshong, Owusu-Banahene, Gyapong, Tapsoba, Askew, Ahiadeke, Killian, Bonku, Combarry & Sampson 2005:23-28). Reports indicate that quality and safety of maternal and infant services are still far from acceptable (Ansong-Tornui, Armar-Klemesu, Arhinful, Penfold & Hussein 2007:130; Ministry of Health 2004:9-11). For example, in 2014, institutional maternal mortality was 150.4 per 100,000 live births while institutional neonatal death was 4.4 deaths per 1000 live births (Ministry of Health, Ghana 2015a:7). New approaches to implementing evidence-based quality improvement strategies in childbirth services (that is, ante-natal, delivery and postnatal) thus need to be explored to help address the situation.

Globally, institutionalising client-centred health care is seen as one of the acceptable approaches to improving quality maternity care. This approach is guided by the recognition that clients and their families are key to the achievement of optimum care and that services must be informed by client's values, culture, needs and preferences (IAPO 2007:10). Hobbs (2009:53) argues that despite the wide acceptance of client-centred care, there is a lack of clarity or agreement regarding what is meant by the term and how it can be applied in practice. In this regard, it has been recommended that for effective operationalisation of client-centred care, all stakeholders in the health organisation must have a common understanding of the concept and what it takes to implement it (IAPO 2007:5; Jayadevappa & Chhatre 2011:16).

The WHO (2010a:1) notes that in many developed countries, health systems are moving towards people-centred approaches but this appears not to be the case in most low-and middle-income countries. Making health services client-centred is mentioned in the strategic document of the Ministry of Health, Ghana (Ministry of Health 2006:21) and the Ghana Health Service Reproductive Health Strategic Plan 2007-2011 (Ghana Health Service 2007:13-14) but action points to guide implementation seem not to have

been clearly delineated. The national reproductive health protocol states that ante-natal care must be individualised (Ministry of Health 2008a:3) and recommends the need for courtesy and kindness as well as listening and answering questions from the client as key components of ante-natal care (Ministry of Health 2008a:7). Indications are that some elements of principles of client-centred care are being implemented. For example, the code of ethics for all health professionals (Ghana Health Service 2002a) and Patient's Charter (Ghana Health Service 2002b) were introduced in 2002. These documents among other things are designed to give patients the right to have a say in the treatment that is offered to them. A programme on improving customer care among health professionals was also introduced in 2009 to enhance collaboration between the health worker, patients and families in the delivery of health care (Ghana Health Service 2009a:14). Despite these efforts, not much is known about how client-centred care is understood, operationalised and its impact on outcomes in the country. Furthermore, there appears to be no guideline document that specifically addresses client-centredness of childbirth services, a requirement that can help health workers to better tailor service to the needs and preferences of women. Also, whether or not existing organisational and management systems support the demands of client-centred care has not been clearly documented. Therefore, the study explored how health professionals understood client-centred care, its attributes and how it was being implemented in health facilities. To determine some of the outcomes of implementation of client-centred care, the views and experiences of women who have used the childbirth services in the health facilities were explored. The findings from the explorative studies were used to develop guidelines to help improve the experience of women.

1.3 STATEMENT OF THE PROBLEM

Although promoting client-centred care is captured in the national health strategy as one of the guiding principles to improve quality in Ghana (Ministry of Health 2006:21), not much is known about how health workers understand the concept and its attributes, and the extent of implementation in health facilities. Furthermore, there has been very little research into how client-centredness of childbirth services are experienced by women. This notwithstanding, there appears to be no specific guidelines to assist health workers in the delivery of client-centred childbirth services.

1.4 PURPOSE OF THE RESEARCH

The purpose of the study is to examine client-centred childbirth services in Ghana's health care services, and the influence it has had on the quality of childbirth services so as to develop guidelines to assist to improve client-centred childbirth services in Ghana.

1.5 OBJECTIVE OF THE RESEARCH

The objectives are to:

- Assess the factors that influence client-centredness of the care given to women from ante-natal to immediate post-natal period.
- Explore and describe women's views of and experiences with client-centred childbirth services.
- Explore and describe health professionals (doctors and midwives) views of and experiences with implementing client-centred childbirth services.
- Based on the findings from the views and experiences of health professional and women, guidelines will be developed to improve client-centred childbirth services in hospitals in Ghana.

1.6 RESEARCH QUESTIONS

The research questions of the study were:

- What are the factors that influence client-centeredness of ante-natal, delivery/labour and immediate post-natal care in health facilities in Ghana?
- What are the views and experiences of women regarding the client-centred childbirth services in Ghana?
- How do doctor and midwives understand client-centred care and its attributes?
- What are the views and experiences of doctors and midwives regarding the implementation of client-centred childbirth services in Ghana?
- What should be the scope of the guidelines to improve the client-centredness of childbirth services in health facilities?

1.7 SIGNIFICANCE OF THE STUDY

For decades, many developed countries have been studying and looking for mechanisms to make health systems more client-centred. In many developing countries, efforts are still in their early stages. The good thing is that developing countries have very good lessons to learn from the developed countries. The high level of maternal mortality ratio in Ghana is often attributed to the non-availability of quality maternal services (Ministry of Health 2010). The importance of client-centred care to improvement of quality and safety has already been highlighted. As very little is known about the meaning, attributes, implementation and impact of client-centred care in Ghana, this study will offer policy makers a better appreciation of how women and health professionals view these elements to inform healthcare designs. Information on institutional factors that hinder or facilitate operationalisation of client-centred care to guide action is limited. Effective operationalisation of client-centred care requires that key stakeholders have a common understanding of the concept as well as measurement strategies to make it a reality (Jayadevappa & Chhatre 2011:16). The recommendations of this study may help health care providers evaluate and determine whether current practices and services are in line with evidence-based client-centred practices. The research process will offer clients the opportunity to express their views on the quality of childbirth services while implementation of the recommendations may help to make services more client-centered. The findings and guidelines could be reflected in or linked to other clinical protocols and training guidelines for service providers to support institutional level behaviour change and ultimately advance the knowledge on client-centred childbirth in developing countries.

1.8 DEFINITION OF TERMS

1.8.1 Conceptual definitions

1.8.1.1 *Client*

‘A person who uses the services or advice of a professional person or organisation’ (Oxford Advanced Learners Dictionary 2005:263). In this study, the client refers to women who receive childbirth services in health facilities.

1.8.1.2 Client-centred care

An approach to providing health care which entails ‘informing and involving patients, eliciting and respecting their preferences; responding quickly, effectively and safely to patients’ needs and rights; ensuring that patients are treated in a dignified and supportive manner; and delivering well-coordinated and integrated care (Coulter 2004 cited in IAPO 2007:9).

1.8.1.3 Guidelines

Guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances (Field & Lohr 1990:38).

1.8.1.4 Patient-centred care

‘Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions’ (IOM 2001:40).

1.8.1.5 Person-centred care

‘An approach to practice established through the formation and fostering of therapeutic relationships between all care providers, older people and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development’ (McCormack, Dewing, Breslin, Tobin, Manning, Coyne-Nevin, Kennedy & Peelo-Kilroe 2010:13-14).

1.8.1.6 Woman-centred care

“Focuses on the woman’s individual needs, aspirations and expectations, rather than the needs of the institution or professionals” (Leap 2009:12).

1.8.1.7 *Maternal mortality ratio*

The annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100 000 live births, for a specified time period (World Health Organization 2015:30).

1.8.1.8 *Health care worker*

All people engaged in actions whose primary intent is to enhance health (World Health Report 2006:1).

1.8.2 Operational definitions

1.8.2.1 *Clients*

Women who use childbirth services in the health facilities.

1.8.2.2 *Women*

Women who use childbirth services in the health facilities and also participated in the study. In this study women and mothers will be used interchangeably.

1.8.2.3 *Doctor*

Medical officer irrespective of specialisation; and who work at the maternity wards in the health facilities.

1.8.2.4 *Experience*

The Oxford Advanced Learners Dictionary (2010:534) defines experience as things that have happened to people and influence the way they think and behave. In this study, experience refers to how doctors, midwives and women think, feel and behave regarding ante-natal, delivery and immediate post-natal services.

1.8.2.5 Guidelines

Suggestions and recommendations based on the findings of the study designed to assist health care workers improve the client-centredness of childbirth services in health facilities.

1.8.2.6 Midwife

A person who has been trained and has qualified to attend to women in labour (Kasner & Tindallie 1984:254).

1.8.2.7 Health professionals

Refers to doctors and midwives irrespective of grade or specialisation.

1.8.2.8 Childbirth services

Refers to ante-natal, delivery/labour and immediate post-natal services.

1.9 DETERMINING THE THEORETICAL GROUNDING OF THE RESEARCH

Client-centred care is an approach to care that includes ‘informing and involving patients, eliciting and respecting their preferences, responding quickly, effectively and safely to patient’s needs and rights; ensuring that patients are treated in a dignified and supportive manner; delivering well-coordinated, and integrated care (Coulter 2004 cited in IAPO 2007:9). In the Ghanaian health sector, client-centred care is seen as an innovation – a new process of providing services that focus on client’s needs, expectations and perspectives. It is seen as one of the approaches to assist quality improvement. Even after decade of introducing the concept of client-centred approach to care, there still seems to be many concerns about the quality of services. An examination of the approach can therefore not be over-emphasised.

The Diffusion of Innovation Theory by Rogers (2003) provides a useful theoretical framework for examining how client-centred approach to childbirth service provision has

permeated service delivery in Ghana. Rogers (2003:5-6) defines diffusion as the process by which an innovation or new ideas spread within social system overtime. He further states that innovation is an idea, practice, project, service or policy that is perceived as new by an individual or other unit of adoption (Rogers 2003:12). An innovation needs not be a new invention, as long as individuals perceive it as new, then it constitutes an innovation for them. A social system, as captured in the definition of diffusion of innovation, could be individuals, groups, or organisations. Rogers further propounds a five-step process through which individuals pass to evaluate and decide to adopt or incorporate a new idea into on-going practices. The steps are: knowledge of the innovation; persuasion; decision to adopt or reject the new idea; implementation; and confirmation of the decision. In addition, the attributes that make it easier or more difficult for an innovation to diffuse and be sustained at both the individual and organisational levels are: the relative advantage; the compatibility; the complexity; the trialability; and the observability (Roger 2003:221).

A number of researchers have adapted the diffusion theory but the model proposed by Greenhalgh, Robert, MacFarlane, Bate and Kyriakidou (2004:595) was employed in this study due to its relevance to the study objective and its focus on health care delivery. Greenhalgh et al's (2004:582) proposed model comprises the:

- Innovation attributes
- Individual adopter's factors
- The inner organisational contextual factors
- The external contextual factors
- The implementation and routinisation process factors

1.9.1 Innovation attributes

The innovation attributes delineated in Greenhalgh et al (2004:594-598) are: (1) *Relative advantage* – refers to the extent to which the innovation offers improvement over current methods; (2) *Compatibility* – refers to the consistency of the innovation with social practices and norms among its users; (3) *Complexity* – relates to the ease of use or learning of the innovation; (4) *Trialability* – entails the opportunity for users to try the innovation before committing to use it; (5) *Observability* – this attribute is the extent to

which the innovation outputs and gains are clear to see' and (6) *Re-inventability* – deals with whether the innovation can be adapted or modified to suit user's needs. Greenhalgh et al (2004:597) further state that many complex innovations can be conceptualised as having a 'hard core' (that is, the irreducible elements of the innovation itself) and a 'soft periphery' (that is, the organisational structures and systems required for full implementation) and that the adaptiveness of the 'soft periphery' is a key attribute for the innovation to be easily adopted. Equally important for adoption are: the level of perception of individual and organisational risk; the extent to which the innovation is relevant to the person's task; the knowledge required to use the innovation; and the availability of technical training or practical support to enable people use the innovation.

1.9.2 Individual adopter's factors

Greenhalgh et al (2004) noted that individuals go through a number of processes in the adoption of an innovation. They actively seek innovations, experiment, evaluate and modify them based on information often obtained from other users. This process is influenced by a mirage of individual psycho-social variables such as tolerance of ambiguity, motivation, values and learning style (Greenhalgh et al 2004:599). For most innovations in the health sector, the unit of adoption may not only be at the individual level but is often a team, department or the whole organisation. The adoption decision thus could be taken exclusively by authorities or through a formal collective decision-making process, evaluation phase, with planned and sustained efforts at implementation.

1.9.3 The inner organisational contextual factors

The existing organisational context influences the process of adopting an innovation. Greenhalgh et al (2004:604-610) suggested that there are two antecedents of innovation adoption at the level. These are system antecedents and system readiness for innovation. The system antecedent has three attributes, namely: the structure (for example, size); the absorptive capacity for new knowledge (for example, ability to identify, interpret, share and use new knowledge); and the receptive context for change (for example, availability of strong leadership and conducive climate for risk taking). Systems readiness relates to the tension for change in the organisation, how the

innovation will be able to fit into the existing systems, a comprehensive assessment of implications of adopting the innovation, availability of support and effectiveness of advocacy for change, providing dedicated time and resources for implementing the innovation, and having the capacity to monitor and evaluate the implementation of innovation.

Greenhalgh et al (2004:582) also underscore the notion that many innovations are spread through both passive and active means in organisations. The passive means are per word of mouth and through network. Active methods involve a number of deliberately planned dissemination activities (ibid). Diffusion is the passive spread while dissemination constitutes an active planned effort to persuade target groups to adopt an innovation (ibid). Both strategies are important for effective spread of the innovation in an organisation. There are various formal and informal channels and influences that facilitate the spread of an innovation. These include: the existing social networks, opinion leaders, champions, boundary spanners and use of formal dissemination programmes.

1.9.4 The external contextual factors

This component deals with the influences of the external environmental on the adoption of an innovation. The critical influencers are: the informal inter-organisational networks such as the extent to which other comparable organisations have done or intend to implement the idea; the intentional spread strategy of the proponents of the innovation; and political directives.

1.9.5 The implementation and routinisation process factors

This aspect covers activities involved in putting the innovation into use and includes process through which the new idea and the organisational characteristics are redefined and or restructured to get a good fit. The success of this process depends on many of the components already discussed. Mechanisms applied to clarify issues to make individuals in the organisation get a good understanding of the innovation and its implications; and the steps taken to make the innovation a routine are issues to consider. Key factors to address include funding arrangements, internal communication strategies, use of external collaborators, and continuous monitoring and evaluation of

the innovation. Greenhalgh et al (2004:612) stress that good linkage between all the elements outlined is vital. The three linkages discussed are: the linkage of the developers of the innovation with the intended adopters during the early developmental stages to capture and incorporate users' perspectives; the change agent should have the requisite capacity, commitment, technical skills and good communication skills to relate effectively with intended adopter; and if the decision is to use an external change agent, the selection criteria should be credible to gain users' commitment.

1.10 RATIONALE FOR USE OF THEORETICAL MODEL

The elements in Greenhalgh et al (2004:594-598) model offer relevant areas to study and understand issues associated with the adoption and implementation of client-centred childbirth in Ghana. A successful adoption and implementation of client-centred childbirth would mean that health facilities have put mechanisms in place to: elicit information on women's needs, expectations and preferences; and also respond effectively and safely to their needs, expectations and preferences. It would further mean that women are treated in a dignified and supportive manner through well-coordinated and integrated service delivery approaches so as to improve client experience and quality of childbirth services.

Furthermore, determining potential users' views on attributes of innovations which is expected to be extensively done at the initial stage of introducing the innovation (Fleuren, Wiefferink & Paulussen 2004:120), would have helped to tailor services to the needs of users. Considering the fact that the concept of client-centred care was introduced in the Ghanaian health sector more than a decade ago (Ghana Health Service 2007:13-14; Ministry of Health 2006:21), it was expected that the implementation of client-centred care would be largely at the implementation and routinisation stage of the model described in Greenhalgh et al (2004:582). This notwithstanding, the study examined the doctors and midwives understanding of client-centred care and its attributes as well as their experiences of implementing some of the key attributes of client-centred childbirth. Some factors and processes that influence the operationalisation or implementation of client-centred childbirth approach in health facilities were examined. Specifically, the steps that were taken to make doctors and midwives know and understand the tenets of client-centred care, how some key aspects of client-centred childbirth care were being implemented and whether the

approach to care was helping to improve the experience of women were examined. Finding answers to these variables required an assessment at both the individual healthcare provider and user levels; hence the study subjects were doctors and midwives who are the major childbirth service providers and women who use the services. The details of the conceptual framework are discussed in Chapter 2.

1.11 RESEARCH DESIGN AND METHODOLOGY

1.11.1 Setting

The study was conducted in Ghana, which is located in West Africa. The population of Ghana is estimated to be about 24.7 million with a growth rate of 2.4% (Ghana Statistical Services 2011:1). It is divided into 10 Regions with 216 Administrative Districts. Ghana is a multi-cultural, multi-ethnic and multi-religious country. It is politically stable and was classified as a lower middle income country in 2010 (Schieber, Cashin, Saleh & Lavado 2012:14). English is the official language. Average life expectancy is 64 years for females and 61 for males. As stipulated in the Ghana 2010 Population and Housing Census Report (Ghana Statistical Service 2013:92-98), 71.2 % of the populations profess the Christian faith while 17.6% are Muslim. Only a small proportion of the population of Ghana either adhere to traditional religion (5.2%) or are not affiliated to any religion (5.3%). Majority (74.1%) of the population from 11 years and older is literate. The main economic activities are agriculture, forestry and fishery. Further details on the health sector of the study setting are outlined in Chapter 4.

1.11.2 Study design

The fixed mixed methods design comprising both quantitative and qualitative methods (Creswell & Clark 2011:54) were used in the study. Mixed method study design was useful to capture the best of both quantitative and qualitative approaches (Creswell 2003:22). The study was also exploratory, descriptive and contextual in nature. In this regard, the explanatory sequential design (Creswell & Clark 2011:71) was also adopted.

The study was done in four (4) phases. Phase 1 used questionnaire to ascertain the client-centredness of ante-natal, delivery/labour and immediate post-natal services in the hospitals. In phase 2 of this study, the qualitative study was used to further explore

and describe the views and experiences of women who utilised childbirth services in the hospitals with focus on informed choice. Phase 3 also utilised qualitative methods to explore and describe the views and experiences of doctors and midwives on client-centred care. The meaning of client-centred care, the key attributes or characteristics and its implementation were explored. The views and experiences of doctors and midwives on informed choice (decision-making process) regarding key components of client-centred childbirth services were explored. Phase 4 used the findings from Phase 1, 2 and 3 as well as expert knowledge and consensus building approach to develop guidelines on the implementation of client-centred childbirth services in health facilities.

1.11.3 Phase 1: Questionnaire study to assess the factors that influence client-centeredness of the care given to women from ante-natal to immediate post-natal period

1.11.3.1 Design

Quantitative study design was used at this stage. A questionnaire was used to assess and describe the client-centredness of childbirth services from ante-natal through to immediate post-natal period. The expanded Hospital Consumer Assessment of Health care Providers and Systems (HCAHPS 2012) questionnaire and the Picker Women's Experience of Maternity Care questionnaire (Picker Institute Europe 2010) were adapted and pretested to make it culture fair before being used for the study. The first draft of the tool(s) were discussed with my supervisor and then with a sample of doctors and midwives to determine its relevance, comprehensiveness, readability and applicability or feasibility and then pre-tested in two primary level hospitals before finalisation. The details of the process of developing the tools are provided in Chapter 4.

1.11.3.2 Population, sampling technique and sample

All women who used childbirth services in the hospitals constituted the population of women. The temporal (period) sampling technique was used. All women delivering (both vaginal and Caesarean section) at the hospital during the period of data collection were invited to participate in the study. Temporal sampling was used because it would have been difficult to obtain a suitable sampling frame to facilitate the use of a more objective sampling method.

Excluded in the study were:

- Women below 18 years of age who were not accompanied by their spouse/parent/guardian to give consent to participate in the study.
- Women who had observable psychiatric or substance-abuse problems.

1.11.3.3 Data collection

Data were collected throughout the week between 8 am and 6 pm. Trained research assistants administered the questionnaire(s). All women who meet the inclusion criteria were approached immediately on discharge but while still on the ward to inquire their willingness to participate in the study. This approach was adopted because experience from previous studies found that it would be difficult to trace mothers once they left the maternity wards. Interviewing the women immediately on discharge or receipt of service also helped to control for changes in perception and recall. The research assistants first sought the consent of the women and proceeded to administer the questionnaire only when they agreed to participate. The research assistants read out all the questions and possible answers to each individual and recorded response. Each completed questionnaire was numbered with a unique identification number. The researcher provided daily supervision.

1.11.3.4 Data analysis

Data were coded and captured in Excel and transferred to STATA version 13 for the analyses. Data were checked for completeness, coded and checked for accuracy. Descriptive statistics including means, standard deviations, and medians were calculated. Items were grouped under the different dimensions and scores assigned to those that could be scored on a scale. The scores for negative questions were recoded so that positive responses had higher scores compared with negative responses. To calculate the dimension scores, missing data of relevant items were addressed by calculating the mean score of the total number of responses. The dimension score was calculated as the sum of the standard score obtained in each dimension divided by the maximum dimension score obtainable (that is, the numbers of applicable standard(s) multiply by applicable items) expressed as percentage. The outcome variable the

'overall client-centred care score' was computed. The scores were then classified as "excellent client-centred care" if the score is 75% or more, "needing more room for improvement" category was for a score of between 55-74%, and "having to do a lot of work" category was for scores below 55%.

To investigate the predictors for 'excellent client-centred care', the 'more room for improvement' and 'having to do a lot of work' categories were collapsed so that the outcome of interest was defined as "1" for excellent client centred care and "0" otherwise. The independent variables used for this analysis were the socio-demographic characteristics and other general items (see Annex 1 for copy of questionnaire). Mean and standard deviations were reported for all continuous variables that were normally distributed. Fishers' Exact test and the Chi-square test of association with their corresponding p-values were used to detect associations between each categorical predictor (socio-demographic factors) and the binary outcomes (excellent client-centred care). Crude odds ratios were estimated from simple logistic regression analysis and corresponding confidence intervals were estimated to determine variables required for the multivariable regression analysis. Binary logistic regression technique was used to assess the effects of socio-demographic factors on excellent client-centred care. Goodness of fit test of the logistic regression model was based on Hosmer-Lameshow Goodness of fit statistic respectively. Unless otherwise stated, significant association was observed at 95% degree of confidence ($p < 0.05$).

1.11.4 Phase 2: In-depth interview with women on their views and experiences with childbirth

1.11.4.1 Design

Using semi-structured interviews, data were gathered from women on their views of and experiences with client-centred childbirth services. This approach was suitable for gaining in-depth information and additional perspectives on client-centred childbirth in Ghana.

1.11.4.2 Population, sampling technique and sample

All women who used childbirth services in the catchment areas of the hospitals constituted the population of women. Using purposive sampling technique, women who delivered at the hospitals during the period of data collection and who were willing to be part of the study, were recruited by the researcher through the ward in-charges. Nineteen (19) women agreed to participate in the study. However, the interviews were stopped after the fifteenth (15) participant when the point of theoretical saturation was reached.

1.11.4.3 Field work

Most of the mothers agreed to be interviewed just after discharge. However, a few arranged to be interviewed on their first post-natal visit which took place a day after discharge. Issues of confidentiality, anonymity and consent were discussed during recruitment but were repeated prior to the interviews. The timing of the interviews was also appropriate as it offered the opportunity to limit any recall bias due to time lapse. Interviews were conducted by the researcher and were held in an office at the hospital premises. Each interview was audio-taped and field notes were taken on observations during data collection.

1.11.4.4 Data analysis

All interviews were transcribed and analysed using Miles and Huberman's (1994:58) proposed steps for qualitative data analysis. Audio tapes were transcribed by two transcriptionists after which they were all reviewed by the researcher. An independent reviewer was engaged to review 30% of the transcripts against the audio tapes independently for consistency. The products were consistent with the original scripts. Meetings were organised with the women during one of their post-natal visits to the hospitals to discuss the content of the transcripts. As regards analysis, data reduction was done through coding, segmenting and summarising the content of transcripts in relation to pre-determined categories (ibid). Transcripts from interviews and field notes were reviewed systematically to identify codes. Other categories were identified based on the data. Similarities, variability and ideas relevant to the aim of the study were noted. The researcher reviewed the scripts and codes several times to ascertain

consistency. The analysis identified emerging patterns and then generated themes. The generated categories and themes were further checked and refined in relation to the codes. One other independent reviewer and my supervisor reviewed the scripts, codes, themes and categories for consistency. Chapter 4 presents further details on methods used in this phase.

1.11.5 Phase 3: In-depth interview with doctors and midwives views and experiences with implementation of childbirth services

1.11.5.1 Design

Similar to the methods used in phase 2, qualitative study design using a semi-structured interview was used in this phase. Data were gathered from doctors and midwives on their views of and experiences with providing client-centred childbirth services.

1.11.5.2 Population, sampling technique and sample

The population of health professionals includes all doctors and midwives offering childbirth services in the selected health facilities. All doctors (30) and midwives (55) working in the maternity units were invited to participate. The number that agreed to participate was four (4) medical officers and twenty one (21) midwives. Using the saturation theory methodology (Bowen 2008:137), the interviews were terminated after the 19th participant. The final number of participants was thus nineteen (19) comprising two (2) doctors and seventeen (17) midwives.

1.11.5.3 Field work

Interviews were held in an office at the health facility premises on the scheduled date and time with the participants. Interviews were conducted by the researcher. Each interview was audio-taped. Field notes were also taken on observations during data collection.

1.11.5.4 Data analysis

The Miles and Huberman's (1994) model, comprising three concurrent components: data reduction; data display; and drawing and verifying conclusions were used in analysis. Data from interviews were transcribed by two professional transcriptionists. The transcripts were reviewed by the researcher against the tapes. Prior to analysis, an independent reviewer was engaged to review 30% of the transcripts against the audio tapes independently. The products were consistent with the original scripts. The transcripts were discussed with the doctors and midwives on phone for agreement. Data reduction was done through coding, segmenting and summarising the content of transcripts in relation to pre-determined categories (ibid). Transcripts from interviews and field notes were reviewed systematically to identify codes. The analysis was both deductive and inductive analysis. Other categories were identified based on the data. Similarities, variability and ideas relevant to the aim of the study were noted. The researcher reviewed the scripts and codes several times to ascertain consistency. Analysis identified patterns to generate themes. The generated categories and themes were further checked and refined in relation to the codes. One other independent reviewer and my supervisor reviewed the scripts, codes, themes and categories for consistency. Chapter 4 presents further details on methods used in this phase.

1.11.6 Phase 4: Development of guidelines on client-centred childbirth

Health care professionals are required to apply knowledge and expertise that reflects current best practice to meet client's needs and expectations. The findings of the quantitative and qualitative studies in addition to information gathered from international and local literature review was used to develop guidelines for application of client-centred childbirth in Ghana.

The process of guidelines development followed the key steps recommended by the World Health Organization (2003:5). A draft of the guidelines was developed by the researcher and presented to a six-member team of local experts for review. Consultations were also held with five key informants and five users. The draft guidelines document was reviewed by a group of 27 senior health professionals made up of directors of Ghana Health Services and other policy makers, doctors, nurses, midwives, and health services administrators at a workshop session to build consensus.

The objective of the stakeholder review was to ascertain the comprehensiveness of the guidelines, gather additional information, and determine the applicability and or feasibility of the tenets of the guidelines. Details of the process of guidelines development is presented in Chapter 8.

1.12 SCIENTIFIC RIGOUR

1.12.1 Qualitative study

The four criteria of trustworthiness put forward by Lincoln and Guba (1985:301-318): credibility; transferability; dependability; and applicability were used to establish the trustworthiness of the qualitative study.

1.12.1.1 *Credibility*

This refers to the confidence one can have in the truth of the findings. Cohen and Crabtree (2008:334) states that activities that increased the credibility of findings are: triangulation, peer review or debriefing, external audits/auditing, member checking, prolonged engagement, negative case analysis, iterative questioning, background qualifications and experience of the investigator and examination of previous research findings. This assertion was also mentioned in Shenton (2004:65- 69) and Creswell and Miller (2000:126-129). In this study, three approaches that were used to assure credibility are:

- Methods triangulation - semi-structured interviews and use of field notes- were used to elicit data on client-centred childbirth. In addition, the study seeks to compare views from different perspectives such as doctors, midwives and nurses, and clients. These enhanced data source triangulation.
- Peer review or debriefing – the entire research process was reviewed by one independent reviewer and my supervisor who are experts in the field and the applied research method.
- Member checking – interview transcripts were discussed with all interviewees to check accuracy of facts and observations.

1.12.1.2 *Transferability*

Shenton (2004:70) outlines that to enhance transferability, researchers should clearly indicate: the number of organisations taking part in the study; inclusion and exclusion criteria; number of participants; data collection methods; duration and time periods of data collection. Transferability was attained through clear description of these processes and all aspects of the methodology.

1.12.1.3 *Dependability and confirmability*

It is generally noted that dependability and confirmability are primarily achieved through the use of audit trails. In this study, dependability and confirmability were promoted through inquiry audit. One independent reviewer using the coding scheme of the researcher selected at random and reviewed 30% of the transcripts and codes. The independent reviewer also reviewed the themes and the categories. My supervisor examined documentation on all the steps in the research and the findings for consistency. My supervisor authenticated the write-up on the methodology, tape recordings of interviews, transcripts and outline of data analysis. A panel of experts will review the whole research.

1.12.2 Quantitative study

1.12.2.1 *Reliability*

Reliability concerns the stability of what is being measured on more than one occasion (Langdridge 2004:35). Reliability was ensured by documenting all procedures that were carried out in the development and conducting of the study so that future researchers could replicate the study. Additionally, the research assistants were given a two-day training to enable them to conduct the interview sessions in the same manner for all the participants. This was done as a means of standardising the processes to limit external sources of variations. The researcher re-interviewed 30% of the interviewees during the pre-testing stage to assess inter-rater reliability. They obtained concordance rate of 86%. The internal consistency reliability of items of the questionnaires was determined using STATA MP Version 13.

1.12.2.2 Validity

Validity refers to the degree to which a test or other measuring device truly measures what it is intended to measure (Langdrige 2004:35) and performs as it is designed to perform. Some approaches of testing validity are content validity, construct validity and predictive validity. Content validity is concerned with a test's ability to include or represent all of the content of a particular construct while concurrent validity refers to a measurement device's ability to vary directly with a measure of the same construct or indirectly with a measure of an opposite construct. Predictive validity relates to the ability of a test to predict future behaviour. Content validity was assured in this study through the following means:

- The questionnaire was adapted from tool(s) that have been used extensively and had high reliability and validity ratings. An extensive review of the literature was conducted to enrich the tool.
- The draft tool(s) were discussed with my supervisor and then with a sample of 10 senior health professions (doctors and midwives) to determine its relevance, comprehensiveness, readability, conceptual clarity and applicability or feasibility.
- The draft tool(s) were presented to a cross-section of local experts at a workshop session to build consensus on items.
- The second draft of the questionnaire(s) was pre-tested in two selected hospital that did not take part in the main study.

1.13 ETHICAL CONSIDERATIONS

Approval was obtained from the Research Ethics Committee of the Ghana Health Service/Ministry of Health (see Anexure 11). Ethical approval was also obtained from the Research Ethics Committee of the University of South Africa (see Anexure 12). In addition, participation in the study was with the consent (verbal and/or written) of the participants. The participating hospitals, gave permission for the study to be conducted. The notices to the hospitals outlined the purpose and objectives of the study, doctors and midwives that will be involved, mode of recruitment and how data will be gathered. The participants could opt out of the research at any stage without being penalised or victimised. Refusal to participate or to continue did not lead to any loss of personal benefit. In adherence to the principle of anonymity and confidentiality, no names were

required on the questionnaire. Coded identifiers were used in the interview recording or transcripts. The responses cannot be linked to any individual health professional or woman as only group statistics was produced. Copies of the typed transcripts were offered to participants for verification. A copy of the participants informed consent form is attached in Annexure 2.

1.14 STRUCTURE OF THE THESIS

The thesis is in seven chapters.

Chapter 1 provides an overview of the entire research. The background captures the global and national importance of client-centred care. An overview of the research methodology is also presented.

Chapter 2 discusses details of the theoretical or conceptual framework of the study based on the diffusion of innovation theory. The chapter presents relevant literature supporting the use of diffusion of innovation theory in health care.

Chapter 3 presents the literature review on client-centred care under the overarching principles underlying quality in health care. The concept of client-centred care in general and specifically in maternity care as well as the factors that influence client-centred care practice in health care are delineated. The literature on the major variables that influence client-centred childbirth are discussed.

Chapter 4 is the methodology. The chapter describes in detail the research design, population, sampling technique, sample, data collection and data analysis. Issues of validity and reliability of quantitative methods as well as measures employed to ensure trustworthiness of qualitative approaches are described. Included are ethical considerations.

In Chapter 5, the result of the quantitative study on the client-centredness of childbirth services are presented and discussed. This chapter is in two parts. The first part presents the results and the second part is on the discussion.

Chapter 6 presents the findings and discussion on the interviews with the women with the supporting literature.

Chapter 7 presents the findings and discussion on the health professional interviews with relevant literature.

Chapter 8 explains the process of developing the guideline and presents the final product.

Chapter 9 deals with the conclusion and recommendations of the study.

The letter from the statistician that assisted with the quantitative data analysis as well as the letter from the editor of the thesis are in Annexure 13 and Annexure 14.

1.15 CONCLUSION

There is growing international support for provision of client-centred care in all disciplines in health care. Many developed countries have gone very far in assessing and designing services to suit clients' needs and preferences. Developing countries like Ghana need to accelerate their efforts. The thesis explored the views and experience of the key players in the delivery of childbirth services, the health professions and the women who use the services. This study has the potential of facilitating the process to make services better for women. The schedule of activities for the field work and report writing is presented in Annexure 3.

CHAPTER 2

CONCEPTUAL FRAMEWORK

2.1 DIFFUSION OF INNOVATIONS THEORY AS IT APPLIES TO HEALTH CARE AND CLIENT-CENTRED CHILDBIRTH

The Diffusion of Innovation Theory in Rogers (2003) is generally seen as one of the pioneering theoretical frameworks for evaluating client-centred care. In this study, the model of diffusion proposed by Greenhalgh et al (2004) was employed due to its relevance to the study objective and to health care delivery. However, the discussion also incorporated aspect of Roger's conceptualisation where necessary, to provide a more comprehensive understanding. The literature review in relation to the application of the diffusion process generally and specifically in health care is also presented.

2.1.1 Definition and attributes of an innovation

Greenhalgh et al (2004:582) defined an innovation as a "set of behaviours, actions and new ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or user's experience and that are implemented by planned and coordinated actions. It also relates to new product, process, or structures. Inherent in this definition is the suggestion similar to Rogers (2003:12) that for a set of behaviour or actions to be classified as an innovation, it need not be a novel invention but so long as the unit of adoption deems it as new, it can be considered as an innovation. Furthermore, the objective of adopting the innovation should be to improve the aspect of the health system – inputs, process or outcomes for which it is being targeted.

It has been noted that adoption varies based on the attributes of the innovation. The study employed the proposed model of adoption of innovations in the health sector Greenhalgh et al (2004:594-597). The elements of the model are as follows:

- The innovation attribute
- Adoption by individuals

- Assimilation or adoption at the organisational level, and the contextual antecedents for innovation readiness
- The external context
- The implementation and routinisation process

2.1.2 The innovation attributes

The key attribute of an innovation that influences adoption are: the relative advantage; compatibility; complexity; triability; observability; and re-inventability.

2.1.2.1 The relative advantage

This is the extent to which the innovation offers improvement over current methods; for example, the effectiveness and cost-efficiency relative to alternatives needs to be made known. Innovations that have clear advantage in their effectiveness have a better chance of being adopted and implemented. If users do not perceive a strong relative advantage for themselves, there is little likelihood for successful adoption and implementation. Relative advantage alone may not be enough, as people make extensive efforts to understand what the innovation is about before adopting.

2.1.2.2 Compatibility

This refers to the consistency of the innovation with social practices and norms of not only the individual users but also the organisational norms, values and ways of working. It is the fit of the innovation to established ways of accomplishing the same goal. With regards to client-centred care, addressing compatibility would involve determining whether the principles are easily incorporated into the routines of the care provision. It is also imperative to ascertain whether the staff deems the tenets as essential.

2.1.2.3 Complexity

This attribute related to the ease of use or learning how to use the innovation. Innovations that are perceived as simple to use are adopted faster. Does the staff see the processes as simple or complex? Overcoming this process can be facilitated by

demonstration and practical experience. Study tours could be arranged for organisations that have implemented the concept for staff to learn.

2.1.2.4 Trialability

The adoption process is faster when adoptees get the opportunity to try the innovation before committing to use it. An example is conducting a pilot study for example in a ward or in few health facilities.

2.1.2.5 Observability

This related to the extent to which the gains from using the innovation are visible. As indicated in Robinson (2009:2), visible results lower uncertainty and also stimulate peer discussion of the new idea, as friends and neighbours of an adopter often request information about it. At the health facility level, this may require institutionalisation of mechanisms to make the benefits visible to all.

2.1.2.6 Re-inventability

This has to do with whether the innovation can be adapted or modified to suit users' needs. In other words, the success of any innovation would be how it is regularly reviewed to meet the needs and preferences of users. One mechanism of achieving this in client-centred childbirth would be regular assessment of client's views and using the findings to redesign services.

Additional attributes outlined by Greenhalgh et al (2004:598) are: *Fuzzy boundaries or systems fit* - The organisational readiness in terms of organisational structure and systems for implementation. The more adaptability the systems, the better for effective adoption; *Risk* - The level of perception of individual and organisational risk as compared to benefits and that people with regard the innovation as risky if it carries a high degree of uncertainty of outcomes; *Task issues* - the extent to which the innovation can help improve performance and people will be more favourable to adopt when it is relevant to performance improvement; *Transferability* – the ease with which knowledge can be transferred from one context to the other; and availability of technical support (augmentation support) in terms of customising the innovation, offering training and

making available a help desk. Innovations that are centrally developed are more likely to be widely successfully adopted if the perspectives of potential users are incorporated in the early stages (Greenhalgh et al 2004:612). Omachonu and Einspruch (2010:9) stressed the fact that individual perceptions of the innovation are very influential and that the different stakeholder especially in health (for example, physicians and other care providers, patients, organisations, regulatory agencies) have different needs, wants and expectations that must be met in the process. Fauveau and De Bernis (2006:183) further noted that for innovations to be adopted, they must be simple, easy to use, robust, low cost, safe and affordable and most importantly, users must be involved in the design.

As indicated, how each characteristic or attribute is perceived could affect the rate of adoption. Harting, Rutten, Rutten and Kremers (2009:226), in a study that used focus group discussion to understand the determinants of adherence to guideline among physical therapists in the Netherlands, stated that the participants mentioned several unfavourable opinions about the characteristics of the guidelines that hindered its effective dissemination. For example, while some felt it was useful, others thought it was not evidence-based. Most of the participants also received the guidelines to be too large and also not compatible with other competing guidelines (Harting et al 2009:227).

In this study, the innovation is the implementation of client-centred childbirth in Ghana. In the Ghanaian health sector, client-centred care could be seen as a new process of providing services that focus on clients' needs, expectations and perspectives designed to assist quality improvement. The key attributes of client-centred childbirth include: accessibility and reception; respect, courtesy, dignity and privacy; and respect for women's preferences regarding decision-making, place of birth, birth attendant, mode of birth, birth position, support during labour, labour pain management and length of stay after delivery (Registered Nursing Association of Ontario 2002:12; Picker Institute Europe 2004:9-10). Other attributes related to respect for socio-cultural, psychological and emotional needs, communication and information giving, integration and coordination of care, safety, continuity of care, empowerment and engagement and issues related to the build environment of the health facility. The literature on these attributes is presented later in this chapter.

2.1.3 Adoption by individuals

According to Rogers (2003:12), the rate of adoption generally follows a predictable S-curve, reflecting the relative degree of conformity or resistance to change of individuals within the system. The S-shape is due the initial slow rate of adoption, which then speeds up when a critical mass adopts and finally levels off as the number of individuals who have not yet adopted the innovation dwindles. The different categories of adopters based on the rate of adoption are: innovators; early adopters; early majority; later majority; and laggards (Rogers 2003:280). A pictorial depiction of these categories is in Figure 2.1. However, it must be noted that although most innovations have an S-shaped rate of adoption, the slope of the 'S' often varies from innovation to innovation, with some ideas diffusing more rapidly than others (Yuan, Nembhard, Stern, Brush & Krumholz 2010:1-2).

Innovators and early adopters are generally innovative seekers. They do not feel constrained by their colleagues. These people are very willing to take risks, and are often opinion leaders who are the first to develop new ideas. They are likely to be better educated, may be convinced by rational arguments, have social networks that supports change and some self-efficacy to try new practices before accepting or rejecting them (Rogers 2003:590). The *Early majority* group comprises those who wait to see some evidence of beneficial outcomes before adopting. They are rarely leaders but do adopt new ideas before the average person. *Late majority* people are skeptical of change, and will only adopt an innovation after the majority had tried it. The *Laggards* are characteristically resistant to change and may never adopt the new idea. These people are very conservative. They are very skeptical of change and are the hardest group to bring to accept new ideas.

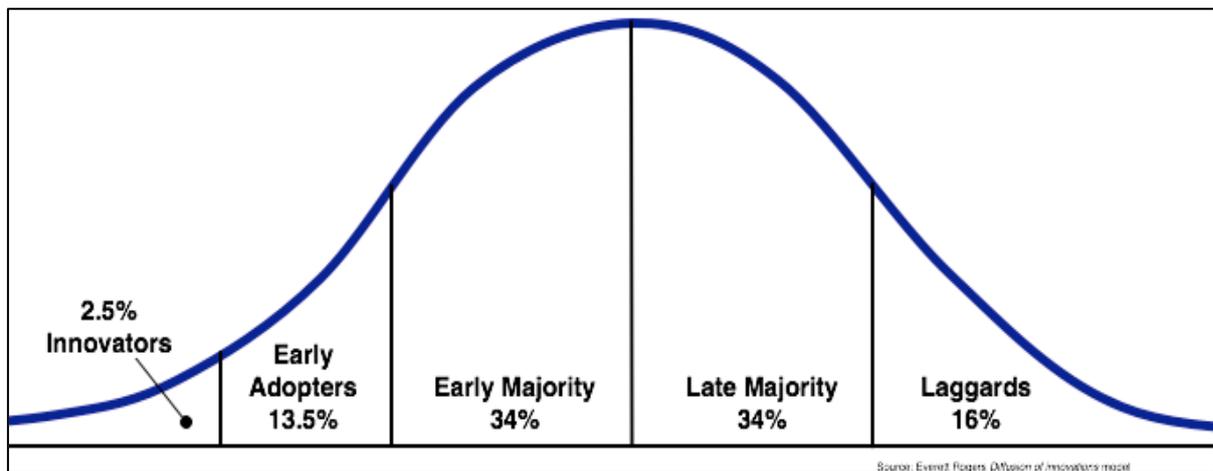


Figure 2.1 Rogers (2003) category of adopters

Also, Rogers (2003:590) outlined that the process of adoption at the individual level goes through five stages: awareness or knowledge (when the person or group begins to learn and know about a new innovation and gains some understanding of how it functions); persuasion (the person begins to form attitudes through interactions with others and engages in activities that lead to a choice to adopt or reject the innovation); decision (there is a drive to seek additional information and a decision is made); implementation (when the adopter utilises an innovation); and confirmation (occurs when the adopter seeks reinforcement of an innovation-decision that has already been made but continued use is justified or rejected based on the evidence of benefits or drawbacks).

However, Greenhalgh et al (2004:598) disagree with the categorisation of adopters by Rogers (2003:280). They argue that adoption does not happen or spread just by making people aware of the new innovation or evidence of effectiveness, but rather, it passes through an active process of evaluation of the nature of the innovation by individuals, professionals and communities based on their values, beliefs and social network. Greenhalgh et al (2004:599) noted that people actively seek innovations, experiment, evaluate and modify them based on information often obtained from other users. This evaluation process is influenced by a mirage of individual psycho-social variables such as tolerance of ambiguity, motivation, values and learning style. Also, a match between the meaning that one attaches to the innovation and that of the top management, service users and other stakeholders fosters early adoption or not. Greenhalgh et al (2004:599) further explain that 'meaning' is not fixed but could be negotiated and reframed through discourse and networking. Additionally, the decision to adopt is rarely

independent of other decision but may be contingent on decision by others, collective or authoritative (Greenhalgh et al 2004:600).

Despite acknowledging the usefulness of the propositions by Rogers on the different categories of adopters and stages in the process of adoption, Hall and Hord (1987) cited in Greenhalgh et al (2004:600) also stated that the staging fall short of adequately explaining the complex nature of the adoption process and rather proposed the Concern-based Model of Adoption with three stages (namely; early, early use and established use). Concerns during the early stages of the adoption were more self-oriented and relate to: being aware of the innovation; having or not having adequate information about what to expect and how to use it; and how the innovation would affect them personally. In the early use stage, concerns become more task-oriented and include ability to have continuous access to information about the innovation and sufficient training and support. In established users, focus of concern shifts to impact such as consequences of the adoption, having sufficient opportunity and autonomy and support to refine the innovation (Greenhalgh et al 2004:600). According to Hall and Hord (1987) cited in Greenhalgh et al (2004:600), the process of change can be more successful if the 'concerns' of the individual are considered.

2.1.4 Assimilation or adoption at the organisational level, and the contextual antecedents for innovation readiness

At the organisational level, the process of adoption is different in that the unit of adoption may not only be an individual but is often a team, department or the whole organisation. At this level, the process of adoption is more of assimilation where often a formal decision-making and planning for implementation, including a sustainability process is used (Greenhalgh et al 2004:561). For example, the adoption decision could be taken exclusively by authorities or through a formal collective decision-making process, evaluation phase, with planned and sustained efforts at implementation. Two antecedents of innovation adoption are put forward in Greenhalgh et al (2004:604-610) - systems antecedents and system readiness for innovation. The *system antecedent* has three attributes namely, the:

- structure (for example, size)

- the absorptive capacity for new knowledge (for example, ability to identify, interpret, share and use new knowledge)
- the receptive context for change (for example, availability of strong leadership and conducive climate for risk taking)

A large, mature, functionally differentiated and specialised, availability of resources to channel into new projects, decentralised decision-making structure organisation will normally have a faster process of adoption (Greenhalgh et al 2004:606). It must be indicated however that, structural innovativeness is moderated by or contingent on other factors such as radicalness of the innovation, whether it is administrative or technical and the stage of adoption. The absorptive capacity for new knowledge relates to the learning culture in the organisation (namely; the ability of the organisation to systematically identify, capture, interpret, share, reframe and recodify new knowledge and link it to its own existing knowledge base). Receptive context for change include effective and visionary leadership, clear strategic vision, climate conducive for experimentation and risk taking, and effective data management system (Greenhalgh et al 2004:607).

Organisational systems readiness for adoption also includes:

- the level of tension for change by the staff
- innovation system fit to existing values, norms and strategic goals; knowledge of the implications and what to expect
- availability of support and advocacy schemes; allocation of dedicated time and resources
- having the capacity to monitor and evaluate the innovation

At the level of organisational change, flexibility and responsiveness to wider pressures – the capacity to continue to adapt to current and foreseeable system is also very important (Martin, Weaver, Currie, Finn & McDonald 2012:197-198). English, Ntoburi, Wagai, Mbindyo, Opiyo, Ayieko, Opondo, Migiro, Wamae and Irimu (2009:[4-7]) described the contextual factors that hindered the implementation of interventions in developing countries such as Kenya as: high turnover of and reallocation of staff to other sections; inability to retain expert staff in remote and underserved areas;

challenges with structural and organisational arrangements for service delivery; lack of utilities such as electricity and water; inadequate equipment and logistics; and provision of substandard care.

According to the diffusion theory, innovations are spread through both passive and active means. The passive means are per word of mouth and through networks. Active methods involve a number of deliberately planned dissemination activities (Greenhalgh et al 2004:582). Greenhalgh et al (2004:582) further differentiate between diffusion and dissemination. Diffusion is the passive spread while dissemination constitutes an active planned effort to persuade target groups to adopt an innovation. This is supported in Dearing and Kreuter (2010:S101) who referred to dissemination as how evidence-based practices are communicated to potential adopters and implementers while diffusion occurs after dissemination and is a process where potential adopters seek advice from their colleague about adopting a new intervention. Effective adoption required both dissemination and diffusion of the new idea or practice (Bergman & Beck 2011:361). Greenhalgh et al (2004:601) provide more explanation that the two terms should be seen as a continuum between pure diffusion (where spread is unplanned, informal, decentralised and largely horizontal or mediated by peers) to active dissemination (where spread is planned, formal, often centralised and likely to occur through centralised hierarchy). Furthermore, Dearing and Kreuter (2010:103-108) wrote that the initial dissemination is important but not sufficient to precipitate interest, attitude formation and behaviour change that will lead to adoption of the innovation; social influence is very important. Adoption is not only about providing more messages, more channels, more support and more control or monitoring, more partnerships but innovations that take into consideration the beliefs, wants and practices of intended users have a greater likelihood of being positively perceived, as such, early involvement of partners increases successful adoption (Dearing & Kreuter 2010:103-108).

The various formal and informal channels and influences through which to spread an innovation include: existing social networks, opinion leaders, champions, boundary spanners and use of formal dissemination programmes. Different groups have different social networks and different use of different types of influences (Greenhalgh et al 2004:601) Horizontal influences such as use of peers are more effective in spreading innovations at the individual level than vertical ones which work better when passing authoritative decisions (Greenhalgh et al 2004:602).

Practitioners obtain information from various formal and informal sources (Belizan, Meier, Althabe, Codazzi, Colomar, Buekens, Belizan, Walsh & Campbell 2007:850). These include: use of printed materials and peers. Regarding printed materials, traditional approaches to improve uptake of research findings and other innovations have focused on better availability and presentation of evidence. This was done by identifying, synthesising, and disseminating evidence per reviews in clinical journals, provision of clinical guidelines, ensuring better access to electronic sources of information, continuing medical education courses, and conferences (Grol & Grimshaw 2003:1225). Findings on the effects of these approaches in the literature have been inconsistent. For example, Farmer, Légaré, Turcot, Grimshaw, Harvey, McGowan and Wolf (2011:10) found that the use of printed education materials such as guidelines in itself is often not very successful in improving practice. Some users even find these materials too long and at times complex or too impractical for use (Weiner, Helfrich, Savitz & Swiger 2007:S43). In terms of using peers, Pedersen, Brereton, Newbould and Nolte (2013:34-35), in a review of peer influence on effectiveness of interventions, concluded that though available evidence generally seems to support a positive impact of peer support worker schemes on person-centeredness of care, the impact of peer support approaches appears to be varied and highly dependent on the nature and setting of a given programme. For example, peer approaches in mental health settings appear to have very little positive impact on outcomes whereas in other areas the evidence is less consistent (Pedersen et al 2013:35).

In some instances, opinion leaders and champions were employed to assist in the dissemination or diffusion of innovations. It is believed that expert opinion leaders can influence through their authority and status and also that peer opinion leaders exert influence through their representativeness and credibility (Greenhalgh et al 2004:602). Likewise, it is assumed that in every society or grouping, there are certain people called champions that others turn to for advice about adoption of a new practice or innovation (Bergman & Beck 2011:363). The different champions' roles include one who gives the innovators autonomy from the organisational rules and procedures and systems so they can establish creative solutions to existing problems, the transformational leader who harnesses support from other members of the organisation (Greenhalgh et al 2004:604). Daniels and Lewin (2011:3-4) noted that effective diffusion of evidence-based practices in obstetric care in South Africa was facilitated by having a pool of

academics and key professionals that championed and advocated for effective implementation through personal contacts.

However, as noted by Greenhalgh et al (2004:604), adoption could be more successful if key individuals in the social networks are willing to support the innovation. Hendy and Barlow (2012:353-354) studied the effectiveness of champions in implementation of remote care. They found that though the champions were all committed and highly motivated at the early stages of implementation, at the latter stages when the scale of implementation widened and other stakeholders were directly involved some of them felt threatened by not having exclusive right to the work and this negatively affected outcomes. The findings of Hendy and Barlow (2012:353-354) also contradicted the assumption that greater engagement and identification with change agents increases the likelihood of adoption and organisational change. In the same vein, Greenhalgh et al (2004:602) cautioned that care should be taken in harnessing the influence of opinion leaders as this can produce unacceptable results.

The literature identified other strategies that were deployed to spread information on innovations as use of boundary spanners to link organisation to the outside world relationships, external change agents and use of women groups (Greenhalgh et al 2004:604; Lewycka, Mwansambo, Rosato, Kazembe, Phiri, Mganga, Chapota, Malamba, Kainja, Newell, Greco, Pulkki-Brännström, Skordis-Worrall, Vergnano, Osrin & Costello 2013:1723).

Spread and adoption are more successful if the change agent is employed from external organisation; is part of the dissemination; has good human relations and is supportive; facilitates networking and collaboration among organisations; is committed; has technical capabilities and project management skills (Greenhalgh et al 2004:613). Lewycka et al (2013:1723), in a study in Malawi, noted that using women's groups in the community and female volunteer peer counsellors produced positive results on maternal, perinatal, neonatal and infant mortality rates.

2.1.5 The external contextual factors that influence adoption of innovations

This component deals with the influences of the external environmental context on the adoption of an innovation. The critical influencers are: the informal inter-organisational

networks such as the extent to which other comparable organisations have done or intend to implement the idea; the intentional spread strategy of the proponents of the innovation; and political directive (Greenhalgh et al 2004:608-9). In their article on utilising the implementation of post-exposure prophylaxis for HIV, Norton, Larson and Dearing (2013:S77-S79) support the notion that a strong collaboration between primary care (preventive care sector) and public health (curative health sector) can be very fruitful in implementing health interventions. In addition, Reed, Conrad, Hernandez, Watts and Marcus-Smith (2012:3-7) also noted that the strategic decision to offer patient-centred care was greatly influenced by parent provider organisations and demands from patient-consumer. Weiner et al (2007:S43) found that it was easier for those health facilities that were involved in a quality improvement collaboration to implement the changes than those who were not.

2.1.6 The implementation and routinisation (sustainability) process

Implementation and routinisation cover activities involved in putting the innovation into use and includes process through which the new idea and the organisational characteristics are redefined and or restructured to get a good fit (Greenhalgh et al (2004:612). Implementation is what happens after adoption and refers to the 'how' of putting evidence into practice (Bergman & Beck 2011:361). On the other hand, sustainability is making an innovation routine until it reaches obsolescence (Greenhalgh et al 2004:582). Bergman and Beck (2011:361) refer to sustainability as the continuing use of the innovation and associated activities to achieve desired outcome. This process of implementation and routinisation depends on many of the components already discussed. Mechanisms to be applied need to be directed at clarifying issues to make individuals in the organisation get a good understanding of the innovation and its implications; and the steps taken to make the innovation a routine. The process begins with carrying out an in-depth analysis of challenges (Omachonu & Einspruch 2010:9) and then the development of an implementation plan with goals that are understood by all and which comprehensively addresses issues of staff development, recruitment of consultants or coaches to help facilitate implementation, funding and staff support mechanisms (Bergman & Beck 2011:363). Key facilitating issues include: employing a structure and process that support devolution of decision such as use of teams; continuing leadership and management support, commitment and advocacy; continuing motivation, competence building and involvement of practitioners; making dedicated

funding arrangements; effective internal communication strategies; promotion and use of external collaborators; and continuous monitoring and evaluation of the innovation (Greenhalgh et al 2004:612). Usually, different approaches are used at different level and periods to facilitate the process. Figure 2.2 presents the proposed conceptual framework for the study. The framework was developed based on the findings from the literature review.

2.1.7 Description of the proposed conceptual framework for the study

The study conceptual framework identifies three key dimensions: the attributes of client-centred childbirth; the conditions required for diffusion and the results or outcome of adoption. According to this framework, the major attributes important for effective adoption are: (1) how accessible services are and the kind of reception that women receive; (2) demonstration of respect, courtesy as well as promotion of dignity and privacy in the health facility; (3) respect for women's preferences and needs; (4) responding to socio-cultural and psychological needs of women; (5) effective communication and information giving; (6) existence of a well integrated and coordinated care; (7) ensuring safety of care; (8) promotion of continuity of care; (9) empowering and engaging women, families and communities in the design and care process; and (10) fostering an enabling built environment. the framework also acknowledge the fact that demographic charaterisitics of women as well as the condition of the newborn are influential.

The conceptual framework further indicates that how the attributes are perceived by both women and health professionals individually and collectively, the inner and external organisational factors, including processes used to enhance diffusion or dissemination as well as how client-centred childbirth care is operationalised greatly enhances or hinders adoption. Ultimately, the success or otherwise of adoption is demonstrated in the overall assessment findings, including the overall client-centred score.

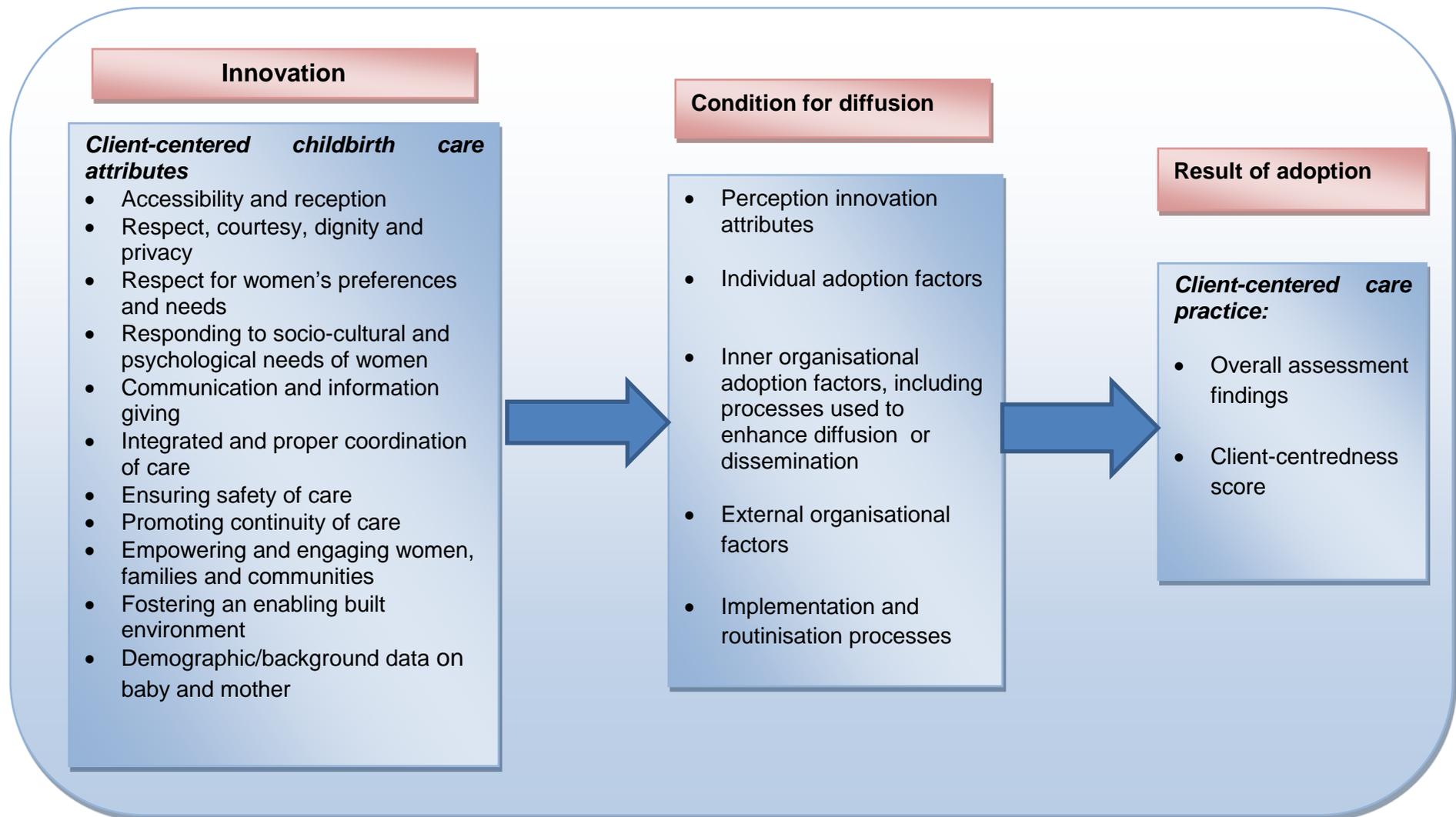


Figure 2.2 Conceptual framework for evaluating client-centred childbirth

2.2 ADOPTION OF INNOVATIONS IN HEALTH CARE

A number of diffusion of innovations studies were identified in the literature. However, as noted in Martin et al (2012:19), to date, many of the studies largely address only the initial phase of implementing change or adoption, focusing almost exclusively on the trialling and roll-out of novel approaches to care. Far less attention has been devoted to the question of how to sustain organisational change introduced with initial success. However, recognition is increasing, regarding the fact that apparently successful initial implementation of organisational innovations – such as reconfigured roles, revised protocols and new care pathways – do not always result in sustained, longer-term change (Martin et al 2012:190).

Martin et al (2012:192-198) conducted an in-depth interviews with key stakeholders (clinical leads and other clinicians, referring clinicians, business managers, commissioners and service ‘champions’) who were involved directly in an intervention on clinical genetics and concluded that leadership was a key factor in sustainability. Fujita, Perrin, Vodounon, Gozo, Matsumoto, Uchida and Sugiura (2012:483-487) assessed implementation of humanised maternity care and how it affected care providers in a hospitals in Benin and reported that initially the staff saw the practice as foreign and were very hesitant but with further training and support from top management and senior clinicians good outcomes such as improved communication, staff satisfaction, increased professional value and self-esteem were achieved. However, they noted inadequate human resource and funding as major challenges. Vedel, Lapointe, Lussier, Richard, Goudreau, Lalonde and Turcotte (2012:77-79) also noted that the sustenance or continuing use of a clinical information system was influenced by support from colleagues who acted as change agents and the perception of positive impact on use. Participants in Belizan et al (2007:848) believed that changes were more likely to be sustained if the staff received frequent reminders and if their behaviour was closely monitored by department administrators.

Implementing even seemingly simple health care innovations has proven to be challenging (Bergman & Beck 2011:363-364; Fauveau & De Bernis 2006:180). Many organisations often ascribe several reasons for not putting evidence into practice – workload, job satisfaction, lack of supportive supervision, inadequate training, lack of appropriate equipment and technology, reluctance from senior clinicians to

acknowledge benefits of innovations, inadequate budgetary allocations and many others (Fauveau & De Bernis 2006:180). For example, a study in Kenya noted that health professionals complained about poor communication and teamwork, organisational constraints, and limited resources, among others, for poor implementation of interventions (Nzinga, Mbindyo, Mbaabu, Warira & English 2009). Financial related barriers were also reported in Reed et al (2012:3-7).

In a study in United States of America, Yano, Goldzwei, Canelo and Washington (2006:233-234) noted that even after 10 years of adopting a policy on women's health clinics so as to provide more control, authority and privacy in care delivery, much is yet to be realised. Even when an evidence-based innovation is implemented successfully in one part of a hospital or clinic, it may spread slowly or not at all to other parts of the organisation (Berwick 2003:1970). The situation is no different in many developing countries. A study that explored the implementation of the breast feeding policy in Ghana showed that despite successes in adoption of breastfeeding by many mothers, policy implementation only focused on a part of the policy (exclusive breast-feeding) and not on early initiation of breastfeeding (Tawiah-Agyemang, Kirkwood, Edmond, Bazzano & Hill 2008:S46-S52). The same report noted that in many developing countries, policies are usually generated or modified based on WHO/UNICEF recommendations at workshops and through discussions in a fora but often not passed down effectively to the lower levels (Tawiah-Agyemang et al 2008:S46-S52). Concerns were raised about availability of policies and other learning materials as well as effective education of users on their use. Participants also reported staff shortages, inadequate health education and ineffective use of community strategies to facilitate implementation. Another study on the development and implementation of a computerised decision support system for health workers to use in maternal care in rural area in three developing countries in Africa, Baker, Tomson, Somé, Kouyaté, Williams, Mpembeni, Massawe, Blank, Gustafsson and Eriksen (2012:8-9) found poor distribution and utilisation of guidelines.

However, some studies noted positive findings. Brazier, Andrzejewski, Perkins, Themmen, Knight and Bassane (2009:683-689) conducted an intervention study that used communication strategies, individualised birth preparedness counselling during ante-natal care, community level campaigns using community outreach agents,

performing artists and local leaders to influence availability and quality skilled birth care in Burkina Faso. They found significant increases in births at intervention districts. In addition, Aglmand, Akbari, Lameei, Mohammed, Small and Arab (2008:6-7) report positive improvement in evidence-based practice and women satisfaction but acknowledged that participation and raised awareness among clinicians played an important role in the successful implementation of the guidelines. Furthermore, Thomson, Bilson and Dykes (2012: 259-263), in an initiative to reduce hospital-based constraints that disadvantaged breastfeeding in United Kingdom, observed positive outcomes. They attributed their success to the strong leadership at all levels of implementation, wide engagement and involvement of key partners through both formal and informal means (including formation of interdisciplinary teams, project board, audit and training teams to monitor adherence, celebrations of events, presentations at different fora, recruitment of champions in each facility to promote engagement with standards), and promoting activities such as giving consistent messages per training, learning materials and research evidence to change attitudes (Thomson et al 2012:259-263). In their view, the engagement revitalised interest, values and beliefs and gave doctors and midwives confidence to forge ahead (Thomson et al 2012:262). In a related study, Althabe, Buekens, Bergel, Belizán, Campbell, Moss, Hartwell and Wright (2008:1930-1938) reported successful implementation and sustenance in a cluster randomised controlled trial conducted in 19 public maternity hospitals in Argentina and Uruguay to ascertain outcome of implementation of a behavioural intervention. Their approach of implementation included use of facility teams comprising physicians, residents, or midwives as opinion leaders, extensive involvement of the teams in all the process – training, learning material development, regular monitoring and reporting, multi-faceted behavioural intervention (including selection of opinion leaders, interactive workshops, training of manual skills, one-on-one academic detailing visits with hospital birth attendants, reminders, and feedback). In a cross-sectional study, Barnett, Vasileiou, Djemil, Brooks and Young (2011:342) explored factors that either facilitated or obstructed the innovation implementation and diffusion in health care organisations in the UK. They reported that the role of evidence of proof of effectiveness, the function of inter-organisational partnerships, the influence of human-based resources such as champions, and the impact of intra-organisational and extra-organisational contextual factors were considered an integral part of the process of developing, establishing and diffusing the innovations.

Regarding the scale of implementation, while some projects start with pilots (Patil Abrams, Klima, Kaponda, Lesshabari, Vonderheid, Kamanga & Norr 2013:[6]), others were more centralised (Department of Health, United Kingdom 2007:17-26). For example, the implementation of the policy to improve choice in childbirth was more centralised with active involvement of governmental and prescriptions on approached and frameworks (Department of Health, United Kingdom 2012) to aid implementation, this is supported by Patel and Rajasingam (2013:605-606).

2.3 CONCLUSION

In this chapter the Diffusion of Innovation Theory model as espoused in Greenhalgh et al (2004) was presented as the conceptual framework that underpinned the study. The rationale for the choice of the Theory was put forward. It must be indicated that though a number of the elements of the Theory were examined, more focus was paid to the implementation and routinisation component of the Diffusion of Innovation Theory model. The attributed of client-centred childbirth, the approaches used to create awareness and promote the conditions for adoption among health professionals and how the innovation was being implemented to improve the experience of women were examined.

CHAPTER 3

LITERATURE REVIEW

3.1 INTRODUCTION

Patient/client centred care is increasingly being regarded as one of the best-practice approach to health care quality improvement. This is based on the emerging evidence that a health care system that is truly patient-centred is likely to provide higher quality health care with greater efficiency and also improve patient experience (Clif 2012:86; Joint Commission 2010:1). This literature review focuses on the background literature and issues related to the concept of quality and the evolution of patient/client-centred care as a key dimension of quality. It covers literature on conceptualisation of patient/client-centred care and its influence on health outcomes including childbirth service delivery. Special attention is paid to variables that have been found to be important to women with regards to client-centredness of childbirth. Multiple sources of literature, both published and unpublished were reviewed.

3.2 THE CONCEPT OF QUALITY IN HEALTH CARE

Quality in health practice dates back to the Hippocrates era and has gone through series of changes (De Jonge, Nicolaas, Van Leerdam & Kuipers 2011:338; Raven, Tolhurst, Tang & Van den Broek 2012:e677) The upsurge of research work in the 21st century to define, measure and improve quality of health care; however, arose out of growing demand for health care, rising costs, constrained resources, evidence of variations in clinical practice, and need for efficiency and cost effectiveness (Campbell, Roland & Buetow 2000:1611).

Initial definitions of quality in health care generally focused on professional standards and outcomes. Donabedian (1980:5), one of the first proponents of quality in health care, defined quality health care as application of medical science and technology in a manner that maximises its benefits to health without correspondingly increasing the risks. In other words, the degree of quality is the extent to which care provided is expected to achieve the most favourable balance between risks and benefits. In further

conceptualisation, Donabedian (1988:1745-1746) noted that quality in a health care setting is dependent on three dimensions: structure, process, and outcomes. The structure reflects attributes of the physical environment, the process reflects the step-by-step way of carrying out activities, and outcomes are the end results of health care such as patient satisfaction and the status of patient at discharge. However, Campbell et al (2000:1612-1614) argue that 'outcome' as identified in Donabedian (1988) is not a component of care but a consequence of care. Likewise, 'structure' should not be seen as a component of care but the conduit through which care is delivered and received. Rowmer and Aguilar (1998:3) define quality health care as 'degree to which the resources for health care or the service included in health care corresponds to specific standards'. Quality health care is also defined as doing the right thing, at the right time, in the right way for the right people to produce the best possible results (AHRQ, 2006a:33). Coulter, Fitzpatrick and Cornwell (2009:2) said quality consists of three components, namely: patient safety; clinical effectiveness; and patients' experience.

These definitions and dimensions notwithstanding, the definition proposed by the IOM (1990:21) 'degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' appears to capture very well the features of many of the other definitions and has also received wide acceptance and will be applied in this study'. The IOM (2001:39-54) further specified that quality comprised six dimensions:

- Safety – avoiding injuries to patients from the care that is intended to help them.
- Effectiveness – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- Patient-centeredness – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timeliness – reducing waiting times and harmful delays for both those who receive and those who give care.
- Efficiency – avoiding waste, including waste of equipment, supplies, ideas, and energy.

- Equitability – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

The IOM further points out that any comprehensive assessment of quality should address all these dimensions.

3.3 QUALITY OF CHILDBIRTH CARE

World Health Organization (WHO 2012) reported that maternal and infant morbidity and mortality rates in developing countries were high. Of the 536,000 women that died in 2005 due to complications of pregnancy and childbirth, 99% were from developing countries with sub-Saharan Africa countries accounting for about 50% of the deaths. WHO (2012) further stated that these deaths are clearly related to poor quality and could be prevented if all women received high-quality care during pregnancy and childbirth; hence the calls for reform both globally and nationally to improve quality.

Hulton, Matthews and Stones (2000:9) define quality maternity care as the degree to which maternal health services for individuals and populations increase the likelihood of timely and appropriate treatment for the purpose of achieving desired outcomes that are both consistent with current professional knowledge and uphold basic reproductive rights. The definition highlights quality of care provision and quality of care experienced by the user. This is supported by Raven et al (2012:e679) who stated that quality care standards should not only be limited to only professional standards but should also be acceptable to women and their families. Several initiatives have been implemented to help improve maternal care; however, progress in the past few decades has been slow (Bowser & Hill 2010:6; Althabea, Bergelb, Cafferatac, Gibbonsa, Ciapponia, Alemánc, Colantonioa & Palacios 2008:51-58). The plateauing of progress has been partly attributed to unacceptable provider-client interpersonal and other economic and geographic barriers that impede utilisation of skilled birth attendance services in health facilities (Bowser & Hill 2010:6; Raven et al 2012:e676; Althabea et al 2008:51-58).

In a systematic review of interventions to improve the quality of maternal and childcare in low- and middle-income countries, Althabea et al (2008:515-8) found that most of the services were either ineffective or had small to moderate effect on outcomes. In

addition, in another study to identify why women refused to deliver in hospitals in Brazil, Jamas Hoga and Tanaka (2011:696) reported the following reasons: inadequate beds; lack of accommodation for companion; inadequate privacy, services not designed to meet the individual needs of women; performance of unnecessary procedures and interventions; inadequate information on condition and procedures; lack of attention to mothers' questions; poor interpersonal relationships between staff and women. Furthermore, Snowden, Martin and Jomeen (2011:[8]) assert that there is still dominance of western patriarchal medical discourse within maternity care that continues to subordinate women. In some countries, many women do not deliver in health facilities because the staff members are deemed to be unfriendly and non-responsive. Bowser and Hill (2010:9) stated that childbirth service in most developing countries is characterised with too much disrespect and abuse - physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities.

Unfortunately, some of these abuses are perceived as a normal practice in the some societies (Bowser & Hill 2010:15-17). People may not use services when they are perceived to be disrespectful of women's rights, needs and preferences. Additionally, the lack of community and client-engagement measures, ineffective leadership, lack of knowledge and skills of both care providers and clients on standards of respective care; and enforcement of policies, guidelines and laws designed to leverage respective care all serve to propagate the disrespected practices (Bowser & Hill 2010:15-24; SEA-ORCHID Study Group 2008:2-6; Conde-Agudelo, Rosas-Bermudez & Gulmezoglu 2008:1555). Abusive behaviour and collection of illegal fees were also reported in Akin-Otiko and Bhengu (2012:e896-e897). Similarly, in a study on attitudes and beliefs about the uptake of hospital childbirth services using individual interviews and group discussions, Mwangome, Holding, Songola and Bomu (2012:[4-7]) noted that barriers to seeking skilled attendants included lack of resources (monetary, transport and access), customer care (lack of partnership between mothers and doctors, and mothers and midwives), and knowledge and beliefs (lack of knowledge about pregnancy and maternal health). Similar findings were reported in studies in Ghana (Tuncalp, Hindin, Adu-Bonsaffoh & Adanu 2012:[3-6]; Dzomeku 2011:32-34).

Despite the agreed importance among maternal health and human rights stakeholders of achieving respectful, non-abusive birth care for all women, there has been a relative

lack of formal research on this topic, especially in developing countries (Romano 2010:53; Bowser & Hill 2010:3). A vast majority of research in childbirth focuses on interventions that are solely in the realm of the providers (Belizán, Belizán, Mazzoni, Cafferata, Wale, Jeffrey & Vij 2009:155). Maternal and child health research needs to be directed toward innovative interventions involving consumer participation, particularly those that can be implemented in middle- and low-income countries where the accessibility and quality of the health systems are poor (Romano 2010:53; Belizan et al 2009:155). Every patient has a unique set of needs that require specific attention. Quality of care should offer women dignity and should avoid those aspects of care that are disrespected and unnecessary (Raven et al 2012:e680); hence the call for client-centred maternity care.

3.4 MATERNAL HEALTH CARE IN GHANA

It is important to understand the issues of maternal health care service delivery and quality in sub-Saharan Africa and Ghana in particular. The state of maternal, newborn and child health in sub-Saharan Africa is well summarised in Kinney, Kerber, Black, Cohen, Nkrumah, Coovadia, Nampala and Lawn (2010:2). According to Kinney et al (2010:2), every year 4.4 million children, including 1.2 million newborns and 265,000 mothers die in sub-Saharan Africa. The five biggest challenges for maternal, newborn, and child health in sub-Saharan Africa include among others pregnancy and childbirth complications. Though many of the scientifically proven health interventions for maternal, newborn, and child health are available, the knowledge is often not effectively used to save women's and children's lives. This situation is similar to what is happening in Ghana.

According to Mayhew (2004) cited in Ghana Statistical Service, Ghana Health Service and Macro International Inc (GSS, FHS & MII 2009:4), the 1994 International Conference on Population and Development (ICPD) in Cairo sparked important changes in Ghana's reproductive health policy. In 1995, the Ghana Health Service (GHS) launched the National Safe Motherhood (SM) Programme to reduce maternal mortality and morbidity through improving the quality and coverage of maternal health services, and to increase awareness about maternal health issues in communities (Osei, Garshong, Owusu-Banahene, Gyapong, Tapsoba, Askew, Ahiadeke, Killian, Bonku, Combarry & Sampson 2005:1). The focus of this improvement programme

included: the management of both routine and risk conditions in ante-natal labour/delivery and postnatal care (Osei et al 2005:1). With the adoption of the Millennium Development Goal (MDG) in 2000, one of the policy areas that the Government of Ghana focused on was institutionalisation of measures to increase skilled birth attendant coverage so as to reduce maternal morbidity and mortality. The Government of Ghana also undertook a comprehensive revision of reproductive health policy, and finalised the new Reproductive Health Policy and Standards in 2003 (Mayhew 2004 cited in GSS, GHS & MII 2009:4). To promote access and address financial barriers to maternity services, the Government introduced free maternal health care in all health facilities (Ganle, Parker, Fitzpatrick & Otupuri 2014:2).

The interventions aimed at addressing Ghana's maternal mortality burden include: the Safe Motherhood programme; High Impact Rapid Delivery (HIRD); and policy-oriented data gathering using Maternal Mortality Surveys, Maternal Death Notification and Maternal Death Audits (Ministry of Health, Ghana 2008b:7). Another process measure is the Focus Ante-natal Care (FANC) which is designed among other things to offer comprehensive focused individualised care (Ministry of Health, Ghana 2008b:7). Initiatives such as the Community-based Health Planning and Services (CHPS) programme and the Regenerative Lifestyle and Nutrition Programme (RLNP) are also designed to provide health care services and other assistance to pregnant women (GSS, GHS & MII 2009:3). Another effort to increase availability of services and decrease access problems has been for midwives to conduct home deliveries (GSS, GHS & MII 2009:5-6).

It should be noted that with these efforts and other investments in health care, maternal mortality decreased from 760 to 380 maternal deaths per 100,000 live births from 1990 to 2013 (WHO 2014a:38). Despite this huge success, Ghana was not able to achieve the target set for the MDGs to reduce maternal mortality rate of 214 per 100,000 live births to 54 per 100,000 live births by 2015 (Ministry of Health, Ghana 2008b:6). Evidence suggests there are problems for the three core areas identified as essential to improving maternal health – family planning, skilled care at delivery and emergency obstetric care (Ministry of Health, Ghana 2008b:6). There is still inequality of access to skilled care at delivery. Access is dependent on regional location and income status (Ministry of Health, Ghana 2008b:6).

Major causes of maternal deaths are: postpartum Haemorrhage; hypertensive disorders; unsafe abortion; anaemia; and sepsis (Ministry of Health, Ghana 2008b:6). Several organisational factors such as lack of basic infrastructure such as water and power supplies, blood transfusion services and theatres, poor geographical access to facilities and referral services contribute to the state of affairs (Ministry of Health, Ghana 2008b:7). Studies have also revealed that factors influencing women's health-seeking behaviour and utilisation of childbirth services include socio-economic status, culture, gender, environmental conditions, self-esteem, family influence and providers' attitudes (Awuah-Peprah 2014:104; Arthur 2012:7-8; Yakong, Rush, Bassett-Smith, Bottorff & Robinson 2010:2437-2439).

Childbirth care is generally poor in many regions of Ghana (Ministry of Health, Ghana 2008b:7). Turkson (2009:68) reports that perceived poor attitude of some health workers, long waiting times, high cost of services, inadequate staff, policy of payment for some health services, frequent referrals and lack of ambulances at facilities were some of the factors that affected delivery of quality health care in health facilities in Ghana. A study in Ghana identified that the key predictors of satisfaction and for that matter client-centred care were: friendliness of the front desk staff or receptionists; amount of information provided about condition and care; provision of information on channels available to lodge complaints; and being treated with respect (Avortri, Beke & Abekah-Nkrumah 2011:231). Another study in 2014 in Ghana found major aspects of client-centred care such as given individualised attention, ability to understand the specific needs of patients, politeness of staff, willingness of staff to answer patients' questions, effective communication and information giving, and attitude of staff as major factors that determined patients' satisfaction (Awuah-Peprah 2014:104-105). The Government of Ghana has clearly demonstrated its resolve to improve quality, addressing some of these variables that have been found to influence quality will require pragmatic efforts at all fronts – management of the health facilities, health staff and clients. The purpose of this study is to develop guidelines on client-centred childbirth it is hoped will positively influence service delivery.

3.5 CONCEPTUALISATION OF PATIENT/CLIENT-CENTRED CARE

Client-centred care that originated from the humanistic psychology is one of many terms used to describe the approach to health care delivery that puts the client or patient at

the centre of care (Brookman, Jakob, DeCicco & Bender 2011:19; Mead & Bower 2000:1102). The concepts, patient-centred and client-centred care are often used interchangeably. While the term 'patient' is used in reference to a person who has an illness and comes to the health care professional for advice and treatment, 'client' is used to describe a person who is not necessarily ill but uses the services or advice of a professional person or organisation (Oxford Advanced Learners Dictionary 2005:263). Though the concepts of client-centred or patient-centred care have been in the literature for decades, the current focus on the terms arose out of concerns of poor quality, growing cost of health care, inadequate workforce and the need to have a coordinated and comprehensive approach to care.

The use of the term "client-centred practice" was introduced by Rogers (1962), who described a non-directive therapeutic approach that focused on creating an atmosphere within which the client was inclined toward positive growth and realising his or her potential. This view differed considerably from the traditional medical (curative) approaches to health in which the diagnosis of the disease or disorder is made and the treatment regimen prescribed solely by the professional. Client-centred care places significant focus on the client and actively involves the client in every decision concerning treatment as well as considers their social and psychological needs. In this regard, patient-centred care among other things, implies that every procedure, treatment, and test ordered should meet the patients' goals for care while fully informing and involving the patient in the decision-making process (Fowler, Levin & Sepucha 2011:699). Rogers (1962) believed that people receiving services are capable of playing an active role in defining and solving their problems.

Since the time of Rogers (1962), a range of theoretical models have been developed on the nature, the context and recipients of patient-centred care (IOM 2001:39-54; Morgan & Yoder 2011:1). Other efforts to further conceptualise the concept in the empirical literature were by researchers and organisations such as Mead and Brower (2000:1088-1091) and the Registered Nursing Association of Ontario (2002:19). The Registered Nursing Association of Ontario (2002:12) stated that client-centred care involves advocacy, respecting clients' autonomy, voice, self-determination and participation in decision-making'. The Picker Institute Europe (2004:9-10) synthesised the core aspects common to a number of models on patient-centred care. The institute reported that the prime aspects are: respecting patients' individuality, coordination of care that is unique

to the environment of hospitals and health care facilities, communication between patients and providers (physician and nurses), intervention strategies for improving quality of patient-centred care within an institution, minimising physical trauma during acute care, supporting patients' social and emotional needs, role of families, and continuity of care. Silow-Carroll, Alteras and Stepnick (2006:15-18) identified similar components and report that the eight aspects of client-centred care are: ensuring a welcoming environment; respecting patients' values and expressed needs; empowering patient; understanding and addressing the socio-cultural factors of patients; effective coordination and integration of care; ensuring comfort and support; facilitating access and easy navigation through the health system; and making demonstrable, proactive efforts to understand and reach out to the local community. The IAPO (2007:29) further corroborates the notion that patient-centred health care should be one that is designed and delivered to address the health care needs and preferences of patients so as to ensure that the care provided is appropriate and cost-effective. Jayadevappa and Chhatre (2011:21-22) propose that patient-centred care model must integrate (1) understanding the patient and the illness; (2) arriving at mutual understanding regarding illness management and therapeutic alliance; (3) providing valued information; (4) enhancing hospital; doctor and patient relationship; and (5) sensitivity about resource allocation and cost.

Regardless of these efforts, to date no single definition of client-centred care is universally acknowledged (Clif 2012:86; IAPO 2007:29). Many similarities can be observed in all the definitions and dimensions. While almost all the proposed definitions agree that the needs and preferences of the client are keys; the definition by the Picker Institute expands the scope to include coordination and integration of care processes. Additionally, the IAPO (2007:12-13) indicated that issues related to patients' rights and responsibilities, evidence-based care and patient safety were also not adequately addressed in many of the propositions on the definition and dimensions of client-centred care. Balik, Conway, Zipperer and Watson (2011:5) recommend the discrepancies about the conceptualisation of client-centred care make it imperative for any organisation wanting to address client-centredness to clearly come out with a definition to meet their needs and mission.

Deductions from the literature demonstrates that the key attributes that impact client-centredness of health care relate to: access and receptiveness of the health system;

respecting the individuality of patients (that is, respecting and addressing their preferences, values and expressed needs); supporting patient's socio-cultural and emotional needs; effective communication between patients and doctors and midwives; coordination and integration of care; safety of care; continuity of care; empowering patient, families and community to be active participants in the care process; and a welcoming built environment. These variables are consistent with those identified in Larkin, Begley and Devane (2009:e49-e53) as key attributes of client-centred childbirth; namely: accessibility and reception; dynamics of the relationship with care givers; perceived promotion of choice and control in the process; nature of support; psychological care; continuity; physical environment and outcome of labour. The literature on these key factors in addition to a number of demographic variables that have been associated with the experience of client-centred childbirth (Van Rijsbergen & D'exelle 2013:282-284; Arthur 2012:4; Phillippi 2009:222) were applied in this study.

3.6 PATIENT/CLIENT-CENTRED CARE AND HEALTH OUTCOMES

A number of studies have shown that a client-centred approach to health care is associated with positive outcomes. For example, in a retrospective study to determine the influence of the Walter Reed PCMH on health outcomes, Christensen, Dorrance, Ramchandani, Lynch, Whitmore, Borsky, Kimsey and Pikutin Bickett (2013:136) report that costs were 11% lower for those with chronic conditions compared to 7% lower for those without. Lewis and Holcomb (2012:1504-1507) also evaluated a programme that applied a patient-centred approach to primary care delivery and found that it improved accessibility to care ($p < 0.05$), patients were less seen in the urgent care section ($p < 0.05$), and the health facilities had a lower no-show rate ($p < 0.001$) for scheduled appointments. In another non-equivalent control group pre- and post-test study using a self-reporting survey to evaluate the effects of family-centred care (perceptions of respect, collaboration, support, and overall family care) on provision of critical care, Mitchell, Chaboyer, Burmeister and Foster (2009:543-553) found that the intervention group was approximately $1\frac{3}{4}$ times more likely than the control group to perceive greater support ($OR = 1.79$; $p = .001$). The researchers also noted that family-centred care intervention was the strongest predictor of scores at 48 hours ($OR = 1.66$; $p < .001$). Mitchell et al (2009:550-551) concluded that partnering with patients' family members to provide fundamental care to the patients significantly improved the respect, collaboration, support, and overall scores on the family-centred care. This assertion was

supported by (Forbat, Cayless, Knighting, Cornwell & Kearney 2009:88-89) who in a pre- and post-intervention study concluded that collaborative work could influence the actions, beliefs and approaches to engagement among key stakeholders and can improve staff attitudes.

In the maternal and child care area, good provider-client relationship was a positive motivator for prenatal service use (Phillippi 2009:223). Positive outcomes were also reported in a quasi-experimental study at the Neonatal Intensive Care Unit in the United States (Cooper, Gooding, Gallagher, Sternesky, Ledsky & Berns 2007:S33-S35). Picklesimer, Billings, Hale, Blackhurst and Covington-Kolb (2012:e4-6) compared client-centred and traditional prenatal care and found 47% reduction in the preterm birth among those that participated in the client-centred care group.

3.7 FACTORS THAT INFLUENCE CLIENT-CENTRED HEALTH CARE PRACTICE

Epstein, Fiscella, Lesser and Stange (2010:1492) posit that effective implementation of patient-centred care depends on three factors: an informed and involved patient and family; receptive and responsive doctors and midwives who can focus on disease and knowing the patient; and a well-coordinated and well-integrated health care environment that supports the efforts of patients, families, and their clinicians. This view is supported by Morgan and Yoder (2011:6) who notes that within the health care environment, the antecedents that create a person-centred climate include: vision and commitment of leaders; good organisational attitudes and behaviours; and shared governance. In this regard, care environment (for example physical and cultural) dictates the parameters for care and either fosters or stifles the ability for care to be individualised.

Manley, Hills and Marriot (2011:37), Shaller (2007:V-VI, 8-13) and Silow-Carroll et al (2006:18-23) identified similar contextual issues as: provision of feedback and measurement; involvement of client, family and community; development of the workforce; promotion of effective leadership; availability and constant communication of strategic vision; institutionalisation of committees and departments devoted to patient-centred care related issues; involvement of stakeholders in research; provision of appropriate technology and structural support; and integration of client-centred care principles into the institution.

3.8 FACTORS THAT INFLUENCE CLIENT-CENTREDNESS OF CHILDBIRTH SERVICES

As identified in the conceptualisation of client-centred care, the key factors that influence client-centred childbirth include: socio-demographic variables; issues of accessibility and receptiveness of the health system; respect for the individuality preferences, values and needs, including socio-cultural and emotional needs; effective communication and information giving; good coordination and integration of care; safety of care; continuity of care; empowerment and engagement of patient, families and community; and a welcoming built environment.

3.8.1 Socio-demographic factors that affect women's experience and client-centredness of childbirth services

The literature identified a number of socio-demographic variables (for example, age, parity, marital status, education, household income) that influence women's preferences and experiences. Neuman, Neuman and Neuman (2010:413-414) found that age significantly affected preferences and also noted that women with lower level of education are more influenced by experience than highly educated ones. Another study that tested the psychometric properties of the Childbirth Perception Questionnaire in an inpatient obstetric setting reported that younger women (23-33 years) perceived birth more positively than older women (Bertucci, Boffo, Mannarini, Serena, Saccardi, Cosmi, Andrisani & Ambrosini 2012:270).

As regards parity, William, Lago, Lainchbury and Eagar (2010:619) noted that primiparous women tended to be less satisfied with their intrapartum care and felt that they had little say in decisions concerning them. They also needed more information about progress of labour and felt that they were not given individualised care. On the contrary, Neuman et al (2010:413-414) found no association between number of delivery and preferences. In addition, Neuman et al (2010:413-414) further reported that household income significantly affected preferences but religious affiliation, ethnicity and immigration status did not affect preferences.

3.8.2 Accessibility and reception

Accessibility is a multidimensional concept with diverse definitions in the health literature. Wang (2012:2) refers to accessibility as the relative ease by which health services can be reached from a given location. Levesque, Harris and Russell (2013:4) define it as the possibility to identify health care needs, to seek health care services, to reach the health care services, to obtain or use health care services and to actually be offered services appropriate to the needs for care. A number of dimensions have also been proposed. Peters, Garg, Bloom, Walker, Brieger and Rahman (2008:162) conceptualised accessibility into four dimensions as: geographic, availability, financial and acceptability. In addition, Levesque et al (2013:5) described five dimensions as: approachability; acceptability; availability and accommodation; affordability; and appropriateness. In discussing access in maternity care, Simkhada, Teijlingen, Portter and Simkhada (2008:248-249) indicated that the key factors that influence access to maternal health services are: socio-demographic; availability and location; affordability; and other factors relating to the characteristics of the health service, women's status in the household and women's knowledge, attitude, beliefs, culture and linguistic barriers. The different definitions emphasise the multidimensional nature of the concept. This study looked at accessibility in terms of the three dimensions: availability, location and accommodation; affordability; and social-demographic factors. How these factors influence access to childbirth services was examined.

3.8.2.1 Availability, location and accommodation

This refers issues on the ability to reach the health facility physically and timely (Levesque et al 2013:5). It also relates to measures for people to identify the existence of the service, place of residence and the distance or travel time, issues regarding transport and the availability of service providers. Two studies in Ghana (Gething, Johnson, Frempong-Ainguah, Nyarko, Baschieri, Aboagye, Falkingham, Matthews & Atkinson 2012:15-18; Adei, Fiscian, Ephraim & Diko 2012:17) state that long distances and lack of transport limited access to childbirth services. In addition, Phillippi (2009:222) notes that location and working hours as factors that influenced women's access. Kelly, Kohls, Poovan, Schiffer, Redito, Winter and MacArthur (2010:1381) and Masters, Burstein, Amofa, Aboagye, Kumar and Hanlon (2013:152) observed that the cost of transport and travel time had significant effect on use of facility-based delivery

services. According to Gething et al (2012:15-18), geographical access in Ghana is generally poor with long distances to health facilities, particularly in the rural areas. The researcher further noted that the distance factor is complicated by lack of vehicles, bad roads and high costs of transportation. Gething et al (2012:15-18) explain that efforts to reduce maternal mortality by improving the quality and availability of facility-based care during childbirth will have limited impact where long distances, poor infrastructure, and lack of transport hinder women from physically accessing these services within clinically appropriate timeframes.

On the contrary, Van Rijsbergen and D'exelle (2013:282-284) state that distance may not be a key factor in access and that most people will find a way to get to health facilities in emergencies or complications. Likewise, Gabrysch and Campbell (2009:13-14) expressed the view that transport issues are at times given too much impetus and that how patients get to the health facility is often not a huge consideration for them.

In an intervention study, Pilkington, Blondel, Drewniak and Zeitlin (2012:3-4) examined how proximity is valued by women. They argued that proximity is associated with increasing preference for the closest health facility and is related to age, number of birth and professional class. Younger women, nulliparous and women in the manual class households are more likely to choose a health facility based on proximity than older multiparous and women in the professional and managerial group. Likewise, in studying the effect of a number of strategies including provision of transport, Fournier, Dumont, Tourigny, Dunkley and Dramé (2009:33-37) observed increase in the rate of institutional deliveries and the number of obstetric emergencies treated in district health centres but very little effect on obstetric emergencies and maternal mortality.

The use of maternity waiting homes has also been implemented in some countries to help address accessibility challenges. Kelly et al (2010:1378-1381) report positive results on reduction of maternal mortality and still birth rates in Ethiopia with the use of maternity waiting homes. Likewise, Lori, Wadsworth, Munro and Rominski (2013:[4-6]) state that the use of maternity waiting homes improved access into the formal health care system for skilled birth care. On the contrary, Wild, Barclay, Kelly and Martins (2012:100-101) note that implementing maternity waiting homes did not address issues of distance and also did not increase utilisation of service by those who lived far away. Mramba, Nassir, Ondieki and Kimanga (2010:152-153) also observed low utilisation of

maternity waiting homes due to poor quality of practices in the health facility, low community education and awareness of the existence of the maternity waiting home. Another limiting social factor for the use of the maternity waiting home was the need to seek husband's permission to use it (Mramba et al 2010:152-153).

One study that experimented on providing home visits to postpartum women to improve access reported increased satisfaction and reduced use of emergency services but no effect on parenting outcome (Christie & Bunting 2011:699).

3.8.2.2 Affordability factors

Affordability refers to the economic capacity for people to spend resources, such as time to use services. The cost of services and payment system, women occupation and or employment and standard of living are the important variables. In an analysis of the Ghana 2008 Demographic Health Survey, Moyer, McLaren, Adanu and Lantz (2013:226-229) indicate that of all access variables examined, affordability (insurance coverage) was the strongest access factor associated with facility-based delivery. Adei et al (2012:17) support the issue of finance as one of the dominant factors that limit access. Phillippi (2009:222) identified cost and payment systems as factors that influenced women's access. Likewise, Yates (2009:2078-2079) and Lagardea and Palmer (2008:842-844) write that user fees reduce usage of health service and the effect is most pronounced in the suppression of demand for health care by poor people.

Dzakpasu, Soremekun, Manu, Ten Asbroek, Tawiah, Hurt, Fenty, Owusu-Agyei, Hill, Campbell and Kirkwood (2012:2-4), found that providing free care particularly through free health insurance in Ghana resulted in increased health facility delivery, especially among the poor. Similarly, Kruk, Galea, Prescott and Freedman (2007:306-309) reported improvement in the uptake of skilled birth attendant and Caesarean section services due to improved governmental funding. However, it must be indicated that, provision of financial initiatives at times is hindered by some implementation challenges. For example, Powell-Jackson and Hanson (2012:266-277) revealed that very few women (26.5%) actually benefited from the incentive to improve utilisation of hospital delivery services in Nepal due to the bureaucratic processes of disbursement. Moyer et al (2013:226-229) also observed low utilisation of the National Health Insurance stating that only 41.3% of the participants reported having insurance. There is some evidence

showing that the introduction of these incentives does not often impact the quality of services (Lagardea & Palmer 2008:842-844; Witter, Arhinful, Kusi & Zakariah-Akoto 2007:65). In many instances, interventions to address financial access are often implemented universally for all pregnant women but do all women want this?

3.8.2.3 *Socio-demographic factors that influence access*

The literature abounds with several socio-demographic factors that affect accessibility. These include educational level, parity, marital status, women's social status in the household, maternal age and family size. In a review that explored women's perception of access to prenatal care in the United States, Phillippi (2009:222) observed that culture, family's needs and desires, partner characteristics and significant others beliefs about pregnancy and health care influenced access to care. Equally, maternal factors such as poor motivation to begin care, being unaware that they were pregnant, too depressed to act, fear of disclosure and illicit drug use were other key factors that affected access (Phillippi 2009:222). Van Rijsbergen and D'exelle (2013:282-284) observed that wealthier women are more likely to deliver in hospitals. A study in Ghana reports a significant relationship between wealth and education, and childbirth service utilisation (Arthur 2012:4).

Another key social factor that has been found to greatly influence access and for that matter, the utilisation of childbirth services is health staff attitude. Attitude is generally the disposition or tendency of a person to respond positively or negatively towards a certain thing (idea, object, person, and situation). In addition, Idris, Sambo and Ibrahim (2013:28-30) stated that reasons for poor utilisation and or access to both delivery and postnatal services included poor attitude of staff. Adei et al (2012:17) supported the findings and indicated that staff attitude is some of the dominant factors that limited access to care. Poor communication skills, insensitive attitude and cultural insensitivity were noted in Phillippi (2009:222). Yet, Mwangome et al (2012:4-7) reported that poor customer care (lack of partnership between mother and doctors and midwives) as one of the barriers to seeking skilled attendants services. In an ethnography study using participant observation, interviews, case history and focus groups in one district in Ghana, Bazzano, Kirkwood, Tawiah-Agyema, Owusu-Agyei and Adongo (2008:92-94) reported that loss of social status; loss of control; loss of secrecy and increased vulnerability to negative outside forces (for example, the pregnancy is kept secret as

long as possible) were some of the social factors that affected access to skilled childbirth service.

However, Anderson (2004:2011) posits that putting the blame for poor behaviour and or interaction and communication on the health worker alone without understanding the conditions under which some health care workers work blur the facts. Anderson (2004:2003) underscored the notion that very important catalysts such as resource constraint, poor working conditions, underpayment, understaffing, negotiation over social status, the feeling of being the repository of medical knowledge by staff and institutional competence are key determinants of the behaviour of health workers.

3.8.3 Reception and waiting

Issues about reception and waiting that impact client-centredness of care comprises, opening hours, appointment systems, reception on arrival, wait times and the general ambience of the environment. Evidence shows that longer waiting adversely affects satisfaction (Phillippi 2009:222). Regarding the ambience, the Department of Health, United Kingdom (2013:10) recommends that the waiting area should have a welcoming and informal atmosphere. The area should also have a resource space for both printed and electronic information.

3.8.4 Respect and dignity in childbirth

Respect is a foundational element of professionalism that forms the core of the self-image of most health professions (Leape, Shore, Dienstag, Mayer, Edgman-Levitan, Meyer & Healy 2012:2). It is generally agreed that respect is morally important and is expected in everyday interactions even with health professionals (Dickert & Kass 2009:[1]). Though the term respect is widely used, its dimensions and operationalisation are unclear (Ali 2011:73; Dickert & Kass 2009:[1]). Many people equate respect to autonomy, which is “acknowledgment of a person’s right to hold views, make choices, and take action based on personal values and beliefs” (Beauchamp & Childress 2001 cited in Beach, Duggan, Cassel & Geller 2007:693). Beach, Duggan, Cassel and Geller (2007:692) described respect as recognition of the unconditional value of patients as persons and their autonomy. Dillon (1992) cited in Ali (2011:74), identified three dimensions of respect, namely: attention and valuing of the particularity (appreciating

and cherishing each person as an unrepeatable individual); understanding (trying to understand a person in his own terms and avoiding making assumptions about others); and responsibility (caring for a person in the sense of helping them to pursue their end, acting to promote their goods and assisting them to satisfy their needs and wants).

Dignity, just like respect, consists of many overlapping domains such as respect, privacy, autonomy and self-worth and could also be seen as a state, quality or manner worthy of esteem or respect; and self-respect (Cass, Robbins & Richardson 2006:6). 'Dignity in care means the kind of care which supports and promotes, and does not undermine, a person's self-respect regardless of any difference' (Cass et al 2006:6). It also means helping patients to maintain a sense of self-having control of the private sphere and setting appropriate boundaries (Morad, Parry-Smith & McSherry 2013:68). Health care that respects people's dignity should:

have a zero tolerance of all forms of abuse; support people with the same respect they would want for yourself or a member of your family; treat each person as an individual by offering a personalised service; enable people to maintain the maximum possible level of independence, choice and control; listen and support people to express their needs and wants; respect people's right to privacy; ensure people feel able to complain without fear of retribution; engage with family members and carers as care partners; assist people to maintain confidence and a positive self-esteem; and act to alleviate people's loneliness and isolation (Cass et al 2006:10).

Respecting the dignity of women is not the responsibility of the care provider alone but the woman herself also has great influence in preserving her own dignity (Morad et al 2013:68).

Studies in childbirth have found that women are more likely to feel respected when they trust the knowledge and skills of their caregivers, and when they see that information is kept confidential (Morad et al 2013:69). In a phenomenological study in Taiwan, Kuo, Wu and Mu (2010:452-454) reported that women feel respected when their views and values are considered and also when midwives tried to fulfil their expectations and get them involved in decision-making. In a study to assess patients' view on what constitutes respect, Dickert and Kass (2009:[3-7]) report attention to needs, empathy,

care, autonomy, recognition of individuality, information provision and dignity as key elements. However, attention to need was the most widely mentioned.

There is a plethora of evidence suggesting gross disrespect in the provision of childbirth services in many developing countries (Leape et al 2012:5-7; Bower & Hill 2010:3). These disrespectful and abusive behaviour in childbirth includes subtle or overt humiliation of women, discrimination against certain sub-groups, non-dignified care, non-consented care, non-confidential care, detention in facilities, abandonment and physical and verbal abuse during childbirth (Bowser & Hill 2010:3-8). In addition, Leape et al (2012:1), in a similar classification, outlined disruptive behaviour; humiliating, demeaning treatment of nurses, residents, and students as passive – aggressive behaviour; passive disrespect; dismissive treatment of patients; and systemic disrespect. The lack of respectful maternity care deters women from coming to the hospital (White Ribbon Alliance 2013).

In terms of the contributory factors to disrespectful behaviour in childbirth, Leape et al (2012:5-7) contend that these behaviours result from multiple factors relating to both the individual endogenous (for example, treat to self-esteem, insecurity, depression and anxiety) and exogenous factors (for example, organisational culture) in the work environment. Leape et al (2012:7) further argued that, though personality characteristics may predispose some individuals to disrespectful behaviour, for the most part, disrespect is learned behaviour that is supported and reinforced by the authoritarian, status-based culture found in most hospitals. Additionally, stressful health care environment, particularly the presence of “production pressure,” found in many health care organisations is another major contributory factor implicated in disrespectful behaviours of health care staff (Leape et al 2012:1).

3.8.5 Respect for women’s preferences and needs

A key component of the client-centred care is respect for women’s preferences and needs. Childbearing women have preferences regarding many issues such as: having control over decisions on treatment; choice of place of birth, mode of birth and birth position, type of support during birth and comfort measures, labour pain management and length of stay after delivery (Jamas et al 2011:697; William et al 2010:619). These preferences are not static, but change with experience and are also influenced by a

number of socio-economic variables such as educational level (Neuman et al 2010:417-418). Knowledge of these preferences and needs is essential for staff to help to plan appropriate and acceptable services for them (Joint Commission 2010:9). The literature on these preferences and needs is presented below.

3.8.5.1 Control, decision-making and choice

The current childbirth care environment advocates control for women and promotes women's active involvement so as to improve quality (Jomeen 2012:60). This view is supported by the association of positive experience in childbirth to the amount of control experienced by the mother (Snowden et al 2011:9; Goldberg 2009:38). Having control means being given information about why particular decisions are crucial; involved in decision about all aspects of care with information on the whys, how and when; given opportunity to choose among available options and having the right to refuse specific treatments (Martin and Robb 2013:2). Furthermore, it requires not just giving the information but ensuring that the information is understood and that the woman is capable of making the decision or choice (Noseworthy, Phibbs, & Benn 2013:e43; McKenzie 2009:171).

A number of factors influence control, decision-making and choice in childbirth. Personality, education, and experience influence the degree of participation that patients want in the decision-making process (Ontario Medical Association 2010:39). Hibbard, Greene and Tusler (2013:209) note that while highly activated clients may have the skills and confidence to elicit what they need from their care providers, others may not have these skills. Additionally, the desire of patients to participate in the decision-making process will vary depending on the risk implications of the decision and the level of health literacy of the patient (Ontario Medical Association 2010:39). Patients with low health literacy level are more likely to rely on care provider's expert advice than those with high health literacy. There are also instances where choice is not possible for women due to lack of options (Jomeen 2012:60). Another study by Martin and Robb (2013:2) wrote that choice provision is delimited by several obstructions from care providers, care users and the care provision context.

Often, decision-making and choice in childbirth are not only dependent on individuals but are influenced by family and friends as well as beliefs, values, past experiences and

other contextual factors (Noseworthy et al 2013:e44; Pilkington et al 2012:2; Snowden et al 2011:9). Nieuwenhuijze, De Jonge, Korstjens, Bude and Lagro-Jansen (2013:2-4) found that women's sense of control is influenced by birthing position, attending ANC classes, feeling towards the birth in pregnancy, pain in the second stage were significantly associated with sense of control. This view was supported in Wild, Barclay, Kelly and Martin (2010:2040-2044) who found that choices and control were informed by: having previous uncomplicated delivery; fear; the outcome of last delivery; ability to get social support; age (used more by younger women); ability to use upright position during birth; having free care; the location or residence of client; access to transport; cleanliness of facility; and staff attitude.

Noseworthy et al (2013:e44) point out that the traditional paternalistic method of decision-making still exists in health care settings. A study in South Africa reported that the approach during childbirth was characterised by limited participation of women, limited involvement in decision-making and information sharing, a proliferation of practices that fostered dependency and authoritative approach to care (Maputle & Hiss 2010:8). Many women often place themselves in the hands of midwives and allow midwives to make decisions for them, even if their own wishes are neglected (Bluff & Holloway 2008:308). Belizan et al (2007:848) confirm the above that few women who attend public hospital express the desire concerning procedures or treatment. Indeed, one study in South Africa noted that women were comfortable with their dependency on midwives regarding decision-making (Maputle & Hiss 2010:8). Even relatively affluent and well-educated patients at times feel compelled to conform to socially sanctioned roles and defer decision-making to physicians during clinical consultations (Frosch, May, Rendle, Tietbohl & Elwyn 2012:1032).

Although many women defer decision-making to health professions, there are still some that will like to take control. In exploring the subject, Namey and Lyerly (2010:9) note that among American women being in control corresponds to: self-determination; respect; personal security; attachment; and knowledge. Indeed, the term was often linked to a broad notion of the "good" in birth. In a focus-group sessions with 48 people, Frosch et al (2012:1032) reported that the participants voiced a strong desire to engage in shared decision-making about treatment options. Hundley and Ryan (2004:556) offer credence to this in noting that involvement in decision-making was the attribute rated by most women as being very important.

Health professionals often give a number of reasons to justify paternalistic approaches to decision-making. Elwyn, Lloyd, Joseph-Williams, Cording, Thomson, Durand and Edwards (2013:208) outlined a number of reasons why health professionals are unable to effectively involve patient in decision-making. These included: request of inappropriate care by patients based on unreliable or inaccurate information from friends, relatives and the mass media, and inadequate time. In a study in one region in Ghana, Oduro-Mensah, Kwamie, Antwi, Amisah Bamfo, Bainsong, Marfo, Coleman, Grobbee and Agyepong (2013:3-10) identified inadequate decision aids as a hindrance.

Care providers need to identify the decision support needs of women and identify what is available to aid the process. Both electronic and paper-based decision aids have been found to be useful (Elwyn et al 2013:210; Dugas, Shorten, Dube, Wassef, Bujold & Chaillet 2012:1977). Rigorous measures of patient engagement, and of the degree to which health care decisions truly reflect patient preferences, are needed to advance shared decision-making in clinical practice (Frosch et al 2012:1036). In the same way, choice and control can be supported by skilled health professionals who respect and understand the importance of choice in the birth process and have the capacity to help (Snowden et al 2011:9). Most importantly, the meaning of control as understood by women, as subjective as it may be, has to be adequately described to guide action (Namey & Lyerly 2010:9).

3.8.5.2 Place of birth and birth attendant

The literature outlines several factors that determine the decision on where a woman will give birth (Kkonde, Dolamo & Monareng 2011:10-11; Guliani, Sepehri & Serieux 2012:1185-1187; Edmonds, Paul & Sibley 2012:556-558). While many women may prefer and do give birth in public health facilities- hospitals, clinics or maternity homes (Overgaard, Fenger-Gron & Sandall 2012:978; Gamble, Creedy & Teakle 2007:117), some would rather have their babies at home (Vedam, Schummers, Stoll, Rogers, Klein, Fairbrother, Dharamsi, Liston, Chong & Kaczorowski 2012:601; Kempe, Alwazer & Theorell 2010:133; Bazzano et al 2008:92) or in a private health facility (Karaku & Sahin 2011:61). The choice of where to give birth is often limited by the assumption that birth outside the health facility is not safe. This assumption has been questioned by emerging evidence which demonstrated positive outcomes for either planned hospital or

planned home births for low-risk pregnant women (Olsen & Clausen 2012:15). However, the context of where the birth is taking place and who is assisting is important. In developed countries, both hospital and home births are attended by skilled health professionals that have ready access to medications and other hospital services. This is often not the case in many developing countries where home birth is not well integrated into the formal health care system.

As stated by Vedam et al (2012:601), women usually indicate that 'home birth increases their privacy, comfort and convenience, decrease their rate of interventions, provide greater cultural and spiritual congruency, change the provider-patient power dynamics and facilitates family involvement and relaxed, peaceful atmosphere'. In another study, Bazzano et al (2008:92), supported the view and reported that delivering at home with skilled attendant was seen as the ideal situation for the women. Similarly, in a study in a developing country, Kempe et al (2010:133) found that women who gave birth at home felt more authority over their childbirth and felt more involved in decision-making. Home birth has also been associated with higher satisfaction level (Christiaens & Bracke 2009:e17). Unfortunately, the decision to deliver at home, even in some developed countries is often met with negative reactions relating to fear for life and death, irresponsible and self-centred even by some close relatives and friends (Sjoblom, Idvall, Radestad & Lindgren 2012:e13-15). This attitude is also prevalent among some health professionals who deem home birth as less safe (Vedam et al 2012:604).

It must be noted that the decision on place of birth is influenced by factors such as distance, staff attitude, cost, spousal and significant others influence (Kkonde et al 2011:10-11). It is also influenced by the number of ante-natal visits, educational level, urban residence, increasing maternal age, parity and women's employment status were found to be associated with health facility birth (Guliani et al 2012:1185-1187; Edmonds et al 2012:556-558). For example, Edmonds et al (2012:556-558) found that women who delivered at home were poorer, had less formal education, married at younger age, had higher parity and had fewer ante-natal clinic visits. Contrarily, Shiferaw Spigt, Godefrooij, Melkamu and Tekie (2013:3-4) found no statistically significant difference between women who delivered at home and those who did in health institutions based on educational status and household decision-making capacity, but they mentioned belief and customary system, cost, distance and transportation as important factors.

Regarding birth attendants, Bashour and Abdulsalam (2005:4) found that 60.4% of women in their study preferred to be attended by doctors compared with midwives (21.2%), while more than 85% of them preferred the obstetrician to be a female. In the same vein, Gamble et al (2007:117) note that the preferred birth attendant for women in their study were midwives who had medical backup. Even in the formal health system, women may have preferences for the category (doctor or midwife) of staff that should attend to them.

The right to choose where and with whom to give birth may differ on choices available, but as outlined earlier, it is imperative for health care providers to know the preferences of women. They should investigate the options available and understand how the dynamics of the interaction of these factors can help to inform policies and strategies to make childbirth services more client-centred.

3.8.5.3 Mode of birth and birth position

There are a number of ways by which women may choose to give birth – Caesarean, vaginal or assisted. The choice as is with other aspects of childbirth are often dependent on the options available and to some extent the condition of the woman. It is often stated that many women in developed countries prefer caesarian section (Karaku & Sahin 2011:61). As outlined in Karlstrom, Nystedt, Johansson and Ingegerd (2011:624), women who opt for caesarian section may have very good reasons for their choice. These reasons include childbirth related fears, previous negative birth experience and previous caesarian section. On the contrary, vaginal delivery appears to be the most preferred mode of delivery in many developing countries such as Ghana (Danso, Schwandt, Turpin, Seffah, Samba & Hindin 2009:30). In a qualitative study in Argentina, Liu, Mazzoni, Zamberlin, Colomar, Chang, Arnoud, Althabe and Belizan (2013:3-4) report that most of the women preferred vaginal delivery and cited emotional and other psychological benefits of the mode of birth.

Evidence also shows that women who had normal birth or delivered per their preferred mode of delivery expressed better perception including more sense of control (Bertucci et al 2012:270). However, in terms of Caesarean section, Gamble et al (2007:337) espoused that the choice for many may not necessarily be a preference, but rather, a

choice for safety and predictability versus risk and danger or opting for perceived higher quality care.

In discussing birth position, Priddis, Dahlen and Schmied (2012:104) state that more and more women in both developed and developing countries are still giving birth in the recumbent positions in health care facilities. This practice is contrary to current evidence that demonstrate more positive birth outcomes of using the upright position. A number of factors have been put forward for this phenomenon. According to Makuch (2010), the design and facilities in some labour wards may not be conducive for women to remain in an upright position or walking around during labour. In promoting client-centred childbirth, it is imperative for service provided to study and devices means to make the childbirth experience, including their preferred birth position, good for mothers. Nieuwenhuijze et al (2013:2-4) investigated the factors that are related to birth position using self-reported questionnaire in the Netherlands and observed that women who preferred supine position were often highly educated and primiparous. In addition, De Jonge, Riinders, Van Diem, Scheepers and Lagro-Janssen's (2009:442) study observed that women having 36 years and above were more likely to use the supine position during the second stage compared to the women in the younger ages. The knowledge of these factors could guide birth plans to suit women's needs.

3.8.5.4 Support during childbirth and comfort

A critical component of client-centred childbirth is providing appropriate and continuous support for women during childbirth. As stipulated in Hodnett, Gates, Hofmeyr and Sakala (2012:3), the kind of support needed in childbirth include: emotional support (continuous presence, reassurance and praise), information about labour progress and advice regarding coping techniques, comfort measures (such as comforting touch, massage, warm baths/showers, promoting adequate fluid intake and output) and advocacy (helping the woman articulate her wishes to others). To be effective, there is a need for good interpersonal relationship between the woman and the support provider. Women who receive continuous one-to-one support are more likely to have a spontaneous vaginal birth; are less likely to have intrapartum analgesia or to report dissatisfaction; have shorter labour; and are less likely to have other birth interventions such as Caesarean section, instrumental vaginal birth or regional analgesia (Hodnett et al 2012:15). Kuo et al (2010:452-454) contend that women in their study mentioned that

support provided by the midwives helped them to handle labour pain better. Reporting in a study carried out on 123 pregnant women, 242 obstetricians and 210 midwives in South Australia, Madden, Turnbull, Cyna, Adelson and Wilkinson (2013:36-37) noted that more than 90% of the participants preferred having childbirth support as a means of labour pain relief.

The importance of identifying the need for and the preferred person to give such a support is the key to enhancing the experience of women. While some women are more satisfied with midwives support (Christiaens & Bracke 2009:e15), others may prefer different health professionals. There are still some that prefer having labour companions from their social network, such as husbands/partners and female relatives (Maputle & Hiss 2010:9). According to Lantz, Low, Varkey and Watson (2005:110), some women prefer the services of a doula (that is, a uniquely trained support person that provides social and non-medical aspect of childbirth care). Yet still, there are women who will not want any childbirth companion during labour (Simmonds, West, Porters, Davis, Holland, Preston-Thomas, O'Rourke & Tangey 2012:83). In a study on women's preferences in Iran, Aglmand et al 2008:[7]) reported that women did not want support during labour and birth from their partners or family members but preferred support from care givers. It must be indicated that the effectiveness of labour support from the woman's social network has been questioned in that these people often require support themselves (Hodnett et al 2012:4).

Reports indicate that childbirth support is often less than optimal for women in many countries. Very few women delivering in health facilities in many developing countries have access to childbirth companions. In addition, Gamble et al (2007:117) found that almost all (70%) the women in their study described support after birth as mediocre, or hard to access. Likewise, Aune, Amundsen and Skaget (2013:[5-6]) stated that midwives were unable to offer effective childbirth support to women due to busy shifts. In another study, Howarth, Swain and Treharne (2012:490-492) reported that most women were unable to establish good interpersonal relationship with the midwives during childbirth even when the opportunity was there, thus making their birth stressful.

Implementing childbirth support has been challenging. Brown, Hofmeyr, Nikodem, Smith and Garner (2007:[5-8]) were unsuccessful in institutionalising childbirth companions in hospitals in South Africa even after the expression of the willingness of staff and change

in policy direction. They concluded that implementing childbirth support needs further development and testing especially in developing countries. Health care worker at times expressed concerns about the presence of a partner during childbirth in that it may interfere with their work (Maputle & Hiss 2010:9). Despite these difficulties, it is suggested that health facilities should permit and encourage women to have a companion of their choice during labour and birth, and hospitals should implement programmes to offer continuous support during labour (Hodnett et al 2012:16). In terms of comfort measures, Jamas et al (2011:697) found that women preferred being allowed to eat, walk and even exercise during labour. They also want to be encouraged to carry out self-care activities regarding personal hygiene.

3.8.5.5 Labour pain management

Another aspect of childbirth of great importance to women for which care providers need to respect their preference is labour pain management. Pain, including labour pain, is a subjective experience involving a complex interaction of physiologic, psychological, cultural and environmental influences (Leeman, Fontaine, King, Klein & Ratcliffe 2003:1109; Lowe 2002 cited in Madden et al 2013:1). Individuals may differ in their preference for pain relief. Madden et al (2013:37) observed that while pregnant women had greater preference for physical and psychological pain relief methods, obstetricians preferred pharmacological methods. In the same vein, while some women rated the availability and provision of pain relief highly (Hundley & Ryan 2004:556), others found it not very important (Gamble et al 2007:117; Bazzano et al 2008:92). In one study in Brunei Darussalam, most (74%) of the women preferred to give birth without any anaesthesia (Bamanikar & Amdani 2012:180). Reasons for their choice included: need to feel the pain; previous experience of anaesthesia; and fear of allergies. Interestingly, majority of those who had epidural anaesthesia were influenced by their Medical Officers (Bamanikar & Amdani 2012:182).

It is believed that a major determinant of women's satisfaction with childbirth depends on how effective labour pain was managed (Leeman et al 2003:1110). Though the choice of pain relief to a greater extent depends on what is available in the care delivery context, Jamas et al (2011:697) women still will like their individual choices regarding pain relief to be respected. The decision whetherto use pharmacological or non-pharmacological methods of pain relief or not should be the choice of the woman.

3.8.5.6 Length of stay

Length of stay refers to the time between delivery and discharge. Mclachlan, Foster, Yelland, Rayner and Lumley (2009:130-132) used focus groups to explore views of postnatal women in Australia and reported that women were very unhappy about shorter stay in hospitals and wanted flexible and individualised care options which acknowledge their needs. For instance, first time mothers needed longer stay so as to learn the skills needed for child care. Mclachlan et al (2009:131) also reported that women were not in support of shorter stay in hospitals. Though the Ministry of Health, Ghana (2011a:60) reports that median length of stay after normal birth in Ghana is 42 hours, this literature review did not identify any local study on the preference for length of stay.

3.8.5.7 Socio-cultural, psychological and emotional needs

Childbirth, though a biological event is socio-culturally construed and shaped by the perceptions and practices of the society (Liamputtong 2011:16). Pregnancy and childbirth outcomes often have wide implications at individual, family, communities and society levels. Women's socio-cultural needs in any society are thus influenced by a mirage of factors such as culture, environment and social status at all these levels. A number of social factors that impinge on client-centred care have been discussed under issues related to accessibility and preference in previous pages. This section will thus focus on the influence of culture and how to address cultural needs in childbirth.

Culture refers to the set of attitudes, values, beliefs, and behaviours shared by a group of people and are communicated from one generation to the next (Matsumoto 1996:16 cited in Spencer-Oatey 2012:2). Culture includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs. The manifestation of culture in an organisation includes everything from the physical layout, the dress code, the manner in which people address each other, the smell and feel of the place, its emotional intensity, and other phenomena, to the more permanent archival manifestations such as company records, products, statements of philosophy, and annual reports (Schein 1990:111 cited in Spencer-Oatey 2012:3; Betancourt, Green & Carrillo 2002:1).

In the health sector, service that is culturally competent or appropriate means the existence of a set of policies, structures behaviours and attitudes that respect and take into account the individual cultural background, cultural beliefs, and their values as well as incorporates these into the way health care is delivered (Dudgeon, Wright & Coffin 2010:34 cited in Kruske 2011:7; Betancourt, Green & Carrillo 2002:3). Patients and health care providers bring their cultural perspectives to bear on the health care encounter as such health systems need to reflect an understanding of the diversities between and within these cultures (Beach, Saha & Cooper 2006:6; NHMRC 2006:7 cited in Kruske 2011:7).

Facilitating cultural competence include having an appropriate mix of: a culturally diverse health staff that reflects the community(ies) served; health care providers or translators who speak the clients' language(s); training of staff about the culture and language of the people they serve; signage and instructional literature in the clients' language(s) and which are consistent with their cultural norms; and culturally specific health care physical settings (Dudgeon et al 2010:34 cited in Kruske 2011:7; Anderson, Scrimshaw, Fullilove, Fielding & Normand 2003:69). It also includes having the capacity for cultural self-assessment; being conscious of the dynamics that occur when cultures interact (NHMRC 2006:7 cited in Kruske 2011:7).

Actions to address socio-cultural needs of women comprise identifying, respecting and promoting their cultural uniqueness and that of their families. The benefits that accrue from such practices include improved health outcomes, increased respect and mutual understanding from patients, increased participation from the local community, lower costs as well as fewer care disparities (Wilson-Stronks & Mutha 2010 cited in Health Research and Educational Trust 2013:3). For instance, EACH Social and Community Health (2011:12) reports that women felt less anxious and had a better understanding of procedures and care provided when they had access to accredited interpreters that spoke their dialect compared to those who lacked that service where communication between client and health professional was compromised. Finlayson and Downe (2013:4-6) observed that women have cultural beliefs that influence decisions related to disclosure of pregnancy and ante-natal, labour and postnatal practices. In stating an Ecuadorian government national survey, Dovey and Ransom (2009) wrote that women choose to deliver at home because they want to observe cultural traditions. Women

want to observe cultural traditions such as upright position during birth, they want to be accompanied by family and community members, and desire to drink customary herbal teas and certain foods (Dovey & Ransom 2009). Cultural factors influence the choice of vaginal birth in a study in Argentina (Liu et al 2013). Likewise, cultural reasons were given by many women for choosing to delivery with traditional birth attendants in Ethiopia (Shiferaw et al 2013:4-5).

On the other hand, cultural and linguistic barriers between health care providers and patients can greatly interfere with effective care delivery (Beach et al 2006:4-5). Henderson, Gao and Redshaw (2013:4-10) found many disparities in the maternity care that minority women received compared to those of white women in the United States. Minority women on the whole received poorer ante-natal, labour and postnatal services. It has been reported that despite the existence of policies and guidelines to highlight cultural competence as a core feature of improving health service, there is still no or limited mechanisms to facilitate changes and improvements to embed cultural competence in delivery (Reibel & Walker 2010:72 cited in Kruske 2011:5). It is imperative that providers of health care incorporating patients' perspectives on culturally and linguistically appropriate services into measures of quality improvements (Ngo-Metzger, Telfair, Sorkin, Weidmer, Weech-Maldonado, Hurtado & Hays 2006:25).

3.8.5.8 Psychological and emotional needs influencing childbirth

It is believed that childbirth is a stressful event for many women (Boorman, Devilly, Gamble, Creedy & Fenwick 2013:[4]). Strong moods and emotions are common during these periods. Unfortunately, studies linking the impact of psychological and emotional factors on childbirth outcomes have not attracted much attention (Jomeen & Martin 2008:392). Jomeen and Martin (2008:393-394) report that women do worry about issues such as going to hospital, giving birth and coping with a new baby and going through childbirth interventions. However, promoting choice in maternity care does not necessarily confer greater psychological benefit to women. Women also reported thoughts of mental defeat and of wanting labour to end, poor understanding of what was going on, worry, dissociation, thoughts of death, distorted perception of time, thoughts about the baby, decision-making, disbelief, and evaluation of labour as some of the emotional and psychological issues that they had to contend with during childbirth (Ayers 2007:255-259). Ayer's (2007:259-260) study indicated that though both positive

(for example, feeling happy, pleased, glad, calm, excited, surprised, amazed, relieved, and grateful) and negative (for example, feeling cared, frightened, panicky, shocked, alarmed, stressed, worried, upset, apprehensive, anxious, nervous, disappointed, discouraged, helpless, depressed, bored, frustrated, irritable, annoyed, and angry or aggressive) emotions were expressed by the women irrespective of birth outcome, women with post-traumatic stress or negative birth outcomes mentioned more negative emotions.

Knowledge of these factors is important to guide care providers. Women can be assisted to deal with these emotional and psychological challenges by providing support systems that are tailored to their preferences. These support systems include promoting control and decision-making, facilitating good communication and providing continuous support as discussed in previous pages.

3.8.6 Communication and information giving in childbirth

Women and significant others require education and information to guide pregnancy and childbirth decision and practices. Many health care acts and regulations, as well as professional guidelines clearly state that every pregnant woman has the right to base her maternity care decisions on accurate, up-to-date and comprehensible information (Goldberg 2009:35). To achieve this, women use variety of sources, including their family members and mass media to gain information (Martin & Robb 2013:2-6; Belizan et al 2007:850). While some rely heavily on health professionals for such information (Akin-Otiko & Bhengu 2012:e895-e896), others report preference for paper-based and electronic media such as Television, online programmes, leaflets and bulletins (Metzler, Sanders & Rusby 2012:264). There are yet some women who express preference for provision of information through home visits by health professionals and use of parenting groups were the least preferred in the study (Metzler et al 2012:264).

Martin and Robb (2013:3) noted that education and information needs vary among women. The literature revealed that, while most clients expect to be given information about their condition and the treatment options and want care providers to take account of their preferences (Coulter & Ellins 2006:57), there are others who do not want to know much in advance about the experience of delivery (Belizan et al 2007:850). The participants in Akin-Otiko and Bhengu's (2012:e895-e896) study wished they had more

information on their condition, medicines and how to avoid complications. Another study by Bazzano et al (2008:92) found that some women did not want to waste nurses' time by asking questions. Martin and Robb (2013:3) also identified that information needs varied according to the trimester of pregnancy.

Grilo, Santos, Rita and Gomes (2014:38) indicated that interaction between health professionals and patients is 'profession-centred'. A study that used the Patient-Practitioner Orientation Scale and other tools to measure perception and competence in technical and communication skills regarding two dimensions of patient-centred care (caring and sharing) among 525 student nurses and 108 nurse showed that the staff is less supportive in sharing information and in involving patients in the decision-making process (Grilo et al 2014:38). Health care providers often fail to create an environment and relationship that allows effective communication of all types with the patient (Øvretveit 2012:30). To promote effective communication, Fowler et al (2011:700) outlined the steps for effective communication and information giving as: giving clients an objective, unbiased presentation of reasonable options to consider and the pros and cons of those options; giving adequate time for them to consider their goals and concerns and how each option is likely to play out with respect to those goals and concerns; and offering the advice for client to interact with their providers to further discuss their goals and concerns.

Furthermore, Jucks, Paus and Bromme (2012:181) espoused that the dynamics of communication is also important, in that, encouraging clients to display their technical knowledge and or self-reported lack of knowledge on the subject of interest can help to direct communication approach. Unfortunately, evidence shows that these steps are often not followed (Fowler et al 2011:700). In a study in Ghana, it was reported that educational talks were mainly given in groups and in the open without the use of any information, education and communication materials. Consequently, women rarely asked questions (Akin-Otiko & Bhengu 2012:e895-e896). Studies indicate that patients want more information than they currently receive and that health professionals frequently overestimate the amount of information they supply (Richards 1998 cited in Coulter & Ellins 2006:27). It has also been observed that care providers typically do not have time and often lack the skills to present a complete, balanced presentation of the pros and cons of reasonable medical options (Fowler et al 2011:701). In a study in Ghana, Dzomeku (2011:32-34) reported that women indicated 'not receiving

explanations for interventions and being ignored as key contributory factors for not using health facility services'. The participants in Martin and Robb (2013:6) study reported women's lack of knowledge about availability of some services and difficulty in accessing information (Mattocks, Nikolajski, Haskell, Brandt, McCall-Hosenfeld, Yano, Pham & Barrero 2011:127). The ineffectiveness of communication is at times attributed to sub-optimal skills and consultation contexts (Øvretveit 2012:30).

There are several ways by which communication and information giving could be improved. These include use of survey instruments to assess patients' knowledge and goals; use of decision aids; and monitoring quality of communication through use of check off boxes indicating that patients have been informed and involved in the process (Fowler et al 2011:702-3). Mattocks et al (2011:127) recommended the use of leaflets and booklets. In all instances, the approaches and content should be designed based on the experiences and needs of women. If possible custom made information and educational sessions should be organised for primiparas, multiparas, teenagers and other complicated or high risk pregnancies (Belizan et al 2007:848). This notwithstanding, Coulter and Ellins (2006:21) caution that health literacy is fundamental to effective patient engagement. If individuals do not have the capacity to obtain, process and understand basic health information, they will not be able to look after themselves effectively or make appropriate health decisions (Coulter & Ellins 2006:21).

3.8.7 Integration and coordination of care

According to Waddington and Egger (2008:4), integrated health care refers to "the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system". Another definition is "a network of organisations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served" (Shortell, Gillies, Anderson & Erickson 1996 cited in Hwang, Chang, LaClair & Paz 2013:1). Dudley and Garner (2011:2-3) report that clients' and their families often experience health care that is characterised by fragmentation, duplication and care gaps, especially in many low- and middle-income countries. In response, many governments are fostering linkages or integrating services to improve co-ordination and patient care.

As outlined in Richardson and Patana (2012:4) and Waddington and Egger (2008:3), integration can be horizontal (bringing together of different levels in the care hierarchy) or vertical (could mean integrating the hospital, health centre, health post and community-based health services to ensure the continuum of care). Integrated care can be delivered in many forms (cooperation or communication among service providers, collaboration among professionals across different sectors, the physical or virtual connection of complementary services, or a mix of these). It can even be across sectoral when institutionalised mechanisms enable cross-sectoral funding, regulation or service delivery (Waddington & Egger 2008:4). Integration is about the organisation of various tasks which need to be performed in order to provide a population with good quality health services (Waddington & Egger 2008:1). Integration aims at improving coordination and brings services together at one point or strengthens the linkages between the services (Dudley & Garner 2011:5-6).

Coordination, which is closely linked to integration, refers to “the deliberate organisation of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services” (McDonald, Schultz, Albin, Pineda, Lonhart, Sundaram, Smith-Spangler, Brustrom & Malcolm 2010:4). Childbirth integration and coordination may involve bringing services for mothers and children together. This can be in many different and varied models of care to suit the needs of individual and communities.

It is presumed that an integrated service provides higher quality and more patient-centred care and at a lower cost. It is also believed that integration of care leads to greater public access, including more equitable access for people from different communities and socio-economic backgrounds, a more convenient and satisfying service, and better health overall (Dudley & Garner 2011:2-3). This, in the view of the researcher, could have been the basis for the strategies proposed by the IOM (2001:117) for policy makers and health-system planners to overcome the challenges of modern medicine and to improve the public health needs of the population that they serve. In a systematic review study, Hwang, Chang, LaClair and Paz (2013:1) found some positive correlation between high performance on quality measures and certain indicators of integration (for example, larger practice size, affiliation of the medical group with a hospital, health system, or health plan) but not on financial measures. This was

supported in Briggs and Garner (2006:2) who concluded that there was no clear evidence that integrating primary health care services improves the delivery of health services or people's health status in middle or low income countries. Indeed, it has been noted that integrated care might rather lead to work overload for health professionals or that some health professionals may not have the specialised skills to manage specific diseases which could lead to poor quality services and poor health (Dudley & Garner 2011:24).

Perception of service integration or coordination among key player in the health sector - patient/ family, health care professional(s), or managers/ system representative(s) differ (McDonald et al 2010:4). For instance, integration for clients means health care that is seamless, smooth and easy to navigate (Waddington & Egger 2008:5). In other words, clients want a coordinated service which minimises both the number of stages in an appointment and the number of separate visits required to a health facility. They want health workers to be aware of their health as a whole and for health workers from different levels of a system to communicate well (Waddington & Egger 2008:5). However, health care professionals and managers may be more interested in how team dynamics are deployed to help patients and their families navigate through the health system with ease and efficiency. Consideration of views from these different perspectives is important for measuring care coordination comprehensively (McDonald et al 2010:4).

The National Partnership for Women and Families (2014) outlines that high quality maternity is one that is seamless and effectively coordinated across settings, and disciplines to maximise safety and efficiency as well as reduce waste. As different women have different needs in relation to pregnancy and childbirth, the level of care required should determine whether the woman is at the right place at the right time with the right health professional for her clinical needs (NSW Department of Health 2008:6). Models of care as far as possible should provide a range of options at the same time as achieving a close matching of quality services to clinical needs. The service should also be designed to meet the needs of mothers and their significant others through effective teamwork, communication, coordinated management of care plans and provider responsibilities, medication reconciliation, and other shared information using electronic health records and interoperable data systems (National Partnership for Women and Families 2014).

Epstein et al (2010:1492) wrote that this will require investments in infrastructure (increasing accessibility, use of non-physician staff, quality metrics for index conditions, and systems for coordinating care) and information technology applications (patient registries, performance reporting, tools for organising clinical data, test and referral tracking, electronic pre-scribing) to foster an enabling environment. In all these, particular attention should be paid to transitions of care, including transition from pregnancy to labour to postpartum care, and between settings or providers of care so as to ensure consistent consideration of the woman's health history, values and wishes, plan of care, medications, and evolving needs (National Partnership for Women and Families 2014). This notion was supported in Modiba (2012:18-19) who argued that where care is appropriately organised, and midwives hold interpersonal, clinical skills and knowledge, care is more likely to be positive. Women prefer a multidisciplinary clinic to traditional fragmented ones (Hall & Van Teijlingen 2006). This may be difficult to achieve in childbirth service delivery in many developing countries as these services are often provided individually.

The literature outlines instances where care coordination and integration has been far from optimal. Phillippi (2009:222) reported that the lack of consistent provider was an influential access factor in the study they conducted. Mwangome et al (2012:4-7) found that lack of partnership between mother and health professional was a barrier to seeking skilled attendants services. The lack of coordination between the rural prenatal centres and the urban hospitals as well as that within the hospital, between doctors and nurses were mentioned by participants in Gramling, Hickman and Bennett's (2004:45) study which assessed health care practices that promoted or limited implementation of family-centred care. In addition, Speizer, Fotso, Okigbo, Faye and Seck (2013:6) examined the role of service integration on postpartum family planning use and reported that most women who delivered in the health facility and those who sought immunisation for their children did not receive any information on family planning and were not using any family planning method, implying that integrating delivery and immunisation services was not a good approach to providing family planning services.

In summary, it must be noted that integration and coordination is not about size or structure per se, but rather more about the organisational commitment to and culture of continuous quality improvement that translates into better performance that are

measured by clinical quality, patient satisfaction, organisational learning, and financial performance (Shortell et al 1996 cited in Hwang et al 2013:1). Policy makers and planners considering integrating health care services should also put in place strong systems to monitor and evaluate them.

3.8.8 Safety of care

Globally, high quality of health care is seen as care which is safe, effective and takes account of patient needs and experiences. The importance of safety means that patients should not be harmed by the care that is intended to help them, nor should harm come to those who work in health care (IOM 2001:44). To be safe, care must be seamless, supporting the ability of interdependent people and technologies to perform as a unified whole, especially at points of transition between and among caregivers, across sites of care, and through time (IOM 2001:44). The National Partnership for Women and Families (2014) also posit that a safe health care is one that is reliable, appropriate, and provided in systems that foster coordination, a culture of safety, and teamwork to produce the best outcomes for women and babies and minimise the risk of harm. Safety issues are implicated at all levels of health care: organisations; the immediate environments of care; interactions and procedures directly involving staff and patients; and individuals (both patients and staff).

The concept of safety just like most of the variables on client-centred care may differ based on individuals and societies. For example, Tibetan rural women's views of safety in childbirth include: protection of the foetus or baby from attacks by spirits or demons; avoiding negative health effects of meeting strangers; fear of and taboos against pollution/defilement; injunctions to silence and secrecy; various beliefs about diet and behaviour; and various social and economic obstacles to receiving hospital care (Adams, Miller, Chertow, Craig, Samen & Varner 2005:826-834). Another study in the United Kingdom reported that women place more importance on the skills and professionalism of the individuals caring for them when discussing issues on safety (Magee & Askham 2008:7). Other factors such as cleanliness, being well informed about what to expect, regular monitoring, appropriate equipment, security on the labour ward, shared decision-making and the prevention of accidents were also mentioned by the women (Magee & Askham 2008:7). In another study, perceived safety was related to knowing that care providers worked within the framework that takes account of good

birth outcomes and that if problems arose and possibility of transfer to problems come (Newburn 2012:65).

Despite these differences, pregnancy and childbirth care is an area where safety and risk are a crucial concern (Magree & Askham 2008:1). The World Health Organization (WHO 2012) reported that poor quality of care was implicated in most of the 536,000 women who died in 2005. Another report also noted that although minimum care standards and best practices for safe childbirth have been extensively described, there are existing well recognized gaps in newborn and maternal care practices at birthing sites worldwide (WHO 2013:2-3). A study in 124 birth centres located in 26 African and 15 Asian countries reported that all facilities had gaps in the availability of essential childbirth related technologies and logistics. These include equipment, medicines and consumables which are very critical in the delivery of safe care (Spector, Reisman, Lipsitz, Desai & Gawande 2013:6). This study assessed the views of both health professionals' women on the safety of childbirth services to give improvement efforts.

3.8.9 Continuity of care

Haggerty, Reid, Freeman, Starfield, Adair and McKendry (2003:1221) define continuity of care as the degree to which a series of discrete health care events is experienced as coherent and connected and consistent with the patient's medical needs and personal context. They further noted that three types of continuity exist in all settings: informational, management, and relational (Haggerty et al 2003:1220-1221). Informational continuity is the aspect that links care from one provider to another and from one health care event to another, and comprises accurate documentation and provision of information on diseases, procedures, patient's preferences, values and context of service delivery. Information can be transmitted through several media – electronic, paper-based or verbal. Management continuity refers to the sharing of management plans or care protocols to facilitate continuity in care. It is very important especially in management of chronic or complex clinical cases as it has the benefit of providing a sense of predictability and security in future care for both patients and providers. Relational continuity relates to establishing on-going relationships with individual or multiple caregivers thereby assuring patients of a sense of predictability and coherence. It bridges not only past to current care but also provides a link to future care. The emphasis on each type of continuity differs depending on the type and setting

of care. Likewise, the importance attached to each type differs according to the providers and the context of care, and each can be viewed from either a person-focused or disease-focused perspective (Haggerty et al 2003:1220-1221).

Price and Lau (2013:6-9) added four elements to the dimensions of continuity outlined by Haggerty et al (2003:1220-1) as follows: (1) provider connectedness that facilitates achieving continuity between providers; (2) communication pattern that enables continuity between providers and between providers and the patient; (3) circles of care that are the systems in which continuity exists and can have characteristics that can impact continuity; and (4) environmental factors that influence the circles of care and continuity but are outside the circle. According to Price and Lau (2013:9-10), the relationship between providers greatly influences continuity for their shared patients as such cohesiveness of the relationship. Likewise, the quality of communication, the context within which it takes place as well as other factors outside the circle of care also impinge on effectiveness of continuity.

Continuity of care enables women to develop a relationship with the same caregiver(s) throughout pregnancy, birth and the postnatal period. Different models of continuity exist in maternity care delivery. These models include: midwife-led continuity of care (provide continuity of care to a defined group of women through a team of midwives sharing varying caseload), caseload midwifery' (women receive their ante, intra- and postnatal care from one midwife or her/his practice partner) and a mix of others led by obstetricians, family doctors (Sandall, Soltani, Gates, Shennan & Devane 2013:3). There is also the shared model of care, where responsibility for the organisation and delivery of care, throughout initial booking to the postnatal period, is shared between different health professionals (Sandall et al 2013:3). The model adopted in any given situation is often depended on a number of factors related to availability of resources such as human resource, equipment and logistics. It is rare that the choice of model takes the preferences of women and their families into consideration.

Regarding women's preferences, Hundley and Ryan (2004:555) contend that the availability of continuity of carer has influence on preferences and found that women prefer to have a midwife they had met during their pregnancy and who would be present throughout labour and delivery. Other studies reported that women preferred a single provider or at least better coordination of care with multiple providers (Novick 2009:8).

Jamas et al (2011:697) found that women preferred to have prior contact with care providers and the care environment before they get into labour. Leep, Sandall, Buckland and Huber (2010:239-240) provided support for the association between good midwifery continuity of care and that it helps to build women's confidence around coping strategies for pain and reduces anxiety and use of pain interventions in labour. In addition, William et al (2010:619) also noted that continuity of care helped women to build personal relationships with the midwives and also promoted the feeling of more respectful treatment during ante-natal care.

In maternity care, Homer, Besley, Bell, Davis, Adams, Porteous and Foureur (2013:2) and Novick (2009:8) wrote that midwifery continuity of care allows women to develop a relationship with the same care giver throughout pregnancy and birth. Sandall et al (2013:17) found that women who had midwifery-led continuity were on average less likely to experience: amniotomy; regional analgesia; episiotomy; and instrumental delivery. Positive results of continuity have also been reported in other disciplines. For example, Robinson, Callister, Berry and Dearing (2008:600-607) noted that continuity of care has led to improved outcomes of diabetes care, delivery of preventive care and clinical satisfaction while also decreasing the number of hospitalisations, emergency department visits, readmissions, and reducing length of stay.

Other findings also indicate that some women are not too much concerned about having the same care provider attend to them throughout childbirth; however, they do value having a midwife that they have seen during the prenatal period attend to them at the time of delivery (Rodriguez & Rivieres-Pigeon 2007:9-10). A similar finding was observed by Gamble et al (2007:117), where majority of the participants reported that they felt very comfortable having the same person providing care for them during pregnancy, birth and postnatal care.

However, a few of the women in Gamble et al (2007:117) study indicated that their carer were like strangers to them. There are others who expressed satisfaction with having a small number of caregivers working together to care for them (Rodriguez & Rivieres-Pigeon 2007:9-10). Further support for continuity of care was reported by Hundley and Ryan (2004:555) who found that women with least continuity of care were significantly ($p=0.007$) less likely to prefer having one midwife they met during pregnancy to care for them throughout labour and delivery.

However, the findings on preferences and influence of continuity of care on women's experiences are not consistent in the literature. One study found no significant relationship between continuity and overall satisfaction with care (William et al 2010:619). In a similar vein, Mclachlan et al (2009:131) using a focus groups discussion explores views on alternative packages for postnatal care in Australia and reported that women had mixed feelings on postnatal continuity of care provided by a known midwife but preferred domiciliary care. After conducting a review on interventions on continuity, Aubin, Giguère, Martin, Verreault, Fitch, Kazanjian and Carmichael (2012:2) concluded that no significant difference in patient health-related outcomes was found between patients assigned to interventions and those assigned to usual care. Only a limited number of studies reported psychological health, satisfaction of providers, or process of care measures.

Although continuity of care is seen by both clients and health care professionals as facilitators of client-centred care (Phillippi, 2009:224), continuity is difficult to provide. Gu, Zheng and Ding (2011:245-48) reported that midwives who provided one-on-one care for women from onset of labour to two hours postpartum reported feeling exhausted and fatigued, having a high sense of anticipation and uncertainty, facing many inconveniences of covering on-call shifts, and not having enough sleep. Some other reasons given by health professionals for not providing continuity of care were inadequate staff and using of part-time staff, and inappropriate physical structures (Maclachlan et al 2008:363).

3.8.10 Empowering and engagement of patients, families and community

Patient empowerment is a process designed to facilitate self-directed behaviour change (Anderson & Arbor 2010:1). Health care empowerment is defined as the process and state of being engaged, informed, collaborative, committed to one's health care and tolerant or resilient to uncertainties in treatment outcomes (Johnson, Rose, Dilworth & Neilands 2012:1). Broadly, it can be seen as an enabling process through which individuals or communities take control of their lives and their environment. Patient engagement in health care has also been defined as "the mutual exchange of information and ideas between the care-giver and patient resulting in the emphatic, trusted relationship which benefits the experience of the user" (Patel & Rajasingam

2013:597). Effective active service user engagement at the various levels of health care delivery is seen as a means to enhance the quality of care and the overall responsiveness of health care systems (Pedersen et al 2013:2).

Empowerment and engagement are two concepts that are often used interchangeably in literature. Empowerment can be seen as a process when the purpose is to increase one's ability to think critically and act autonomously as well as an outcome in situations when an enhanced sense of self-efficacy occurs as a result of the process (Anderson & Arbor 2010:2). The empowerment approach involves facilitating and supporting patients to reflect on their experience in an environment characterised by psychological safety, warmth, collaboration and respect (Anderson & Arbor 2010:8). In a concept analysis of empowerment during the childbirth period, Hermansson and Martensson (2011:814) described the following as the major requirements:

“Development of a trustful relationship; starting an awareness process to make it possible for parents to reflect on the changing situation, for example, helping parents to minimise uncertainties; acting based on the patients’ situation on their own terms getting them involved and able to make informed choices; and confirming the personal significance of becoming a parent”.

The antecedents to empowerment in the midwifery care are the willingness of the woman or significant others to: allow choices among available tools and resources to facilitate participation in decision-making; set goals; and to accept behaviours that encourage empowerment (Hermansson & Martensson 2011:815). Additionally, care providers need to possess and use professional skills and knowledge as well as ensure an enabling environment that is characterised by trust, openness, honesty, authenticity, acceptance of people as they are, and regarding of clients as equals. Other characteristics of importance in the empowerment process are self-understanding, courage, respect for others values and choices, awareness and understanding of patients’ limitations. (Hermansson & Martensson 2011:815).

Empowerment and effective engagement calls for a significant change in the traditional health care professional-patient relationship and professional culture as well as investment in time and approaches to make the patient feel fully empowered (Patel & Rajasingam 2013:599). This assertion is supported by Romano (2010:50) who posits

that creating a culture of effective client engagement in maternity care will take a broad effort at every level of the health system. As stressed by Pedersen et al (2013:6), relationships in health care as well as in any setting, do not exist and evolve in isolation but are strongly influenced by the context(s) within which they take place. Understanding the socio-contextual factors is thus imperative.

Empowered parents are better prepared to tackle new and unexpected situations and to understand the meaning of becoming parents, and to take control of their lives (Hermansson & Martensson 2011:816). The level of empowerment or control women experiences through birth may affect a woman's family and social relationships (Namey & Lysterly 2010:9). Do and Kurimoto (2012:29) identified positive associations between women's empowerment and contraceptive practice in four African countries. Similar results were found in Upadhyay and Karasek (2010:23) in some sub-Saharan African countries where they demonstrated an association between several dimensions of women's empowerment and the desire for fewer children.

Many women suffer negative health consequences when they do not agree to assessment and treatment plans in a collaborative way (Øvretveit 2012:7). There is also some indications that empowered patients may be perceived as difficult or demanding by providers resulting in some patients tempering their assertions in clinical encounters by stifling questions or withholding requests for medical tests, additional opinions, or the pursuit of alternative treatment approaches (Johnson et al 2012:6). Grilo et al (2013:38) indicated that interaction between health professionals and patients is still 'profession-centred'. A study that used the Patient-Practitioner Orientation Scale and other tools to measure perception and competence in technical and communication skills regarding two dimensions of patient-centred care (caring and sharing) among 525 student nurses and 108 nurse showed that staff were less supportive in sharing information and in involving patients in the decision-making process (Grilo et al 2013:38). This study among other things will examine system for and women's experiences of childbirth empowerment.

3.8.11 Built environment

Health facility designs and features that provide space, homely environment and hotel-like services are increasingly being promoted (Bromley 2012:1057). These designs are expected not only to give considerations to needs of the care providers but to also reflect patients' needs and preferences. This is because health facility rooms contribute to the lived experience of patients and at times serve as a source of power, place of security and trust, life affirming as well as a place of tenderness and care (Olansson, Lindahl & Ekebergh 2013:239-40).

As espoused in Ulrich, Zimring, Zhu, DuBose, Seo, Choi, Quan and Joseph (2008:63-111), a number of studies have established the relationship between the physical design of hospitals and key outcomes such as patient safety (that is, infections, medical errors, and falls), patient outcomes (that is, pain, sleep, stress, depression, length of stay, spatial orientation, privacy, communication, social support, and overall patient satisfaction) and staff outcomes (that is, injuries, stress, work effectiveness, and satisfaction). The layout, design of equipment and fixtures all impact on the childbirth practice (Hammond, Foureur & Homer 2013:3-4). Additionally, having access to personal belongings and small items associated with one's own home relieves the patients' suffering (Olansson et al 2013:241). Conversely, in reporting on the views of midwives indicated that the midwives Seibold, Licqurish, Rolls and Hopkins (2010:528) felt that the physical environment only makes a marginal contribution to the optimal childbirth space and its effect on clinical risk management practices is minimal.

In relation to women's views, Tuncalp et al (2012:3-6) assessed quality of care in one teaching hospital in Ghana and indicated that women expressed concerns about lack of physical resources such as water, mosquito net and delivery beds. In a related study, Hammond et al (2013:3-4) assessed the impact of physical and aesthetic design of hospitals birth rooms from the perspective of midwives and noted concerns about: space (that is, rooms were crowded with people and things, no storage facilities for equipment and women's belongings or even to sit and offer support); having to work with equipment that were not designed to engender work, safety or comfort; and challenges with creating satisfactory ambience.

The Department of Health (United Kingdom 2013:1) recommends that each childbirth setting should be designed so it is appropriate and safe for use by the client, the family and the staff who provides care. In addition, rooms should be designed to give women choice and control over their labour and birth; should have areas for baby care and must ensure privacy, facilitate counselling and effective communication among others (Department of Health, United Kingdom 2013:1). This view was supported by Jamas et al (2011:697) in their qualitative study in Brazil that found that women preferred having a pleasant atmosphere.

3.9 MEASURING CLIENT-CENTRED CARE OR SERVICE

Though there is a widespread interest to adopt patient-centred care to improve quality of care, there is no consensus yet on how best to measure and report patient-centred care (Jayadevappa & Chhatre 2011:22; Epstein et al 2010:1493). Hudon, Fortin, Haggerty, Lambert and Poitras (2011:156) cautioned that a shared understanding on the definition and a clear conceptual framework are essential first steps for measurement.

The OMA (2010:34-37) and Hudon et al (2011:156) indicate that client-centred care can be measured from different perspectives (service users, direct health care providers and health care managers) and must also be comprehensive enough to cover issues on structures, processes and outcomes of service. Looking at the different perspectives is important because different stakeholders tend to be selective in the emphasis that they lay on the different dimensions of client-centred care. For example, while effective integration of care and access are key at the organisational level, at the health professional and patient levels, effective communication between provider and patient and issues related to shared decision-making process are key measurement aspects of care (OMA 2010:34-37). This notwithstanding, measures of the patients' perceptions are more successful at predicting outcomes (Hudon et al 2011:156).

Similarly, various methodological approaches – both quantitative and qualitative- could be used to measure client-centred care. Lori et al (2013:3) used an exploratory, qualitative study design to examine perceptions of access among community members. Tetui, Ekirapa, Bua, Mutebi, Tweheyo and Waiswa 2012:[3]) used cross-sectional study, including structured interviews in Eastern Uganda to assess process quality and

satisfaction with ANC care. Self-reported questionnaires were used in Nieuwenhuijze et al (2013:2-3) to explore how choices in the birth position contribute to control during birth. Howarth et al (2012:490-492) used semi-structured and face-to-face interviews among early post-partum mothers to ascertain influence of relationship between midwives and doctors on birth experiences.

The literature review also observed more progress in many developed countries regarding development of tools for measuring client-centredness of services in different disciplines. For example, after a systematic review of the literature, Lawrence and Kinn (2011:319-324), produced a measuring tool for assessing patient-centeredness in rehabilitation care. White, Newton-Curtis, and Lyons (2008:114-123) developed tools to measure person-directed care in long-term care, while Van Empel, Aarts, Cohlen, Huppelschoten, Laven, Nelen and Kremer (2010:2516-2526) developed one for assessing fertility care. This study will apply similar processes to develop a client-centred childbirth tool(s). Continuous measurement is central to informing and supporting service quality improvement, improving resource allocation and making health care organisations accountable to the public. It is also imperative for assessing and improving individualised care. However, measurement must be based on the best available scientific evidence and standardised to enable fair and accurate comparisons within and across organisations and practitioners (Shaller 2007:20).

3.10 CONCLUSION

The current governmental policy environment emphasises patient involvement and choice in health care and recommends that patients should become the fulcrum around which services are organised. The client-centred approach in childbirth demands that health care providers empower women, their families and communities to make the most informed health care decisions by providing them the highest quality scientific evidence on the effectiveness, benefits and risks of the different options available for prevention, treatment and care. Optimal maternal health outcomes can best be achieved in an atmosphere of effective communication, shared decision-making, and teamwork, and data-driven quality improvement initiatives. The literature demonstrates that several factors impinge on the client-centredness of childbirth. As stated by Yates (2009:2078), improvement in accessibility is key but in order to assure better quality of

care, health professionals and organisations need to holistically address the other dimensions of client-centred care.

As outlined by Aboud and Singla (2012:590), most interventions in low-resource countries encounter common problems that often lead to little or no change in behaviour and many programmes rarely rely on evidence and insight about their users to identify what and how to change behaviour as well as how willing and able they are to process the change message. To assure effective diffusion or implementation of interventions requires taking the necessary steps not only at the developmental stages but also putting in place mechanisms to increase its chances of being noticed, positively perceived, accessed and tried, adopted, implemented and sustained (Dearing & Kreuter 2010:S100).

The extent to which this client-centred care has actually been adopted in reality, and the degree to which patients are comfortable with the level of responsibility and choice which they are being presented with have not been fully evaluated in Ghana. The elements in Greenhalgh et al (2004) model offer relevant areas to study and understand issues associated with the adoption and implementation of client-centred childbirth in Ghana. A successful adaptation and implementation of client-centred childbirth means that health facilities are putting mechanisms in place to elicit information on child bearing women's needs, expectations and preferences and also responding effectively and safely to the needs, expectations and preferences. It will also mean that women are treated in a dignified and supportive manner through a well-coordinated and integrated service delivery approaches so as to improve client experience and quality of childbirth services.

This study will examine the factors and process that influence the adoption and sustainability of client-centred childbirth approach in health facilities. Specifically, what steps were taken to make childbirth services providers and users know and understand the tenets of client-centred services. What do people think about the benefits of the approach? How and what aspects of client-centred childbirth care are being implemented in hospitals? Whether the innovation is helping to achieve its intended objective or whether there are some unintended consequences will be determined. Finding answers to these variables require evaluation at both the individual health care

provider and organisational levels, including determining the experiences of clients and outcomes of implementation of client-centred childbirth.

CHAPTER 4

METHODOLOGY

4.1 INTRODUCTION

As outlined in earlier chapters, the objectives of this study were to:

- Assess the factors that influence client-centeredness of the care given to women from ante-natal to immediate post-natal period.
- Explore and describe women's views of and experiences with client-centred childbirth services.
- Explore and describe health professionals (doctors and midwives) views of and experiences with client-centered childbirth services.
- Based on the findings from the views and experiences of health professional and women guidelines will be developed to improve client-centred childbirth services in hospitals in Ghana.

This chapter outlines the study design, population, sampling technique, sample, data collection and data analysis. Issues of validity and reliability of quantitative methods as well as measures employed to ensure trustworthiness and authenticity of qualitative approaches are described. Included is how ethical considerations were addressed.

4.2 STUDY DESIGN

Study designs are logical models that guide investigators in the various stages of the research. The study design guides the methods and decisions that researchers must make during their studies and sets the logic by which they make interpretations at the end of their studies (Creswell & Clark 2011:53). It is a plan that outlines how data are collected, from whom they are collected and how data were analysed to answer the research question(s). The study was also exploratory, descriptive and contextual in nature. The fixed mixed methods design comprising both quantitative and qualitative methods (Creswell & Clark 2011:54) were used in the study. Fixed mixed methods designs are mixed methods studies where the use of quantitative and qualitative methods is predetermined and planned at the start of the research process, and the

procedures are implemented as planned (Creswell & Clark 2011:54). The different research approaches, though different in their emphasis, all address the overall problem of interest, the purpose, objectives and research questions guiding the study (Creswell & Clark 2011:60). According to Creswell and Clark (2011:61), the major reasons for using mixed methods could be triangulation, complementarity, development, initiation, and expansion.

The research also applied the explanatory sequential design which occurs in two distinct interactive phases (Creswell & Clark 2011:71). This design starts with the collection and analysis of quantitative data followed by the subsequent collection and analysis of qualitative data. Building from the quantitative results, the researcher conducts a second qualitative phase to obtain deeper meaning of some of the findings in the first phase. The researcher then interprets the two results together (Creswell & Clark 2011:71). In this study, the mixed method design was employed for two reasons. Firstly, the researcher deemed it imperative to use quantitative design to ascertain the factors that influenced client-centredness on the continuum of care from ante-natal to immediate post-natal from women that utilised the services. As noted in Creswell (2003:21-22), if the problem is identifying factors that influence an outcome, the utility of an intervention, or understanding the best predictors of outcomes or to provide an explanation, then a quantitative approach is best. In addition, Burns and Grove (2005:23) note that quantitative research method is useful in describing variables and examining relationships among variables.

Secondly, Cronholm and Hjalmarsson (2011:87) point out that one aims at using a mixed method (qualitative or quantitative research) is to increase the possibility to achieve findings that are more trustworthy and relevant than using the approaches separately. The findings of the study were to be used to develop guidelines for implementation as such it was important to explore as widely as possible views and experiences of individual that are part of the service delivery system. In this regard, it was necessary to understand the views and experiences of care providers and women who use client-centred services. The best approach to better understand these individual and personal experiences was through qualitative methods (Mack, Woodsong, Macqueen, Guest & Namey 2005:1-2). Mack et al (2005:1-2) assert that the strength of qualitative research is its ability to provide complex textual descriptions of how people experience a given research issue and that qualitative methods provides

information about the “human” side of an issue such as behaviours, beliefs, opinions, emotions, and relationships of individuals. Stewart (2001:445) notes that qualitative studies are best suited for investigating the phenomenon of client-centred care as other methods tend to over simplify the intrinsic relationship inherent in the provision of client-centred care. The process of guidelines development also comprised using the consensus building meeting method, which was also qualitative.

Following from the above discussion, in phase one, the study utilised a questionnaire to assess the client-centredness of childbirth services covering the ante-natal, delivery/labour and immediate post-natal periods. In phase two, explorative and descriptive methods were used to further explore and describe the views and experiences of women who utilised childbirth services in the hospitals with focus on informed choice. Phase 3 of this study focused on exploring the meaning of client-centred care and the key attributes or characteristics among health professionals. Furthermore, views on the organisational factors that facilitate and or hinder effective implementation of client-centred childbirth, and health professional’s views on informed choice (decision-making process) regarding key components of client-centred childbirth services were explored. Phase 4 used the findings from phases 1, 2 and 3 as well as expert knowledge and consensus building approach to develop guidelines to help implementation of client-centred childbirth services in hospitals in Ghana.

4.2.1 Descriptive study

A descriptive study aims at describing the state of affairs as it exist regarding an event and or among particular individual or groups (Kothari 2004:37; Polit & Beck 2004:20). Descriptive methodologies could be used for both qualitative and quantitative research, in that, while quantitative description could focus on the prevalence, incidence, size, and measurable attributes of phenomena, qualitative description may use in-depth methods to describe the dimensions, variations, and importance of the phenomena (Polit & Beck 2004:20). A questionnaire was used to assess the client-centredness of services provided to women during pregnancy to immediately after delivery. In addition to the quantitative study, a qualitative study also was used to further explore the views and experience of both women and health professionals in phases 2 and 3. This approach is supported by Kendall (2008) cited in Lois and Gavin (2010:1). Other researchers such as Nieuwenhuijze et al (2013:2-3) used a similar approach to explored choices in the

birth position that contribute to control during birth using self-reported questionnaire. Equally, Thomson et al (2012:259) utilised a similar method to study an initiative to remove or reduce hospital-based constraints that disadvantaged breastfeeding.

4.2.2 Exploratory study

Exploratory research approach was used because the methodology focuses on the discovery of ideas and insight. This approach is supported by Kothari (2004:36) who indicated that exploratory studies are often undertaken when not much is known about the situation or when no information is available on how similar problems or research issues have been solved in the past. Williams (2011:71) posits that more useful information cannot be reduced to numbers and also that people's judgements, feelings of comfort, emotions, ideas, beliefs and many other such view can only be described in words; hence the need for qualitative studies. Exploratory research enables the investigator to examine the full nature of a phenomenon, the manner in which it manifests and other factors to which it is or may be related (Polit & Beck 2004:20). Very little is known about client-centred childbirth in Ghana as such an exploratory study to further understand the issues appeared a suitable method of study.

In doing this, the researcher employed semi-structured individual in-depth interview methodology to gather data from both women and health professionals. Hancock, Windridge and Ockleford (2007:17) and Jeanfreau and Jack (2010:[5]) indicated that semi-structured interview is possibly the most common qualitative research data gathering method in health and social care research as it is relatively straightforward to organise. Furthermore, many studies assessing views and experiences in the health sector have largely been qualitative and exploratory. For example, Lori et al (2013:3) used an exploratory, qualitative study design to examine perceptions of access among community members. Data were gathered using focus groups and in-depth individual interviews with key stakeholders in the domains of (a) availability, (b) accessibility, (c) accommodation, (d) affordability, and (e) acceptability. Vedel et al (2012:77-79) used direct observation, records review and face-to-face interviews to study the adoption of a clinical information system for chronic care and wrote that the use of interviews allowed them to better understand how the system diffused among nurses. In addition, Witter et al (2007:63) evaluated the perception of health care providers on the implementation of a user fee exemption policy for delivery care in two regions in Ghana using key

informants and semi-structured questionnaire. Howarth et al (2012:490-492) also used semi-structured and face-to-face interviews among early post-partum mothers. The aim of the study was to ascertain influence of relationship between midwives and doctors on birth experiences and reported that most women were able to establish good personal relationship with the midwives but not with the doctors even when the opportunity was there.

4.2.3 Philosophical context of the study

The phenomenon under study is client-centred care, its meaning and how it is being practiced as well as how women and health professions experience it. In deciding on the research design, the researcher was reminded of the extent to which the concept might have penetrated the services delivery system and whether or not it was being practiced. Answering these questions required exploring individual views within the context of the environment where the service was being provided. Health care professionals are the direct caregivers of client-centred care; their perceptions in particular were deemed to be important to understanding the implementation of the approach to care in context of health facilities. Equally imperative was to understand the lived experiences of women, the direct services users regarding service delivery as well as obtain data on the whole continuum of care from ante-natal through to post-natal to guide improvements. The study was thus grounded in an inductive process using discrete studies with appropriate methodologies in mixed quantitative and qualitative enquiry. Minnie, Klopper and Van der Walt (2008:52) indicated that a study can be deemed as contextual if validity of the findings is claimed only in the specific context in which the study was conducted. This study was largely contextual since validity of the findings is claimed only in the specific hospitals in Accra where the study was conducted. In addition, a rich description of the context is provided. This is supported by the AHRQ (2013:2-3) who suggests that paying attention to context in designing, conducting, and reporting research in health, regarding client-centred care has great potential as what works in one context often does not work in another.

4.3 SETTING

4.3.1 Characteristic of Ghana health system

The study was conducted in Ghana, which is located in West Africa. The population of Ghana as at 2010 is estimated to be about 24.7 million with a growth rate of 2.5% (Ghana Statistical Services 2011:9). As indicated in Chapter 1, Ghana is divided into 10 Regions with 216 Administrative Districts. Figure 4.1 is the map of Ghana. Ghana's health system is built on the Primary Health Care (PHC) concept and have structures that run from the national, regional, district, sub-district through to the community. At the national level, the health system comprises the Ministry of Health (MOH), the Ghana Health Service (GHS) Headquarters and Regulatory Bodies. The GHS is the major provider of health services and controls all the public or government-owned health facilities, including nine regional hospitals, 109 districts or primary level hospitals, 1081 Health Centres and 795 Community-Bases Health Planning and Services (CHPS) Zones (Ghana Health Service 2009b:17).

The Government of Ghana is the major financier through the Ministry of Health. The hospitals are financed mainly through a private and national health insurance schemes. Public policy making usually takes place at the national level and is then disseminated to the regional level through to the district and community level for implementation. The implementation of centrally developed plans is supervised by the national level. According to an assessment done in 2012, the performance of Ghana's health system is mixed and consumer satisfaction is high (Schieber et al 2012:3). Schieber et al (2012:3) stated that Ghana has fewer physicians and health workers per capita than other countries with comparable income and health spending. It also has a serious shortage of specialists (Schieber et al 2012:4). Ninety per cent (90%) of health workers are employed in the public and the non-profit sectors (Pilliner 2011:6). The Ghanaians health system suffers from a high burden of disease, especially malaria, as well as high rates of maternal and infant mortality that is typical of many developing countries.



Figure 4.1 Map of Ghana

(<https://www.google.com.gh/search>)

Many of these characteristics are typical of most developing countries. The study was limited to GHS hospitals. This was because:

- GHS hospitals seem to be among those that have more unacceptable media publicity regarding quality of childbirth services.
- It will be more feasible and practical to implement changes to improve childbirth care based on the findings of the study because the GHS is supporting this study.

4.3.2 The demographic characteristics of the study region

The study was done in the Greater Accra Region of Ghana, one of the 10 administrative regions of Ghana. It lies in the South East of the country along the gulf of Guinea. Greater Accra Region, the capital city of Ghana, has an estimated population of 4,010.054 million and occupies a land area of approximately 3,245 square kilometres (Ghana Statistical Services 2012:21). It is almost 90% urban. The most densely populated region (1,236 persons per square kilometre) with majority (63.3%) of households being headed by males (Ghana Statistical Services 2012:6). Greater Accra

is one of the regions that recorded the highest population growth rates of 3.1% in 2010 (Ghana Statistical Services 2011:2). Migration in from poorer regions of the country is a major contributor to the high population growth. Though Greater Accra Region is the smallest area of Ghana's 10 administrative regions, over 70% of Ghana's manufacturing capacity is located within this region and it is one of the richest regions in the country. The literacy level is generally high with about 10.1 % of the population that have never been to school. The region is a major centre for manufacturing, marketing, finance, insurance, transportation and tourism but most of the women engage in trading. The region also hosts the largest number of quasi-governmental, private and mission facilities as well as several pharmacies and traditional healers.

Regarding maternal health data in the Greater Accra Region, in 2013, the percentage of skilled birth delivery was 56.4%, ante-natal coverage was 86.9%, total deliveries (all methods) were 586,141, postnatal coverage was 63% and institutional mortality ratio was 198 per 100,000 live births (GHS, Reproductive Health Report, 2014:25-38). Women in Greater Accra are more likely to have completed secondary or higher education (22 %) than other regions in the country (GSS, GHS and MII 2009:26).

4.3.3 Site sampling technique

The Greater Accra Region was purposively selected for the study. The main motivation for selecting Greater Accra Region was the high institutional maternal mortality ratio and the intent of the researcher to help identify some of the contributory factors for redress. In 2013, the region had the highest maternal mortality ratio of 198 per 100,000 live births, far exceeding the national average of 154 per 100,000 live births (Ghana Health Service 2014:39). In the same year, the antenatal coverage reduced from 88.7 % in 2012 to 86.9 while skilled birth attendance also reduced slightly from 56.6 to 56.4 % (Ghana Health Service 2014:16). This performance is against the fact that of the 1880 medical officer in the country, 820 are located in the region. Likewise, out of 9775 professional nurses nationwide, 2624 are in the region (Ghana Health Service 2009b:19). The doctor population ratio is 1:5177 while the professional nurse population ratio is 820 (Ghana Health Service 2009b:20). The region has 3118 hospital bed.

Furthermore, a major focus of the study was decision-making regarding the choices that women had in relation to childbirth. Therefore, it was imperative to conduct the study in

an area where women had the option to make a choice in the health facilities to use. Greater Accra Region is among the regions with high number of health facilities (Ghana Health Service 2009b:17). The wide availability of health services in the region comprises: 1 Teaching Hospital, 1 Regional Hospital and 10 primary level hospitals hundreds of other private hospitals, clinics, and quasi-government hospitals, polyclinics, health centres and CHPS zones (Ghana Health Service 2009b:17).

4.3.3.1 Selection of hospitals

As indicated earlier, the study was limited to Ghana Health Service hospitals. Greater Accra Region has one GHS regional hospital and 10 GHS primary level hospitals (Ghana Health Service 2009b:17). These hospitals serve as the major referral centre for most of the health facilities in and around the region. The regional hospital was purposely selected because it is large and provides wide range of specialist services, including ante-natal, intrapartum and post-natal care. The two primary level hospitals that participated in the study were randomly selected. Financial constraint was the main rationale for the number of hospitals sampled. It must be indicated that though the regional hospital provided a wider range of health services, the three hospitals are quite homogenous in terms of services offered, clientele, cultural traditions and language. Most importantly, they are all GHS health facilities operating under similar policies and guidelines. The characteristics of the hospitals are presented below.

4.3.3.2 Characteristics of the selected hospitals

The information on the hospitals is based on the details provided by the hospital management and observations during the data collection.

- **Hospital A**

Hospital A, believed to have been opened by the British around 1928, consists of a large number of individual buildings in different shades of quality, size, architecture and appearance. It occupies a total land area of about 15.65 acres and is located within the Accra Metropolitan Area. As a regional hospital, its catchment area is the whole of the region with an estimated population of about 4,283,322 inhabitants (80% urban and

20% rural). It had a bed complement of 250 and has facilities to cater for a wide range of services including medical care, obstetrics and gynaecology, surgical, dental, and preventive as well as other support diagnostic services like imaging and laboratory. The hospital also serves as the referral centre for most Polyclinics, Private Hospitals and Clinics, and Quasi Government Hospitals in and around the region.

The maternity department had three units which were manned by 1 consultant, 2 specialists, 3 medical officers and 65 midwives. There are other nurses, paramedics and supporting staff. The total number of beds in the maternity department was 84. In 2013, the maternity department recorded 8,878 ante-natal attendances and a total of 7,591 deliveries (all methods). The Caesarean section rate for 2013 was 40.50% with an average of 10.6 Caesarean section operations per day.

- ***Hospital B***

Hospital B, also situated in the Greater Accra Region, was established in the year 1963 and accredited to a District Hospital status in the year 2004. The hospital is situated in municipality. The hospital provides 24-hour outpatient (OPD), in-patient and emergency services. Maternal health services are integrated and made accessible to all women within the context of Primary Health Care. The integrated services provided are categorised as: General Medicine, Paediatrics, General Surgery, Obstetric and Gynaecological Care, Maternal Health and Family Planning. There are other specialised services such as Eye care and Public Health, and other support services. The hospital serves a catchment population of 20,361 and has a total bed capacity of 161. The doctor-population ratio in 2013 was 1:9,015 and nurse-population ratio of 1:1,784. Doctor-patient ratio was 1:3,992. The hospital has a total of 15 doctors, 6 specialists and 1 consultant. There are only 45 midwives for the whole hospital. The average monthly OPD attendance was 7,660 with a daily OPD attendance was 252. The OPD per capita was 0.4. The total number of admission was 7880.

In terms of maternity care, the maternity section had three wards and a total of 42 beds. In 2013, the average monthly ante-natal care attendance (ANC) was 1,667, average monthly ANC admissions was 68. The total number of deliveries (all methods) was 3,925 with a monthly average of 227 with annual Caesarean section rate of 29.6%.

Institutional maternal mortality ratio was 357/100,000. The three maternity wards are manned by 2 doctors and 45 midwives.

- ***Hospital C***

The hospital is situated in municipality of Accra had a 100-bed capacity with all the units of a general hospital. Similar in size as Hospital B, Hospital C also provides 24-hour outpatient (OPD), in-patient and emergency services. The services provided are categorised as outpatient, in-patient and support services and cover: General Medicine, Paediatrics, General Surgery, Obstetric and Gynaecological Care, Maternal Health and Family Planning. The maternity section has 5 wards and 30 beds. The total number of doctors working in the hospital was 16 with 26 midwives. There were other nurses, paramedic and supporting staff.

In the maternity section, the staff strength of the maternity was 4 doctors and 20 midwives. Averagely, there were 6 midwives per work shift. In terms of workload, the ANC attendance per month ranged 100 to 150, number of ANC admissions per month ranged 200 to 350 and the number of deliveries per month ranged 200 to 250.

4.3.4 Consent from hospitals

Letters detailing information on the proposed research were sent to the Regional Directors of Health Services of the region and the hospitals. A copy of the letter is in Annexure 4. On receipt of consent (mainly verbal) from the hospitals, notices were placed on the notice board in the maternity section by the researcher to inform the staff of the purpose and objectives of the study and to request their support. The hospital management felt that the documentation provided was enough, hence the verbal consent.

4.4 PHASE 1: FACTORS THAT INFLUENCE CLIENT-CENTEREDNESS OF CHILDBIRTH SERVICES

4.4.1 Design

Creswell (2003:21-22) suggests that quantitative approach is best if the study aims at identifying factors that influence an outcome, or at understanding the best predictors of outcomes. Phase 1 is designed to address objective 1 of the study which is to determine the factors that influence client-centred childbirth in health facilities. The study design was thus descriptive and explorative in nature.

4.4.2 Development of the questionnaire

The expanded Hospital Consumer Assessment of Health care Providers and Systems (HCAHPS 2012) questionnaire and the Picker Women's Experience of Maternity Care questionnaire (Picker Institute Europe 2010) were used as guides. The HCAHPS survey was designed by the Agency for Health Care Policy and Research to help improve the quality of care and to make services more patient-focused (Goldstein, Farquhar, Crofton, Darby & Garfinkel 2005:1977-1995). It was developed after extensive fieldwork and pilot testing in three states before being implemented nationwide in the United States of America (USA). The 27-point version of this survey has been validated and was endorsed by the National Quality Forum in 2005. The survey has been used extensively in the USA for collecting a client's perspective of their ambulatory (including paediatric ambulatory) and hospital care experience. The Picker questionnaire was originally developed from extensive literature review, in-depth interviews and focus group discussions with patients (Gerteis 1999) and has been used extensively to assess patient satisfaction since 1987 in hospitals in the USA and other developed countries. Additional items in the questionnaires were derived from the review of the literature. The independent and dependent variables on client-centred care covered in the draft questionnaire were as follows:

Broad independent variables

- Arrival and reception
- Dignity, respect, courtesy and privacy

- Informed choice and decision-making
- Labour pain relief
- Position of birth
- Support in labour
- Length of stay
- Communication and education
- Built environment
- Demographic/background data on baby and mother
- Other questions were included to obtain responses on place of birth, mode of birth and birth attendant

Outcome or dependent variable

- **Overall client-centred care score**

The draft questionnaire was discussed with my supervisor and then with a cross-section of 10 senior health professionals drawn from GHS Headquarters to determine its relevance, comprehensiveness, readability and applicability. The researcher took advantage of a workshop session that was being organised for some senior health professionals in Accra to discuss and review the questionnaire. Five (5) of the participants reviewed the tool with regards to clarity, content and comprehensiveness. These methods were to determine the face and content validity of the tools. The second draft of the questionnaire was pre-tested in two primary level hospitals that were not included in the main study. Prior to the pre-testing, letters were sent to the Regional Director of Health Services (RDHS) responsible for the region in which the hospitals were located and the Medical Superintendent of the hospitals for their approval. Copy of the letter to the RDHS is in Annexure 4. The draft tool was administered to a total of twenty nine (29) women who had delivered in the hospitals and discharged.

Following the pre-testing, modifications and formatting were made to finalise the questionnaire. Changes to the questionnaire included adding more questions such as Question A3, A5 and A6 to the 'arrival and reception' sub-section to offer a more comprehensive assessment. Item 'C6' was reframed and reformulated so specific responses could be obtained on provision of information on choices available to women

on labour pain relief, birth position, labour companion and mode of delivery. The final questionnaire is in Annexure 1.

4.4.3 Population, sampling technique and sample

Polit and Beck (2012:738) define a research population as an aggregate of all the individuals or objects to be studied with some common defining characteristics. The population comprised all women who used childbirth services in the catchment area of the selected hospitals. Period sampling was also used to select the women for the questionnaire study. All women who delivered in the selected hospital from the 24th March to 23rd April 2014 were invited through the ward in-charges while still in the hospital to participate in the study. A few of them who could not wait to complete the questionnaire for various reasons were able to do so on the first post-natal visit the next day. A total of 771 women were invited and 754 completed the questionnaires giving a response rate of 97.8%. Seventeen (17) women declined the invitation. The majority of the women who declined to participate in the study cited lack of time as the reason for refusal.

Excluded in the sample were:

- Women below 18 years of age who were not accompanied by their spouse/parent/guardian to give consent.
- Women who had observable psychiatric or substance-abuse problems.

4.4.4 Preparation for data collection (questionnaire)

Three (3) research assistants were recruited and underwent a two (2) days training session on the data collection process and tools. The research assistants were health professionals that did not work in the sampled hospitals. The researcher assistants also participated in the field work session to pre-test the tools. During the training session, the researcher re-administered 8 (30%) completed questionnaires that were administered to women by the research assistants to assess inter-rater reliability. The three (3) research assistants were assigned one to each hospital and were responsible for administering the questionnaires.

4.4.5 Field work: Administration of questionnaires

The researcher and the research assistant assigned to each of the hospital met the management of the hospital, introduced ourselves and briefed them on the plan of work. All women who meet the inclusion criteria were approached shortly after discharge but while still on the ward to participate in the study. This approach was adopted because experience from previous studies found that it would be difficult to contact the mothers once they left the maternity wards. Interviewing the women immediately on discharge was also to help control for changes in perception and recall due to lapse of time. Research assistants first sought the consent of the women and proceeded to administer the questionnaire only when the woman agreed to participate. A log was kept on all women approached and those that agreed or declined to participate. For the participants that were below 18 years, consent was given by their parents or guardian. Permission was also sought from these participants. The research assistants read out all the questions and possible answers to each woman and documented their response. Completed questionnaires were numbered with unique identification numbers. Data were collected throughout the week between 8am and 6pm. Supervision was provided by the researcher. A copy of the consent form for the participants is in Annexure 2. Exit interview was used because of the researcher's knowledge of the difficulties in obtaining accurate and comprehensive residential and mailing addresses and telephone directories. A similar method was used by Van Rijsbergen and D'exelle (2013:278-280) who employed structured interview and choice experiment that included ranking of attributes that women considered when deciding where to go for services.

4.4.6 Quantitative data analysis

A data entry template with legal values was designed to capture questionnaire data in Excel. Data were checked for completeness, coded and checked for accuracy. Missing data were addressed by calculating the mean score of the total number of responses. Descriptive statistics including means, standard deviations, and medians were calculated. Frequency tables were computed for all items and are presented as tables and graphs. Items that were amenable to scoring were grouped under the different dimensions and scores assigned on a scale. The scores for negative questions were recoded so that positive responses had higher scores compared with negative responses. Annexure 5 provides the details of how the items were scored.

The dimension score was calculated as the sum of the standard score obtained in each dimension divided by the maximum dimension score obtainable (that is, the numbers of applicable standard(s) multiply by applicable items) expressed as percentage. The average score in percentages for a dimension was estimated as:

$$\textit{Average dimension score} = \frac{\textit{Total score obtained on the dimension}}{\textit{Total score obtainable on the dimension}} \times 100\%$$

The overall client-centred score was estimated as the average of the scores calculated from the dimensions. These indicators were: arrival and reception; dignity, respect, courtesy and privacy; informed choice, control and decision-making; birth position; support in labour; length of stay after delivery; communication and education; continuity of care; and built environment. All the items under place of birth, birth attendant, mode of birth and labour pain relief dimensions could not be objectively scored; so, the dimensions were removed from subsequent analysis. The total score on ante-natal, labour and postnatal care experiences were also determined by computing scores of variables that were grouped under them (see Annexure 6). Three (3) client-centred care categories were computed “excellent client-centred care”, “need room for improvement” and “needs a lot of work”. The score was classified as “excellent client centred care” if the score is 75% or more, “needing more room for improvement” category was for a score of between 55-74%, and “having to do a lot of work” category was for scores below 55%.

To investigate the predictors for ‘excellent client-centred care’, the ‘more room for improvement’ and ‘having to do a lot of work’ categories were collapsed so that the outcome of interest was defined as “1” for excellent client-centred care and “0” otherwise. The independent variables used for this analysis were the socio-demographic characteristics of the study respondents. The association of the client-centred care dimensions with the “excellent client-centred care outcome” was also ascertained.

4.4.7 Statistical analysis

Mean and standard deviations were reported for all continuous variables that were normally distributed. The Shapiro Wilk test was used to test for normal distribution of continuous variables. The chi-square test of association with their corresponding p-values was used to detect associations between each categorical predictor (socio-demographic factors) and the binary outcomes 'excellent client-experienced' with childbirth.

Crude odds ratios were estimated from simple logistic regression analysis and corresponding confidence intervals were estimated to determine variables required for the multivariable regression analysis. Multivariable binary logistic regression technique was used to assess the effects of socio-demographic factors on 'excellent client-centred care' experienced with childbirth. Internal consistency of the scale used in measuring specific indicators was based on the Cronbach's Alpha. Unless otherwise stated, significant association was observed at $p < 0.05$. Data were analysed using STATA MP Version 13.

The unstructured data from the open-ended questions in the questionnaire was transcribed into word documents, verbatim and read for relationships and patterns. Similarities and differences were identified; words and phrases were grouped by cutting and pasting the word document into clusters of similar ideas and concepts and highlighting in different colours. This process aided in grouping similar concepts together and identifying the most commonly occurring concepts.

4.5 PHASE 2: IN-DEPTH INTERVIEWS WITH WOMEN ON THEIR VIEWS AND EXPERIENCES WITH CHILDBIRTH

4.5.1 Design

This phase addresses the second objective of the study: to explore and describe the views of and experiences of clients (women who used client-centred childbirth services in Ghana) client-centred childbirth services. The objective lends itself to a qualitative, explorative and contextual research design (Kothari 2004:36). In-depth interview technique offered the researcher the opportunity to further explore some of the findings

from the questionnaire study. Using face-to-face interviews also enabled the researcher to explore issues for better understanding by the women and to also probe or clarify issues.

4.5.2 Pre-testing of the process

The draft interview guide comprising 1 broad question and seven (7) sub-questions was developed, pre-tested and used for the interviews. The broad question requested women to tell the researcher about their experiences with their childbirth from when they decided to go for antenatal care through to delivery and discharge. Seven (7) additional questions addressed other subject areas. DiCicco-Bloom and Crabtree (2006:316) agree with this method and posit that apart from an initial broad question, additional five (5) to ten (10) specific questions are usually developed to delve more deeply into different aspects of the research issue. Additionally, Gill, Stewart, Treasure and Chadwick (2008:292) suggest that the initial question should be one that is easy to understand and should not deal with sensitive issues. This can help put participants at ease, build up confidence and rapport and often generates rich data that subsequently develops the interview further.

The pre-testing was done in one of the hospitals in which the questionnaire was pre-tested. The main objective of pre-testing was to ascertain whether the process of interviewing would generate the required information. Two (2) women were interviewed. No changes were made to the guide (See Annexure 7 for copy of interview guide for women). The two women were not included in the final sample. This notwithstanding, as the interviews progressed some questions were dropped while others were modified to explore themes that were emerging.

4.5.3 Population, sampling technique and sample

Population is the totality from which cases are sampled based on specific criteria and a sample is a sub-set of that population (Robinson 2014:25-26). Another guiding principle in deciding on population and sample is ensuring that there is enough data to support credible analysis and reporting (Marshall, Cardon, Poddar & Fontenot 2013:11). In qualitative studies, it is acknowledged that if the goal of the study is not to generalise to a population but to obtain insights into a phenomenon, individuals, or events, then

purposefully selecting individuals, groups and settings that increases understanding of the phenomena is the most appropriate (Onwuegbuzie & Leech 2007:242; Polit & Beck 2008:338). The same population utilised in the quantitative study was used. All women who have utilised childbirth services in the selected hospitals constituted the population of interest. Purposive sampling was used to ensure that a specific representation of the entire population was selected. Onwuegbuzie and Leech (2007:242) suggest that sample sizes in qualitative research should not be too large that it becomes difficult to extract thick and rich data. Furthermore, the pairwise sampling design, a form of parallel sampling design which involves selecting cases and treating all as a set so as to better understand the phenomenon of interest was used (Onwuegbuzie & Leech 2007:243).

To select the sample, prior arrangement was made with the midwives in-charge of the maternity units of the hospitals for recruitment. All women who delivered in the hospitals were contacted by the ward in-charge to discuss the purpose of the study and elicit their willingness to participate in the study. Once the women agreed to participate the information was relayed to the researcher who paid a visit to the women in the hospital for further discussion and possible interview. Most of the mothers agreed to be interviewed just after discharge. However, a few arranged to be interviewed on their first postnatal visit which took place a day after discharge. This method was convenient because it would have been difficult to obtain a suitable sampling frame of women to facilitate the use of a more objective sampling method. The timing of the interviews was also appropriate as it offered the opportunity to limit recall bias due to time lapse. Nineteen (19) women agreed to participate in the study.

4.5.4 Field work: Interview with women

The individual interviews with women were done in phase 2. The researcher made all the arrangements for the selection of the participant as described under the section on sampling technique in line with the processes suggested in (DiCicco-Bloom & Crabtree 2006:315). At the appointed times, the researcher met participants at an office in the respective hospitals. The purpose of the study and the processes involved, including explanation of the content of the consent form were again discussed with the women. Initially, the mothers expressed some misgivings about giving out their phone numbers but after discussing and explaining the importance of further contacts and the process to assure confidentiality and anonymity they obliged. They were also informed regarding

the use of pseudonyms to be used during the interviews. The researcher then proceeded with asking the first question. Majority of the women offered to be interviewed in the local language. The first question was designed to further help put participants at ease, build up confidence and rapport (Gill et al 2008:292). The participants appeared not to be opening up at the initial stage so the researcher had to use more probes to boost up their confidence.

Semi-structured interviews format is used most frequently in health care as it provides participants with some guidance on what to talk about, which many find helpful. The flexibility of the approach also allowed both the participants and the researcher to elaborate on issues that came up that were not previously thought of (Gill et al 2008:291). Demographic data was collected at the end of each interview. Interviews were audio-taped. In addition, field notes were taken on reflections and observations. Interviews were transcribed at the end of each day's work or as soon as practicable to inform the next interview. Some of the women came with their babies as such some interruptions were encountered when baby was crying or had to be fed. The interviews took between 50 minutes to one and half hours. Field work was carried out from the 10th May to 5th June 2014.

As is common with qualitative methods, data analysis usually occurs concurrently with data collection so that researchers can generate an emerging understanding about research questions, which in turn informs both the sampling and the questions being asked (DiCicco-Bloom & Crabtree 2006:317; Miles & Huberman 1994:50). After each day's work, the researcher reflected on the process to make meaning and understand the key issues that came up and listened to the recordings to familiarise with the content. Transcription of the tape recordings started as soon as possible after each interview, usually within few hours by more experienced transcriptionists in health interview data and fluent in the local dialect in the study area. This made it possible for the researcher to obtain the scripts in time to read, extract codes and identify emerging themes before the next interview. Information from the review of the scripts was used to modify and or drop some of the questions in subsequent interviews. Of the nineteen (19) women that offered to participate, the interviews were stopped after the 15 participants when the point of theoretical saturation was reached. Theoretical saturation is the stage at which the researcher was obtaining no new information and could predict

responses from subsequent interviews (DiCicco-Bloom & Crabtree 2006:317-318). No incentives were given for participating in the study.

4.5.5 Field notes

Field notes taking started immediately after each interview and throughout the process of the study. Muswazi and Nhamo (2013:13) suggest that a good field notes should be descriptive to include verbal portraits of the participants, a reconstruction of the dialogue, and a description of the physical setting as well as accounts of particular descriptions of the observer's behaviour. Notes should also be reflective enough to include reflections of methods of data collection, analysis, reflection of ethical dilemmas and conflicts as well as reflection of the observer's frame of mind and emerging interpretations. The field notes included discussion sessions, arrangement for meetings and phone contacts. During the field work, after each interview, the researcher reflected on the process to make meaning and understand the key issues that emerged. On completion of the first two interviews, the research paid a cursory visit to the different sections of the hospitals noting aspects of the physical environment, interactions between the staff and clients and the general mood of other clients and staff in the wards.

4.5.6 Data analysis

According to Bradley, Curry and Devers (2007:1760), the purpose of qualitative data analysis is to generate taxonomy, themes and theory. They further argue that there is no singularly appropriate way to conduct qualitative data analysis, although there is general agreement that analysis is an ongoing, iterative process that begins in the early stages of data collection and continues throughout the study (Bradley et al 2007:1760). In this study, Miles and Huberman's (1994:10-11) proposition for quality data analysis was employed. This proposition defines qualitative data analysis as constituting of three concurrent flow of activities – data reduction, data display and conclusion drawing and verification. Data reduction refers to the process of selecting, focusing, simplifying, abstracting and transforming the data in the transcript. The data display consists of using an acceptable visual format to systematically present information to facilitate conclusion drawing. The third process is conclusion and verification which entails

identifying regularities, explanations, propositions, patterns and themes. This third component often begins at the initial stages of the study.

4.5.6.1 Preparations for data analysis

All transcripts for women were labelled sequentially with the first one as 'Wp1', second 'Wp2' to 'Wp15'. The researcher read all the transcripts comparing them with the audio tapes. An example of the transcript of one interview is provided in Annexure 8. Prior to analysis, an independent reviewer was engaged to review 30% of the transcripts against the audio tapes independently. The results were consistent with the original scripts. Meetings were then arranged with the women during one of their postnatal visits to the hospitals to discuss the content of the transcripts individually. They all agreed to the contents.

4.5.6.2 Reading and data reduction/coding

Bradley et al (2007:1761) opine that reading data without coding to generally understand the scope and context helps to identify emerging themes without losing connection between concepts and their text. The transcripts typed in Microsoft Word were printed to facilitate easy reading. In addition, the researcher read and re-read the transcripts several times to familiarise with the text. There were instances where the researcher had to re-listen to tape recordings to better understand the importance of what the participant was expressing. Thereafter, the process of data reduction to identify codes was initiated. Furthermore, Bradley et al (2007:1761) note that coding offers a formal system to organise the data, uncovering and documenting additional links with and between concepts and experiences described in the data. Miles and Huberman (1994:56) define codes as tags or labels for assigning units and meaning to the descriptive or inferential information compiled during the interviews. The coding or data reduction initially followed a deductive approach starting with a predetermined framework based on the objectives of the study, the research questions and the literature (Miles & Huberman's 1994:58). The coding was done manually through highlighting with different colours as well as making notes in the computer. This process was laborious and time consuming. The researcher reviewed all transcripts line-by-line to identify codes. In the process, the researcher also wrote down impressions.

4.5.6.3 Data display

The next step was data display to help determine patterns and themes (Miles & Huberman 1994:91-3). A matrix comprising rows and columns was designed in Microsoft Word. The research conceptual framework informed the format. It must be noted however that the format was reviewed several times as new ideas were generated. The researcher scanned through the codes and extracted coded segments in the form of block of text, quotes, phrases and symbols and entered them in the matrix.

4.5.6.4 Conclusion and verification

A critical examination of the data was carried out noting regularities of issues, similarities, relevant ideas to the purpose of the study and patterns to come out with themes. As indicated in Bradley et al (2007:1766), themes are general propositions that emerge from diverse and detail-rich experiences of participants and provide recurrent and unifying ideas regarding the subject of inquiry. Themes typically evolve not only from the conceptual codes but also from the relationship that exists in the codes. In the process of generating themes, the researcher had to return to the data several times to check the evidence supporting each theme. The independent reviewer who reviewed the transcripts once again reviewed the list of codes, the matrix and the themes. A meeting was held with the independent reviewer to discuss areas of disagreements. The codes, matrix and themes were further reviewed by my supervisor and then jointly discussed at a meeting at the university.

4.6 PHASE 3: IN-DEPTH INTERVIEWS WITH DOCTORS AND MIDWIVES: THEIR VIEWS AND EXPERIENCES WITH IMPLEMENTING CHILDBIRTH SERVICES

4.6.1 Design

Research designs are procedures for collecting, analysing, interpreting, and reporting data in research and are useful at guiding the methods and decisions that researchers must make during their studies (Creswell & Clark 2011:53). The design also sets the logic by which researchers make interpretations at the end of their studies. The study in this Phase was designed to respond to objective 3 of the study which was to explore

and describe health professionals' (doctors and midwives) experiences with and views on client-centered care. A similar design used in phase 2 was applied. Being a qualitative explorative and contextual study, semi-structured interviews, as suggested in DiCicco-Bloom and Crabtree (2006:315) were used.

4.6.2 Pre-testing of process

A draft interview guide of ten (10) questions was drawn to elicit responses from health professionals after extensive review of the literature. The interview guide consisted of one (1) broad question and nine (9) additional questions. The interview guide was discussed with my supervisor and then pre-tested on two (2) midwives and one (1) doctor at a primary level hospital who were not included in the main study. The pre-test was to ascertain the flow, flexibility of formats and the feasibility of the guide to elicit the required information. It was observed that the questions were too many and may result in eliciting very brief responses that would not generate adequate data as required for the study. With the support of my supervisor, the interview guide was reviewed. The final guide comprised one (1) broad question that requested health professionals to relate their understanding of the concept of client-centred care, its attributes, and how it was being implemented in relation to childbirth in health facilities. Six (6) other questions were refined to cover the areas of interest in addition to demographic variables. The question format was enhanced to include prompts. The basis for the questions were the key elements of client-centred childbirth as defined in Van Rijsbergen and D'exelle (2013:282-4), Arthur (2012:4) and Phillippi (2009:222) and outlined in Chapter 2. Some questions on the organisational aspects of care provision were also included. This approach is supported in DiCicco-Bloom and Crabtree (2006:316). See Annexure 9 for a copy of the interview guide). To reiterate, the health professionals on whom the interview guide was pre-tested were not included in the study participants.

4.6.3 Population, sampling technique and sample

In view of the objectives of this study, it was imperative not only to ensure that there was enough data for effective analysis and reporting (Marshall et al 2013:11), but also to maintain a measure of sample homogeneity so that the study could remain contextualised within a defined setting (Robinson 2014:27). The population of health professionals included all doctors, midwives and nurses that offered childbirth services

in the selected hospitals. The literature indicated that predicting the sample in qualitative study is challenging (Onwuegbuzie & Collins 2007:281). Thus, the practice of reaching theoretical saturation was used (DiCicco-Bloom & Crabtree 2006:317-318). Purposive sampling technique was used to recruit health care professionals who worked in the maternity units of the hospitals. Purposive sampling strategies are non-random ways of ensuring that particular categories of cases within a sampling universe are represented in the final sample of a project (Robinson 2014:32). The rationale for employing a purposive strategy was informed by the need to obtain a sample that theoretically and practically understood the topic being studied. Per the objectives of the study, it was important to sample categories of individuals who had unique or important perspectives on the phenomenon in question. Onwuegbuzie and Collins (2007:287) and Cohen et al (2007:115) also recommend that if the goal is not to generalise to a population but to obtain insights into a phenomenon, individuals, or events, then the researcher could purposefully select individuals, groups, and settings to maximise understanding of the underlying phenomenon. Additionally, the pairwise sampling design, which involves selecting cases and treating all as a set to better understand the phenomenon of interest was used (Onwuegbuzie & Leech 2007:243).

The inclusion criteria for health professional were as follows:

- Working at the maternity unit of the hospital at the time of data collection and offering direct patient care.
- Should have worked at the maternity unit for at least a year, with at least six months assignment to the labour ward.
- Should have no observable psychiatric or substance-abuse problems.
- Be of statutory working age (not more than 60 years).

A list and phone numbers of all doctors and midwives that provided maternity services at the time of the study were obtained from the hospital administrations after obtaining consent from the hospitals. All the doctors and midwives were contacted personally by the researcher and invited to participate. It should be reiterated that though the sample was recruited from the three hospitals, the sample was treated as a set so as to better understand the phenomenon of interest (Onwuegbuzie & Leech 2007:243). The details of the staff strength at the maternity section of the hospitals have already been presented at the sub-section on characteristics of the hospitals. At time of the study, the

number of medical officers manning all the maternity sections was 12. The total number of midwives at the maternity sections was 130. All the doctors were contacted by the researcher on phone to discuss the purpose of the study and to elicit their participation. For the midwives, the researcher was able to get in touch with 104 (80%) of them after repeated phone calls and visits to the hospitals. Some were on annual leave and others had gone back to study. Some doctors and midwives refused to participate despite several attempts including meeting them personally. Finally, four 4 doctors and 21 midwives agreed to participate. This made a total of twenty five (25) participants. As indicated in the selection of health facilities, the participants were fairly homogenous working under the management of the same health organisation. Though 25 health professionals agreed to participate, the interviews were terminated after the nineteenth (19th) interview when the point of theoretical saturation was reached. The theoretical saturation theory which has its roots in the grounded theory methodology (Bowen 2008:137), entails bringing new participants continuously into the study until data set is complete as indicated by data replication or redundancy (Bowen 2008:40). Theoretical saturation signifies the point at which to end the data collection (Morse 1995 cited in Bowen 2008:40).

4.6.4 Field work: Interview with health professionals

Having obtained approval from the hospitals and verbal agreement from the doctors and midwives to participate in the study, the researcher drew a schedule based on the availability of the participants. However, the schedule had to be changed a number of times often due to changes in the availability of participants. This process is supported in DiCicco-Bloom and Crabtree (2006:315), who stated that usually semi-structured interviews are scheduled in advance at a designated time and location. Each of the hospitals offered an office for the interviews. At the start of each interview, after exchange of pleasantries, the researcher explained the study objectives and procedures, and obtained written consent. Some participants expressed some reservations about the use of the audio tapes but were again assured of the value of confidentiality in the study. It was also agreed that their real names should not be used. The researcher then proceeded with asking the first question. The broad question was used to settle the participants and to provide a non-threatening starter to the interview (Gill et al 2008:292). Generally, the questions were organised around a set of predetermined open-ended questions, with other questions emerging from the dialogue

between the researcher and interviewee(s) (DiCicco-Bloom & Crabtree 2006:315). The face-to-face interview approach also enabled the researcher to interact with the participants in the language that they felt comfortable to use. It also allowed for adequate time to reflect on values and experiences.

As responses were given, the researcher responded with prompts and words used by the participant to clarify paraphrases or to reflect back on what has been said. Demographic data was collected at the end of each interview. There were minimal interruptions. The participants were appreciated at the end of the interview for their participation. The duration for the interviews ranged from one to one and a half hours.

As it is common with qualitative methods, data collection and analysis happened concurrently so that the researcher could generate emerging understanding about research questions to inform both the sampling and the questions being asked (DiCicco-Bloom & Crabtree 2006:317). After each interview or days' work, the researcher reflected on the process to make meaning and understand the key issues that emerged. The researcher also listened to the recordings to familiarise with the content. Transcription of the tape recordings started as soon as possible after each interview, usually within few hours. Most importantly, transcriptionists with vast experience in health interview data and fluent in the local dialect in the study area were utilised. This made it possible for the researcher to obtain the scripts in time to read, extract codes and identify emerging themes before the next interview. Information from the review of the scripts was used to modify and or drop some of the questions in subsequent interviews. The interviews were stopped after the nineteenth participant where the point of theoretical saturation was reached. This is the stage at which the researcher was obtaining no new information and could predict responses from subsequent interviews (DiCicco-Bloom & Crabtree 2006:317-318). The remaining six (6) health professionals were thus not interviewed. The period of data collection was from 19th June to 6th July 2014.

4.6.5 Field notes

Notes were made throughout the process of the study. These included issues addressed during discussion sessions, arrangement for meetings and phone calls. After each interview, the researcher reflected on the process to make meaning and

understand the key issues that emerged. The research paid a cursory visit to the different sections of the maternity wards noting aspects of the physical environment, interactions between the staff and clients and the general mood of other clients and staff in the wards. The period was also used to gather and or verify some of the demographic data on the hospitals.

4.6.6 Data analysis

One major objective of qualitative analysis is to generate themes (Bradley et al 2007:1760). Qualitative analysis often begins at the initial stage of data collection as the information obtained from such analysis helps to guide the study as themes emerge that should be followed and explored (Bradley et al 2007:1760; Heath & Cowley 2004:147-150). Similar to the process used in phase 2 of this thesis, Miles and Huberman's (1994:10-11) proposition for qualitative data analysis was also employed in this phase. This comprised: data reduction; data display; and conclusion drawing and verification. Data reduction is synonymous to coding and involves a process of selecting, focusing, simplifying, abstracting and transforming the data in the transcript. The data display consists of using an acceptable visual format to systematically present information to facilitate conclusion drawing. The third process which is conclusion and verification stage, entails identifying patterns and themes.

4.6.6.1 Preparation for data analysis

Mason (2002:147-148) posits that prior to analysis it is important to organise the data in hard or electronic copy for easy identification and retrieval. This process was an integral part of the research process from the initial planning stage. The transcripts (both electronic and hard copy) for health professionals were labelled sequentially according to how the interviews were conducted with the first one as 'Hp1', second 'Hp2' to 'Hp19'. Annexure 10 provides a sample of the interview transcripts from the doctors and midwives interviews. The researcher read through all the transcripts comparing them with the audio tapes. An independent reviewer was engaged to review 30% of the transcripts against the audio tapes. The findings were consistent with the original transcripts. The transcripts were then discussed with the doctors and midwives on phone for agreement. They were all happy with the contents.

4.6.6.2 Reading and data reduction/coding

It is generally accepted that good analysis of qualitative depends on understanding the data (DiCicco-Bloom & Crabtree 2006:318). The researcher read through the transcripts several times to get better acquainted with the content as well as taking note of how participants responded to questions. Though the reading at this stage was not necessarily to identify codes, but attention was paid to consistencies and differences. Bradley et al (2007:1761) suggest that once the data have been reviewed and there is a general understanding of the scope and contexts of the key experiences under study, coding provides the researcher with a formal system to organise the data, uncovering and documenting additional links within and between concepts and experiences described in the data. According to Miles and Huberman (1994:56), codes are tags or labels that are assigned to segments of the transcripts such as paragraphs, sentences or words to help catalogue key concepts while preserving the meaning of the descriptive or inferential information obtained during the interviews. Coding was both deductive and inductive. The deductive approach started with a predetermined framework based on the objectives of the study, the research questions and the literature (Miles & Huberman 1994:58). In other words, data reduction and coding should be guided primarily by the need to address the salient research question(s). Coding was done manually through highlighting with different colours as well as making notes in the computer. Other concepts were generated inductively during the process. Coding was done manually. This process was laborious and time consuming. The researcher reviewed all transcripts line-by-line to identify codes and writing down impressions.

4.6.6.3 Data display

A matrix comprising of rows and columns was designed in Microsoft Word. The format was informed by the research conceptual framework, the research questions and the codes that were formulated from the data. The researcher scanned through the codes and extracted coded segments in the form of block of text, quotes, phrases and symbols and entered them into the matrix. The matrix offered the researcher the opportunity to easily explore the connections between responses. Miles and Huberman (1994:91-93) opine that data display helps to determine patterns and themes. The format was reviewed several times as new ideas were generated.

4.6.6.4 Conclusion and verification

Miles and Huberman (1994:11-12) note that in reality the process of drawing conclusions often starts from the beginning of the study where the researcher starts identifying meanings of issues, noting regularities, patterns, explanations and propositions; these notwithstanding, the final conclusions are actually done at this stage where patterns and themes are generated. Themes are abstract concepts or propositions, reflecting the researcher's interpretation of patterns across the data (Seers 2012:2). In addition, Seers (2012:2) notes that after identifying codes, the data analysis process continues with generating patterns and themes to describe the data in a form which summarises it, yet retaining the richness, depth and context of the original data. The researcher critically reviewed the codes, taking notes of similarities and differences as well as linkages to generate themes. This process required returning to the data several times to check the evidence supporting each theme. The independent reviewer who reviewed the transcripts once again reviewed the list of codes, the matrix and the themes. A meeting was held with the independent reviewer to discuss areas of disagreements. The codes, matrix and themes were further reviewed by my supervisor and then jointly discussed at a meeting at the university.

4.7 RELIABILITY AND VALIDITY OF QUESTIONNAIRE STUDY

4.7.1 Validity

Validity is about the soundness and rigour of the study (Daymon & Holloway 2011:79). Validity in quantitative research means that the test measures what it is supposed to measure and that the study accurately assesses the phenomenon that the researcher intends to assess (Daymon & Holloway 2011:79). The types include face, content and construct validity. In quantitative data, validity might be improved through careful sampling, appropriate instrumentation and appropriate statistical treatments of the data (Cohen et al 2007:133). In this study, face validity was assured by conducting an extensive literature review on the concepts under study. Greater part of the questionnaire was extracted from two validated tools that have been used extensively internationally, the (HCAHPS 2012) questionnaire and the Picker Women's Experience of Maternity Care questionnaire (Picker Institute Europe 2010). The draft questionnaire was discussed with my supervisor and then with a cross-section of 10 senior health

professionals drawn from Ghana Health Service Headquarters to determine its relevance, comprehensiveness, readability and applicability. Five (5) senior health professionals again reviewed the draft tool at a workshop to establish the clarity, content and comprehensiveness. These methods were to determine the face and content validity of the tool.

4.7.2 Reliability

This refers to the ability of the instrument to yield similar results when repeating the same study under similar conditions. Reliability concerns the stability of what is being measured on more than one occasion (Langdrige 2004:35). Reliability was ensured by documenting all procedures that were carried out in the development and conducting of the study so that future researchers could replicate it. Additionally, the research assistants were given a 2-day training to enable them conduct the questionnaire administration in the same manner for all the participants. This was done as a means of standardising the processes to limit external sources of variations. The researcher re-interviewed 8 (30%) of the women who were helped by the research assistants to complete the questionnaire during the training session to ascertain inter-rater reliability. The internal consistency reliability of tool was $\alpha = 0.73$. These notwithstanding, the study would need to be repeated in future to confirm whether or not it would produce similar results.

4.8 TRUSTWORTHINESS OF QUALITATIVE STUDY

It has also been noted that a good criteria for demonstrating and judging quality of qualitative research is trustworthiness and authenticity (Daymon & Holloway 2011:84). Trustworthiness and authenticity are shown by researcher's careful documentation of the process of the research and the decisions made on the way (Daymon & Holloway 2011:84). As indicated by Daymon and Holloway (2011:84), a study is authentic when the strategies used are appropriate for the true reporting of the participant's ideas, when the study is fair and when it helps participants and similar groups to understand their world and improve it. The four criteria of trustworthiness put forward by Lincoln and Guba (1985:301–318) - credibility, transferability, dependability and applicability were used to establish the trustworthiness of the qualitative studies.

4.8.1 Credibility

Credibility refers to the confidence one can have in the truth of the findings. Cohen and Crabtree (2008:334) and Williams (2011:73) state that activities that increased the credibility of findings are: triangulation, peer review or debriefing, external audits/auditing, member checking, prolonged engagement, negative case analysis, iterative questioning, background qualifications and experience of the investigator and examination of previous research findings. In this study, two approaches – semi-structured interviews and field notes - were used to assure credibility. The study also compared views from different perspectives such as doctors, midwives and clients to enhance data source triangulation. Furthermore, the research process was reviewed by an independent reviewer and my supervisor. The interview guides were subjected to a number of reviews by teams of experts in qualitative study and applied research. Interview transcripts were discussed with all the doctors and midwives on phone to check accuracy of facts and observations. Meetings were also held with the women who participated in the study individually at one of their post-natal visit to discuss their transcripts.

4.8.2 Transferability

Transferability or fittingness of research findings refer to the study findings' fitting outside that particular study setting (Jeanfreau & Jack 2010). In other words, transferability relates to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings. Shenton (2004:70) outlines that to enhance transferability researchers should clearly indicate: the number of organisations taking part in the study; inclusion and exclusion criteria; number of participants; data collection methods; duration and time periods of data collection. Furthermore, Bhattacharjee (2012:111) implore researchers to provide rich, detailed descriptions of the research context (“thick description”) and thoroughly describe the structures, assumptions, and processes revealed from the data so that readers can independently assess whether and to what extent the reported findings are transferable to other settings. Transferability in this study was attained through:

- rich description of the study sites
- clear description of the methodology

4.8.3 Dependability

According to Bhattacharjee (2012:110), dependability, similar to reliability in quantitative research can be viewed as repeat research by different researchers assessing the same phenomenon using the same set of evidence independently and arriving at the same conclusions. To achieve this, researchers must provide adequate details about their phenomenon of interest and the social context in which it is embedded so as to allow readers to independently authenticate their interpretive inferences (Bhattacharjee 2012:110). Dependability is primarily achieved through the use of audit trails. In this study, dependability was promoted through providing enough documentation to facilitate inquiry audit. One independent reviewer reviewed 30% of the interview transcripts independently against the audio tapes and indicated consistency with the original transcripts. The same independent reviewer examined the codes and themes that were generated by the researcher from the data. My supervisor also reviewed the codes and themes, and examined documentation on all the steps in the research process and the findings. The write-up on the methodology, tape recordings of interviews, transcripts and outline of data analysis were authenticated by my supervisor. The study as a whole will be reviewed by a panel of experts constituted by the university.

4.8.4 Confirmability

Confirmability refers to the extent to which the findings reported in a study can be independently confirmed by others (Bhattacharjee 2012:110-111). Confirmability is often demonstrated if the study's participants agree with the inferences derived by the researcher. In this study, the transcripts were discussed with the health professionals that participated in the study on phone. Consensus meetings were held with the mothers at their postnatal visit to discuss the transcripts. A comprehensive literature review was carried out to validate the findings. My supervisor and another expert in qualitative study supported the whole process.

4.9 PHASE 4: DEVELOPMENT OF GUIDELINES ON CLIENT-CENTRED CHILDBIRTH

The process of guidelines development followed the key steps recommended by the World Health Organization (2003:5) in the development of guidelines. The researcher used the findings from the studies in phases 1, 2 and 3 in addition to extensive literature review to draft the guidelines. The draft document was first reviewed by a group of six (6) senior health professionals to build consensus on the content and to determine its feasibility in the Ghanaian context. The document was then reviewed by my supervisor. The second draft guidelines document was presented at a workshop session to a group of 27 senior health professionals made up of directors of Ghana Health Services and other policy makers, doctors, nurses, midwives and health services administrators at a workshop session to build consensus. Comments from participants were geared towards effective implementation of the guidelines. Few typographical corrections were also made. Participants at the workshop indicated that the guidelines were of great importance and should be widely disseminated.

4.10 ETHICAL CONSIDERATIONS

It is generally accepted that all research should be carried out both ethically and with utmost integrity. Request for ethical approval for the whole study was obtained at two levels. Approval for the study was obtained from the Research Ethics Committee of the Ghana Health Service/Ministry of Health. A copy of the ethical clearance is in Annexure 11. Approval was also obtained from the Research Ethics Committee of the University of South Africa (see Annexure 12 for a copy of the ethics approval from the university). The ethical principles that were applied to this study were: consent, confidentiality and anonymity, beneficence and non-maleficence.

4.10.1 Consent

Informed consent is a voluntary agreement to participate in research and consist of a process whereby research participants are provided to adequate information on their rights, the purpose and procedures to help them understand before committing to participate (RCN 2011a:3). Letters to the Regional Directors of Health Services of the region in which the study was carried out and to the Medical Superintendents of the

hospitals outlined the purpose and objectives of the study, the health professionals and women that would be involved, mode of recruitment, and how data were to be gathered and used. All the hospitals gave a verbal consent.

The participation in the study was with the consent (verbal and written). The participants were made aware of the purpose and objectives of the study. They were also informed that they could opt out of the research at any stage without being penalised or victimised. Refusal to participate or to continue will not lead to any loss of personal benefit. Confidentiality was also affirmed in letter to the hospitals and the consent form for participants. These issues were iterated at recruitment and at the beginning of each interview. A copy of the participant's informed consent forms are attached in Annexure 2.

4.10.2 Confidentiality and anonymity

Confidentiality and anonymity were maintained throughout the study by not attaching names to the collected data but using unique identifiers. Though the list of names and phone number of health professionals was obtained, it was only used to contact them to seek their participation in the study. No direct identifiers were obtained on the women during the interviews. No names were provided on the questionnaires and responses cannot be linked to any individual professional or woman. The participants were also assured that the tapes that contained the interview information would be erased after transcription of the interviews and this has been done.

4.10.3 Beneficence and non-maleficence

Beneficence refers to providing benefits and balancing benefits, burdens, and risks in a study (Beauchamp & Childress 2009 cited in Ebbesen, Andersen, Pedersen 2012:1) while non-maleficence means 'we should not harm others' (Lawrence 2007:36). When applied to the context of research, it implies that researchers should take actions that will help others or do good to the participants and in the process should not injure or cause harm to any of the participants. The participants were accorded the utmost respect throughout the process. The researcher was mindful and sensitive when dealing with personal issues. They were assured that their time and information would be put to good use and could go a long way to help improve quality of services. The participants

were also assured that they would not be exposed to any harm. The researcher provided the participants with her contact details should they have any questions about the study.

4.11 CONCLUSION

This chapter outlined the study design, population, sampling technique, sample, data collection, data analysis, the validity and reliability of quantitative methods as well as measures employed to ensure trustworthiness and authenticity of qualitative studies. Included also was how ethical considerations were addressed. The study design was exploratory, descriptive and contextual, and employed both quantitative and qualitative methods. Using mainly purposive sampling techniques, data was gathered from doctors, midwives as well as women who utilised childbirth services in the selected hospitals. While relevant statistical methods were used for quantitative data, the analysis of in-depth interviews was both deductive and inductive using Miles and Huberman's (1994:10-11) proposition for qualitative data analysis.

CHAPTER 5

RESULTS AND DISCUSSION OF THE QUANTITATIVE STUDY ON THE CLIENT-CENTREDNESS OF CHILDBIRTH SERVICES

5.1 INTRODUCTION

Chapters 1, 2, 3 and 4 outlined the purpose and objectives of the study, the conceptual framework, the published and unpublished literature on the concept of client-centred or patient-centred care as well as the methodology respectively. This chapter presents the findings of the questionnaire study on women's experiences with childbirth.

5.2 PART 1: RESULTS OF STUDY ON FACTORS THAT INFLUENCE CLIENT-CENTRED CHILDBIRTH SERVICES

5.2.1 Demographic characteristics

The total number of women sampled for the study was 754. The proportion of the women who participated in the study from hospital A was 51.9%, those from hospital B constituted 36.1%, and hospital C contributed 12.1%. The majority (89.0%) of the women aged between 20-39 years. Thirty-seven (4.9%) of the women aged 14 to 19 years while 40 (5.3%) were above 40 years. Four hundred and nineteen (419) (55.7%) of the women indicated that their highest level of education was primary/junior secondary school; 198 (26.3%) were educated up to the senior secondary school level; 63 (8.4%) had university degree, diploma or higher certificate; and 72 (9.6%) stated that they have never been to school. Two (2) women did not provide information on their educational level.

Five hundred and eight (508) (70.0%) of the women have had previous pregnancies. Regarding the number of children, majority (62.4%) of them stated that they have given birth to one or two children prior to their current delivery, 171 (33%) indicated that they have had three or more deliveries while 20 (3.9%) noted that the current delivery was their first. The number of women that attended ante-natal care at the study hospitals was 546 (72.6%) and 206 (27.4%) only used delivery services in the hospitals. Most (65.1%) of the women live in the urban areas, 18.6% live in the semi-urban and 16.3%

live in the rural areas. About three-fourth (80.1%) of them lived with their respective partners, husband or boyfriends, 17.1% lived with a family member and 2.4% lived alone.

Six hundred and eighty one (681) (90.6%) of women settled their hospital fee through the National Health Insurance Scheme (NHIS) and 4.0% settled their bills out of pocket, 5.4% used both NHIS and out of pocket. Findings showed that 144 (19.2%) of the women paid money to health professionals that attended to them but were not given any official receipt. The details of the socio-demographic characteristics are shown in Table 5.1.

5.2.2 General information on baby

Findings from the information on the babies that were delivered by the women showed that 146 (19.4%) were born between 12:01 am-6:00 am, 194 (25.7%) were born between 6:01am-12:00 noon, 180 (23.9%) were born between 12:01 pm-6:00 pm and 234 (31.0%) were born in the evening (6:01 pm-12:00 midnight). The majority (83.69%) of the babies were born after 37 weeks of gestation. Three hundred and sixty (360) of the women stated that their baby weighed 2500 g/2.5 kg or more at birth while 1.1% weighed less than 2500 g/2.5 kg. About 51.2% of the women could not tell or remember the birth weight of their babies.

5.2.3 Arrival and reception during labour

Regarding reception and arrival, the findings showed that the greater proportion of the women (85.9%) were attended to immediately on arrival during labour while 106 (14.1%) had to wait for assistance. Of the number that waited, 145 (53.5%) waited between 31 minutes to 1 hour before they were seen. Table 5.2 presents the findings on arrival and reception during labour.

Table 5.1 Frequency and percent frequency distribution of socio-demographic characteristics

Item	Number of respondent	Frequency	Percent frequency
Number of women that participated in study per facility	754		
Hospital A		391	51.9
Hospital B		272	36.1
Hospital C		91	12.1
I3: Age	752		
14 – 19 years		37	4.9
20 – 24 years		123	16.4
25 – 29 years		248	33.0
30 – 34 years		197	26.2
35 – 39 years		107	14.2
40 – 49 years		40	5.3
I5: Highest level of education	752		
Never been to school		72	9.6
Primary/Junior secondary		419	55.7
Senior secondary/Vocational		198	26.3
University degree/diploma and higher		63	8.4
I1: Have you had any previous pregnancies	752		
Yes		508	69.7
No		244	30.3
I2: Number of babies given birth to	508		
None		20	3.9
1-2		317	62.4
3 or more		171	33.7
I6: Ante-natal care attendance at study hospital during this pregnancy	752		
Yes		546	72.6
No		206	27.4
I9: Area of residence	751		
Urban		489	65.1
Semi-urban		140	18.6
Rural		122	16.3
I4: Who do you live with currently	755		
I live alone		18	2.4
With a partner/husband/boyfriend		605	80.1
With family members other than a partner/husband/boyfriend		129	17.1
Others (specify)		3	0.4
I7: Mode of payment of hospital fee	752		
Health insurance		681	90.6

Item	Number of respondent	Frequency	Percent frequency
Fee for services (out of pocket)		30	4.0
Both Health Insurance and out of pocket		40	5.3
Others (specify)		1	0.1
I8: Paid money to health professional(s) and not given an official receipt	752		
Yes		144	19.2
No		595	79.1
Cannot remember		13	1.7

Table 5.2 Frequency and percent frequency distribution on arrival and reception during labour

Item	Number of respondent	Frequency	Percent frequency
A1: Wait on arrival before seen by health professional	754		
Yes		106	14.1
No		648	85.9
A2: How long did you wait?	271		
Less than 15 minutes		20	7.4
16 to 30 minutes		34	12.5
31 minutes to 1 hour		145	53.5
More than 1 hour		5	1.8
Cannot remember		67	24.7
A3: Able to find comfortable place to sit	271		
Yes, I found a comfortable place		139	51.3
Yes, but it was not comfortable		123	45.4
No I could not find a place to sit		2	0.7
Cannot remember		7	2.6
A4: Did staff keep you inform about reason to wait?	271		
Yes		200	73.8
No		1	0.4
Cannot remember		70	25.8
A5: Front desk staff friendly	106		
Yes, certainly		4	3.8
Yes, somehow		26	24.5
No		76	71.0
A6: Did staff treat you with courtesy and kindness while waiting?	106		
Always		53	50.0
Usually		21	19.8
Sometimes		16	15.1
Never		16	15.1

5.2.4 Ante-natal care experience

The results showed that midwives cared for the majority (77.6%) of the women on their first visit to the hospitals and 21.5% were seen by a doctor. Less than 1% indicated that they were seen by other health workers but could not indicate the category of worker. Findings on the number of weeks that women were pregnant before they first saw a health professional, categories of health professional seen during ante-natal check-ups, the number of ante-natal check-ups they had, preferred choice of category of health facility for delivery, provision of information by health professionals to guide choice of place of birth and other general information on antenatal care are in Table 5.3. The finding on provision of information by health professionals to help women decide where to have their baby is in Figure 5.1 and the one on the number of ante-natal check-ups that the women had is in Figure 5.2.

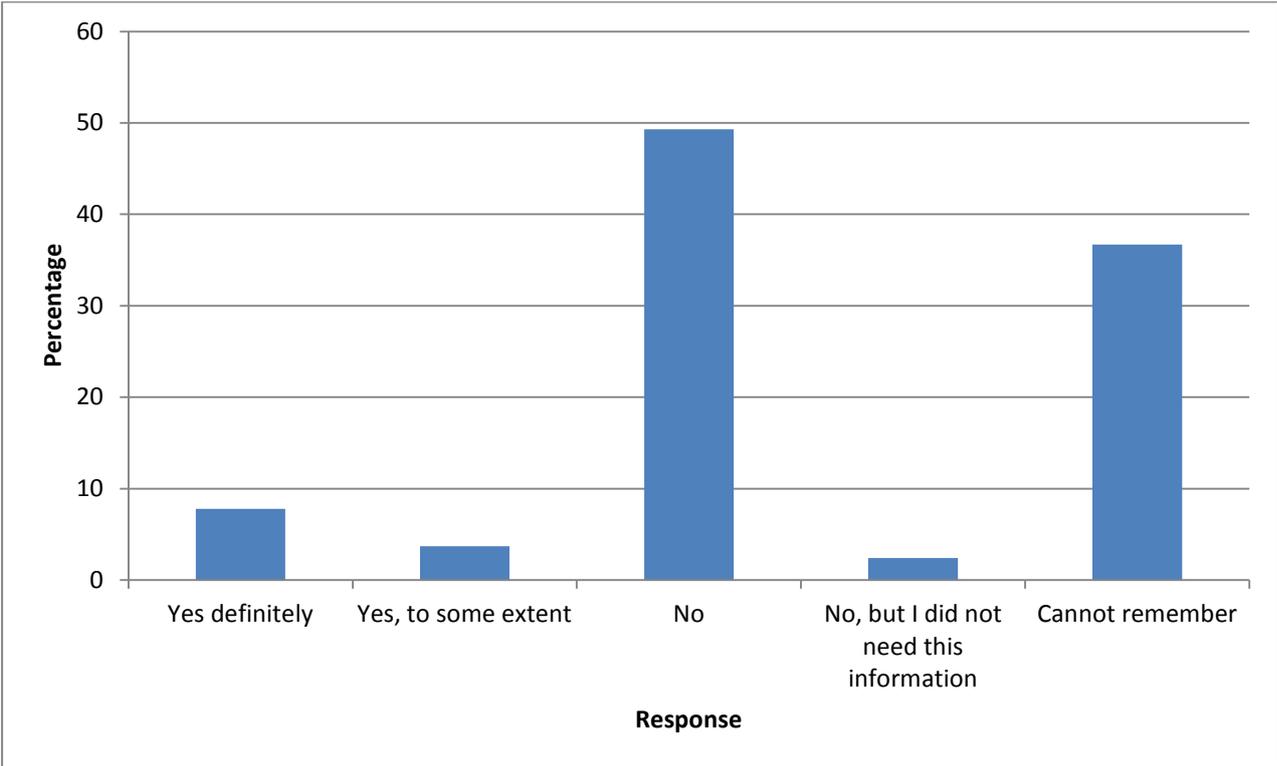


Figure 5.1 Findings on provision of information from midwife or doctor to help women decide where to have their baby

Table 5.3 Frequency and percent frequency distribution on general information on ante-natal experience

Item	Number of respondent	Frequency	Percent frequency
C1: First health professional seen at first visited for ante-natal care	750		
Doctor		161	21.5
Midwife/ Nurse		582	77.6
Others (specify		7	0.9
C2: Number of weeks pregnant when first saw health professional	750		
Before I was 7 full weeks pregnant		109	14.5
When I was 7 to 12 weeks pregnant		306	40.8
When I was more than 12 weeks pregnant		311	41.5
Cannot remember		24	3.2
C3: Had a choice about where you could have your baby	751		
Yes		563	75.0
No		178	23.7
Cannot remember		10	1.3
C5: Preferred place of delivery of baby	754		
At public hospital		625	82.9
Private hospital		92	12.2
Maternity home		9	1.2
At home by a trained midwife		2	0.3
At home by a TBA		13	1.7
At home by a relative		0	0.0
Do not know		13	1.7

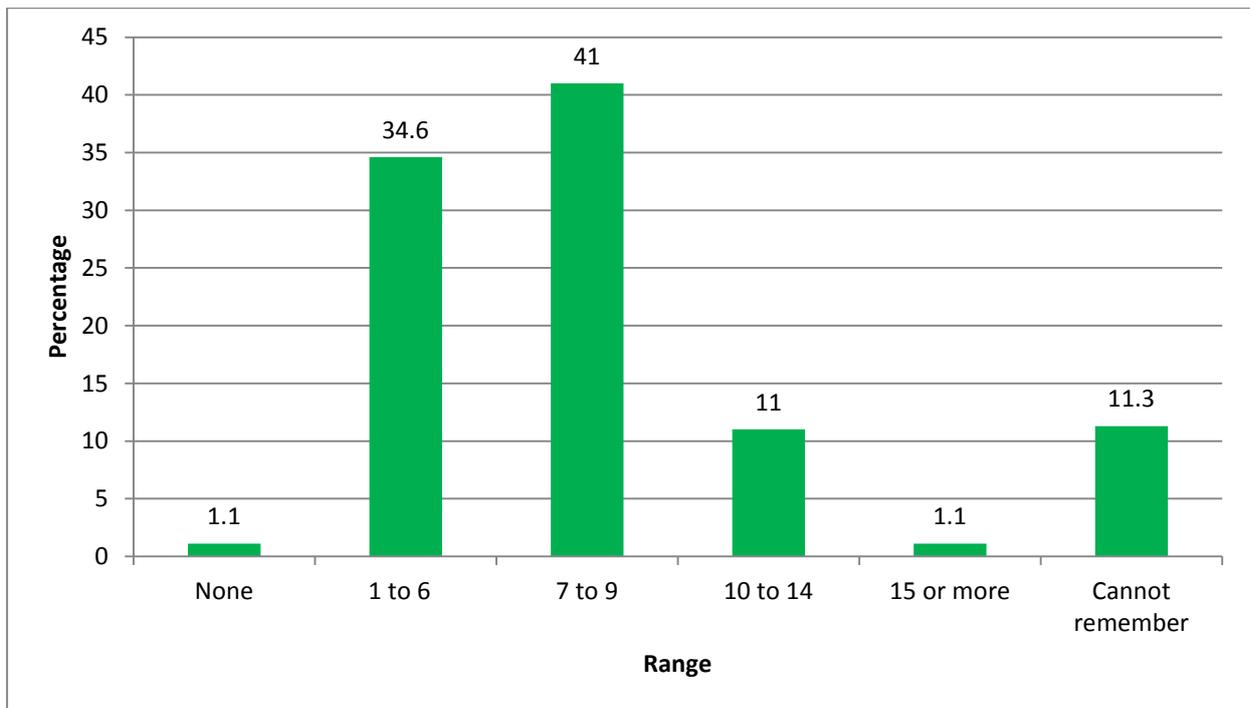


Figure 5.2 Findings on number of ante-natal check-up that women had

Table 5.4 presents the findings on the provision of information on choices available regarding labour pain relief, birth attendant, birth position, labour companion or support, mode of delivery, and where to have ante-natal check-ups.

The majority (56.5%) of the women indicated that their major care provider during the ante-natal period was a midwife or nurse. Three hundred and twelve (41.6%) received care from different categories of staff while 13 (1.7%) stated that their major care provided was a doctor. In addition, 629 (84.3%) of the women either saw the same midwife every time or most of the time that they came for ante-natal. The results on women having the name and telephone numbers of midwives they could contact during pregnancy, those who contacted midwives about their concerns, whether they were spoken to in a language they could understand, their involvement in decision-making, attendance at ante-natal classes and other items on ante-natal experience are presented in Table 5.5.

Table 5.4 Frequency and percent frequency distribution on provision of information on choices available regarding labour pain relief, birth attendant, birth position, labour companion or support, mode of delivery and choice of where to go for antenatal check-up

Item	Number of respondent	Frequency	Percent frequency
C6.1: Provision of information on choice of labour pain relief	750		
No		52	5.8
Cannot remember		690	76.3
Yes		8	18.0
C6.2: Provision of information on choice of birth attendants available to you	746		
No		56	7.5
Cannot remember		656	87.9
Yes		34	4.6
C6.3: Provision of information on choice of birth position	746		
No		78	10.5
Cannot remember		644	86.3
Yes		24	3.2
C6.4: Provision of information on choice of labour companion	746		
No		56	7.5
Cannot remember		653	87.5
Yes		37	5.0
C6.5: Provision of information on choice of mode of delivery	746		
No		50	6.7
Cannot remember		621	83.2
Yes		75	10.1
C8: Provision of information on choice of where to have ante-natal check-up	746		
No		3	0.4
Cannot remember		597	80.0
Yes		146	19.6

Table 5.5 Frequency and percent frequency on additional items on ante-natal experience

Item	Number of respondent	Frequency	Percent frequency
C9: Type of health professionals seen during ante-natal check-ups	750		
Midwife/nurse		424	56.5
Doctor		13	1.7
Different categories of staff		312	41.6
Others (specify)		1	0.1
C10: Saw the same midwife at every ante-natal visit	746		
Yes, every time		315	42.2
Yes, most of the time		314	42.1
I only saw a midwife once		105	14.1
Cannot remember		12	1.6
C11: Did you have the name and telephone number of midwives you could contact during pregnancy?	748		
Yes		2	0.3
No		204	27.3
Cannot remember		542	72.5
C12: Did you contact a midwife when had concerns about your pregnancy?	562		
Yes		97	17.26
No		465	82.74
C13: If you contacted a midwife, were you given help needed?	96		
Yes, always		89	92.71
Yes, sometimes		5	5.21
No		2	2.08
C14: Thinking about your ante-natal care, were you spoken to in a way you could understand?	750		
Yes, always		1	0.1
Yes sometimes		7	0.9
No		702	93.6
Cannot remember		40	5.3
C15: Were you involved enough in decision about your care?	746		
Yes, always		335	44.9
Yes sometimes		273	36.6
No		17	2.3
I did not want/need to be involved		26	3.5
Cannot remember		95	12.7
C16: Did you attend any ante-natal classes provided in study hospital?	743		
Yes		174	23.4

Item	Number of respondent	Frequency	Percent frequency
No, I was not offered any classes		1	0.1
Cannot remember		568	76.5
C17: Did you attend any other ante-natal class?	750		
Yes		6	0.80
No, I was not offered any classes		720	96.00
Cannot remember		24	3.20
C18: Did you have scan at start of your pregnancy?	750		
Yes		653	87.07
No		95	12.67
Cannot remember		2	0.27
C19: Was the reason for scan explained to you?	653		
Yes, definitely		3	0.5
Yes, to some extent		201	30.8
No		410	62.8
Cannot remember		39	6.0
C20: Did you have any screening tests?	750		
Yes		737	98.27
No		10	1.33
Cannot remember		3	0.40
C21: Were the reasons for screening test clearly explained to you?	750		
Yes, definitely		7	0.9
Yes, to some extent		193	25.7
No		493	65.8
Cannot remember		57	7.6
C22: Number of ultrasound scan had	750		
None		43	5.7
One		127	16.9
Two to Three		432	57.6
Four or more		140	18.7
Cannot remember		8	1.1

Figure 5.3 below outlines the results on the ratings of the women on their antenatal experience.

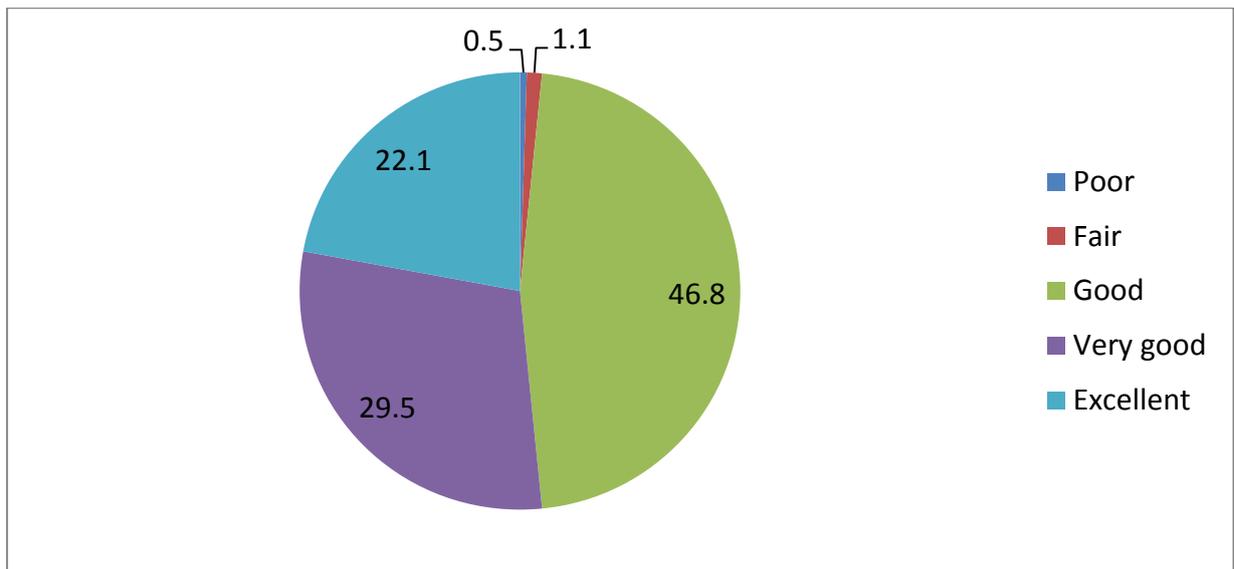


Figure 5.3 Findings on overall rating of care received during the ante-natal period by women

5.2.5 Labour experience

In terms of length of labour, 354 (48.2%) of women stated that they laboured for less than 8 hours. One hundred and thirty one (131) (17.9%) of them laboured between 8 hours and 12 hours, 78 (10.6%) had 12 to 18 hours, 114 (15.5%) stated that their labour lasted 18 hour or longer and 57 (7.8%) could not tell the duration of their labour. Figure 5.4 outlines finding on ability of the women to move around during labour.

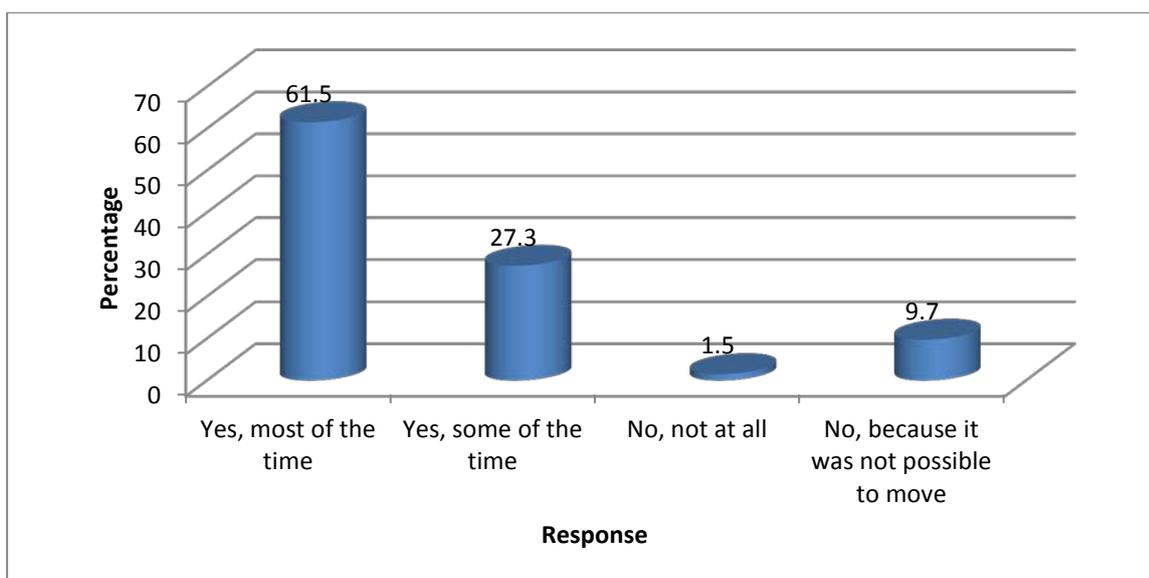


Figure 5.4 Finding on being able to move around during labour

The experiences of women with regards to birth position, labour pain relief, mode of delivery and category of health professional that assisted them with delivery were also assessed. The findings on these variables are outlined in Table 5.6 and Figures 5.5 and 5.6. Of those who had some form of pain relief, 162 (86.2%) stated that they were satisfied or satisfied to some extent while 19 (10.1%) noted that they were not satisfied and 7 (3.7%) could not remember whether they were satisfied or not.

The majority (88%) of the women were delivered by a midwife or nurse, 6.2% were assisted in delivery by a doctor, 5.8% did not know the category of staff that assisted them with their delivery. As to their preferred choice of health professional that should assist them in delivery, 357 (63.1%) mentioned a midwife/nurse, 70 (12.4%) preferred doctors and 135 (23.9%) of the women stated that they had no preference. Though 4 (0.7%) of the women stated that they would prefer other health professionals, none of them mentioned the category of staff.

Table 5.6 Frequency and percent frequency distribution on choice of birth position, type of pain relief method women planned to use, type of pain relief method used

Item	Number of respondent	Frequency	Percent frequency
D3: Able to choice position that made you comfortable during labour	754		
No, not at all		7	0.9
No, because it was not possible to move		166	22.0
Yes, some of the time		306	40.6
Yes, most of the time		275	36.5
D4: Type of pain relief method planned used during labour	686		
Natural methods (e.g. breathing, massage)		44	6.4
Injection of pethidine or a similar painkiller		9	1.3
Epidural or similar (injection in your back)		0	0
I did not intend to use any pain relief		266	38.8
Cannot remember		360	52.5
Other (specify)		7	1.0
D6: Type of pain relief method used during delivery	188		
Natural methods (e.g. breathing, massage)		70	37
Injection of pethidine or a similar painkiller		51	27
Epidural or similar (injection in your back)		28	15
I was not told		24	13
Cannot remember		15	8

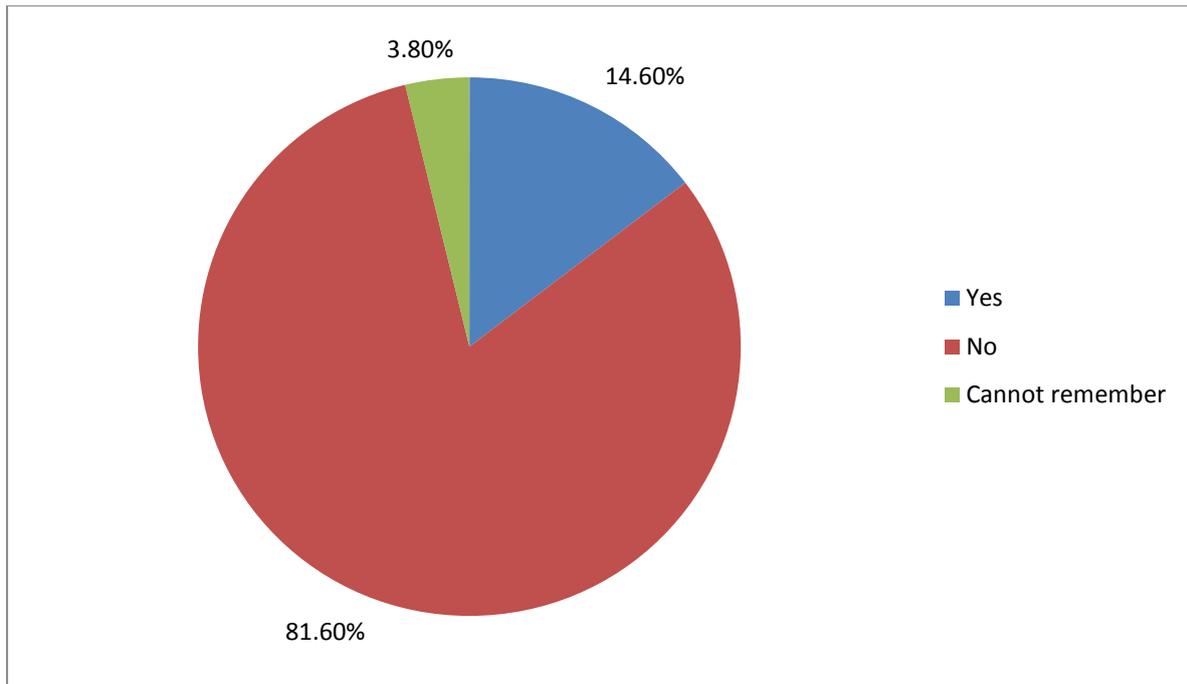


Figure 5.5 Findings on giving of pain relief during labour



Figure 5.6 Findings on types of delivery that women had

In response to the location in the hospitals that the women gave birth, 96.64% indicated that they delivered on the delivery bed in the labour room, 1.6% delivered on the bed in

which they were admitted during the first stage in the ward, and 1.8% delivered on the floor. The finding on the findings on position the women assumed during delivery is in Figure 5.7.

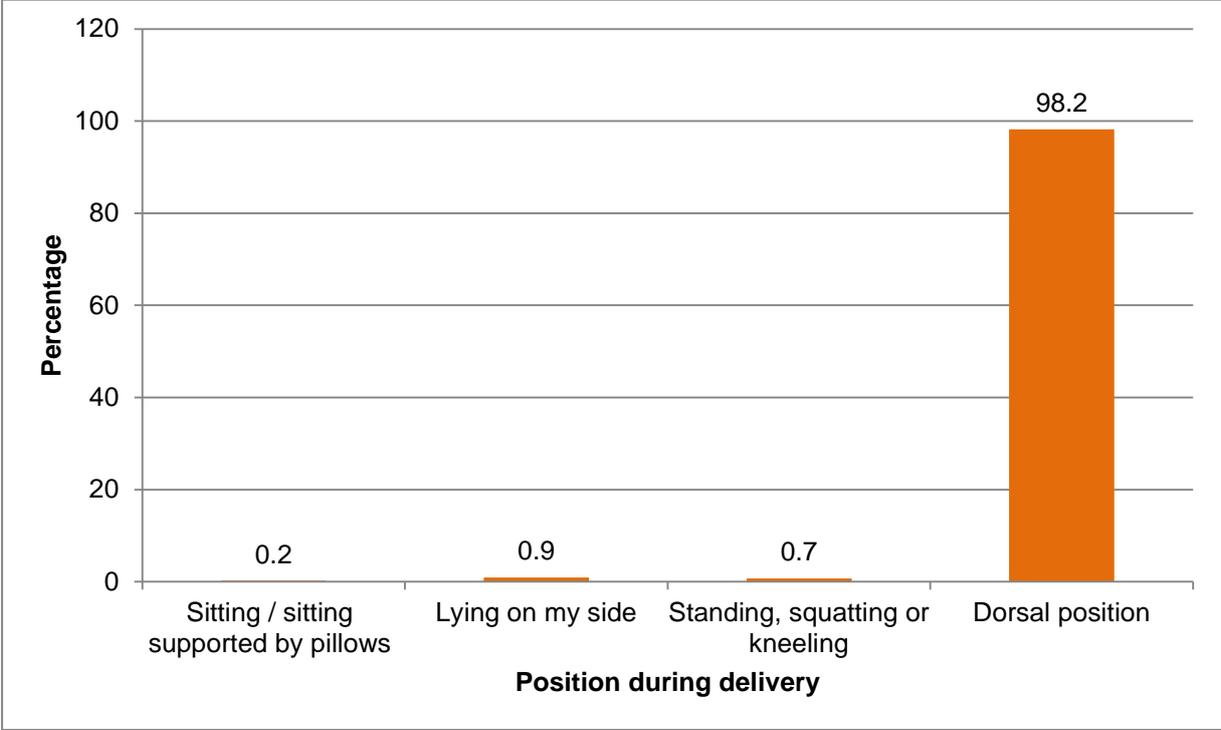


Figure 5.7 Findings on position the women assumed during delivery

As regards their preferred birth position, most (92.2%) of the women noted the dorsal position, 3.7% stated standing or squatting/kneeling position, 1.6% preferred sitting position, and 1.4% indicated lying on the side. Of the women that delivered vaginally, 304 (59.1%) of the women did not have episiotomy or perineal tears. Of those that had episiotomy, 194 (43.3%) had it stitched within 30 minutes, 9 (1.6%) had theirs stitched between 31 minutes to 1 hour and only 1 women had hers repaired after 1hour. Seventeen (17) (3%) of the women did not stitch their episiotomy. Figure 5.8 presents results on women who had skin-to-skin contact with their baby shortly after delivery.

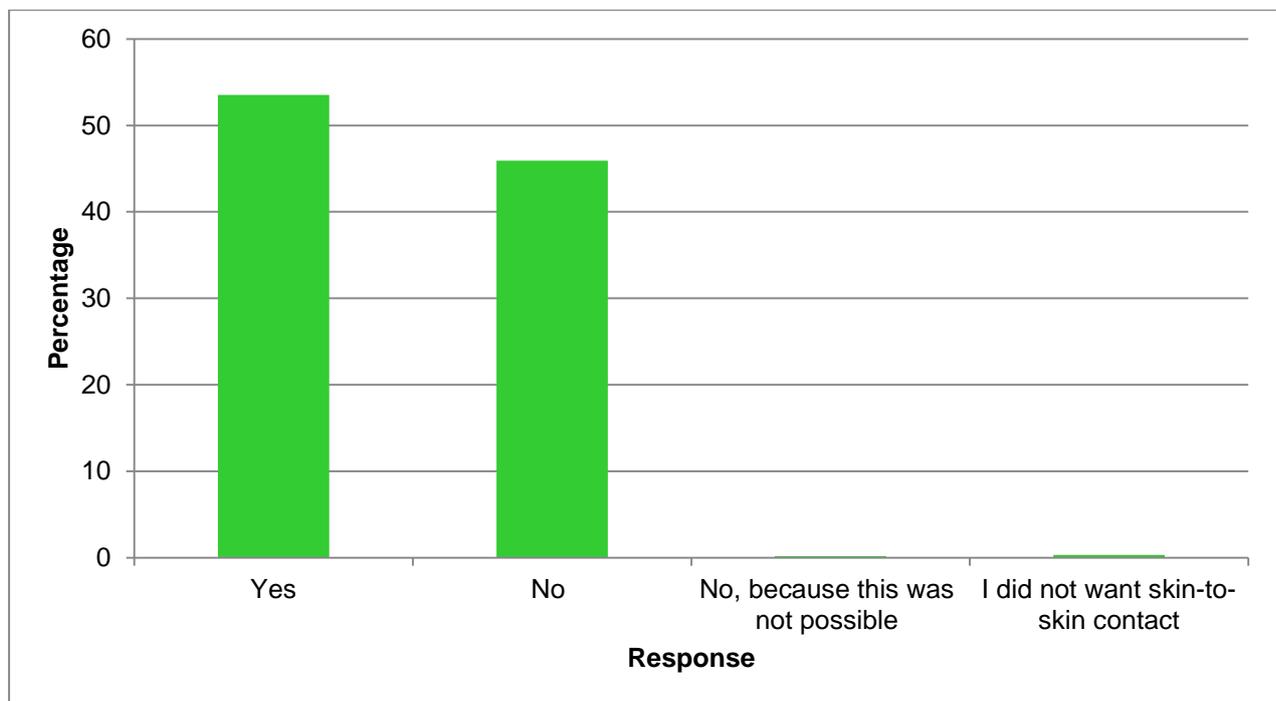


Figure 5.8 Results on women who had skin-to-skin contact with their baby shortly after delivery

Table 5.7 displays the finding regarding whether women knew any of the staff that cared for them before they went into labour, whether the staff who cared for them introduced themselves, issues of confidence and trust in staff and other findings on labour experience. The findings showed that most (73.9%) of the women did not know any of the staff that care for them during and before they went into labour. Likewise 70% could not remember if the staff that cared for them introduced themselves. In the same vein, the greater percentage of the women (82.7%) stated that they had confidence and trust in the staff that cared for them. The overall rating on the labour experience is presented in Figure 5.9.

Table 5.7 Frequency and percent frequency distribution on variables on labour experience

Item	Number of respondent	Frequency	Percent frequency
D16: Prior meeting of any of the staff who cared for you during labour	754		
Yes		12	1.6
No		185	24.5
Cannot remember		557	73.9
D17: Did the staff caring for you introduce themselves?	754		
Yes, all the staff		24	3.2
Yes, some of them introduced themselves		174	23.1
Few introduced themselves		27	3.6
None introduced him/herself		4	0.5
Cannot remember		525	69.6
D18: Confidence and trust of women in health professionals	753		
Yes, definitely		623	82.7
Yes, to some extent		96	12.8
No		24	3.2
Cannot remember		10	1.3
D19: Preferred labour support person(s)	754		
Spouse/partner		320	42.4
Family member/friend		397	52.7
Others (specify)		37	4.9
D20: Were labour companions or partners welcome by staff during labour?	754		
I did not have a partner or a companion		754	100.0
D22: During labour were you spoken to in a way you could understand?	753		
No		699	92.8
Cannot remember		38	5.1
Yes sometimes		14	1.9
Yes, always		2	0.3
D23: Involvement in decisions taken about your care during labour	754		
No		530	70.3
I did not want/need to be involved		84	11.1
Cannot remember		124	16.5
Yes sometimes		6	0.8
Yes, always		10	1.3
D24: If you raised some concerns during labour, did you feel that it was taken seriously?	754		
Yes, always		426	56.5

Item	Number of respondent	Frequency	Percent frequency
No		278	36.9
I did not raise any concerns		50	6.6
D25: When you called did you receive assistance within reasonable time?	754		
Yes, always		450	59.7
Yes, sometimes		155	20.6
No		1	0.1
I did not call		114	15.1
Cannot remember		34	4.5

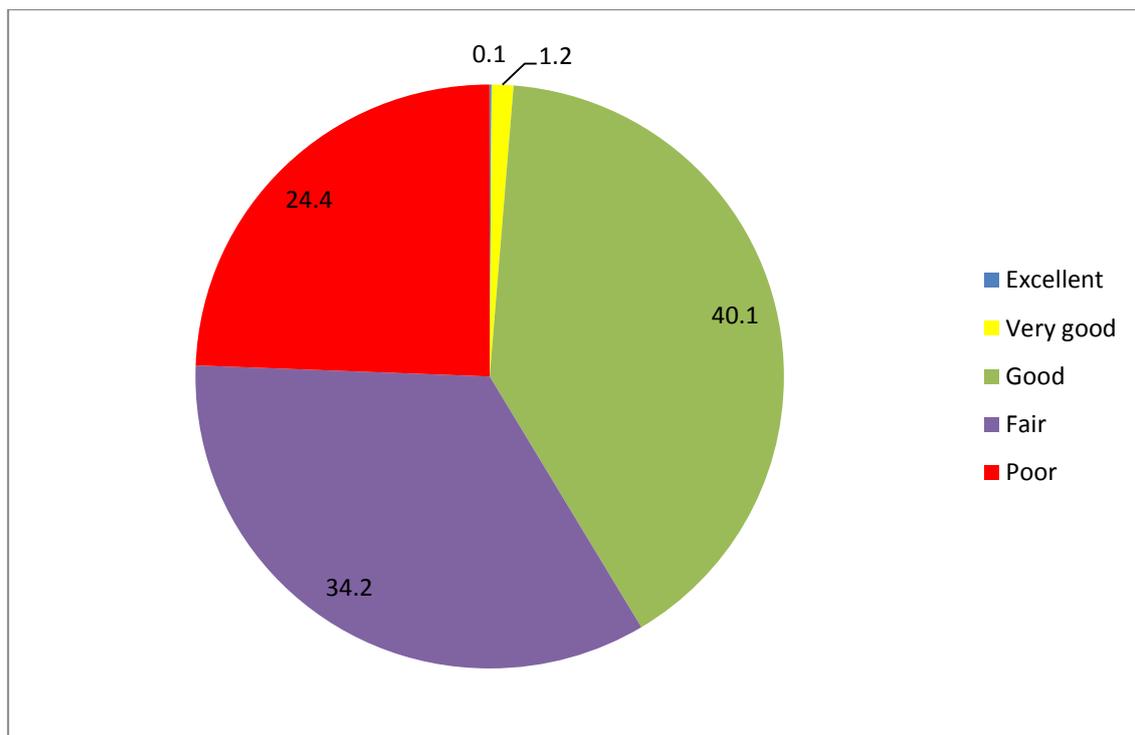


Figure 5.9 Findings on overall rating on labour/delivery experience by women

5.2.6 Postnatal experience

5.2.6.1 Care in hospital after delivery

Regarding length of stay after delivery, the findings showed that 7.8% of the women stayed for about 12 hours, 7.7% stayed between 12 to 24 hours, as much as 53.5% stayed between 1 to 2 days, 17.3% spent 3 to 4 days and 13.7% stayed for 5 or more days. Most (74.6%) of the women felt that the length of stay was too short, 14.2% noted that the length of stay was about right, 10.8% were not certain and only 0.4% stated that the length of stay was too long. In response to the item on whether they were given the

information or explanation they needed after delivery, 50% of the women said 'Yes always', 32.1% indicated 'Yes sometimes', 15.4% could not remember and 2.5% said 'No'.

The majority (85.3%) of the women noted that they were not treated with respect and kindness after the birth of their baby.

5.2.6.2 Feeding your baby

Table 5.8 presents the findings on feeding of the baby after delivery.

Table 5.8 Frequency and percent frequency distribution on the feeding of the baby after delivery

Item	Number of respondent	Frequency	Percent frequency
F1: Discussion of infant feeding during ante-natal	753		
Yes, definitely		564	74.9
Yes, to some extent		67	8.9
No		10	1.3
Cannot remember		112	14.9
F2: How baby was fed after delivery	749		
Breast milk (or expressed breast milk) only		682	91.1
Both breast and formula (bottle) milk		19	2.5
Formula (bottle) milk only		16	2.1
Not sure		32	4.3
F3: Consistency of advice on feeding of baby	750		
Yes, always		264	35.2
Yes, generally		396	52.8
No		12	1.6
I did not want or need this		3	0.4
Do not know		75	10.0
F4: Giving of active support by health staff after delivery	753		
Yes, always		105	13.9
Yes, generally		2	0.3
No		485	64.4
I did not want or need this		124	16.5
Do not know		37	4.9

5.2.6.3 Information on care at home after delivery

Four hundred and seventy three (473) (62.9%) of the women stated that they received enough information about their recovery after birth, 188 (25%) indicated to some extent information on their recovery after delivery was given. However, 87 (11.6%) could not remember whether they were given enough information or not while 4 (0.5%) felt that they did not need any information. In terms of information on emotional changes to expect after delivery, 269 (35.8%) responded 'Yes definitely', 289 (38.4%) indicated to some extent, 171 (22.7%) felt that they were not given enough information on emotional changes, 3 (0.4%) could not remember and 20 (2.7%) felt that they did not need information on emotional changes. Of the 752 women that responded to the item on provision of information on contraception, 332 (44.1%) stated that health professionals gave them information on contraception, 11 (1.5%) were not given any information and 409 (54.4%) could not remember whether they were given information or not. Figure 5.10 below presents the finding on how women rated their experience with care after delivery.



Figure 5.10 Findings on overall rating of postnatal care experience by women

5.2.7 Hospital environment

Figures 5.11 below presents the finding on type of accommodation that women were admitted into in the first stage and after delivery and the type of accommodation they

preferred. Figure 5.12 outlines details of findings on cleanliness of wards, washroom and bedsheets.

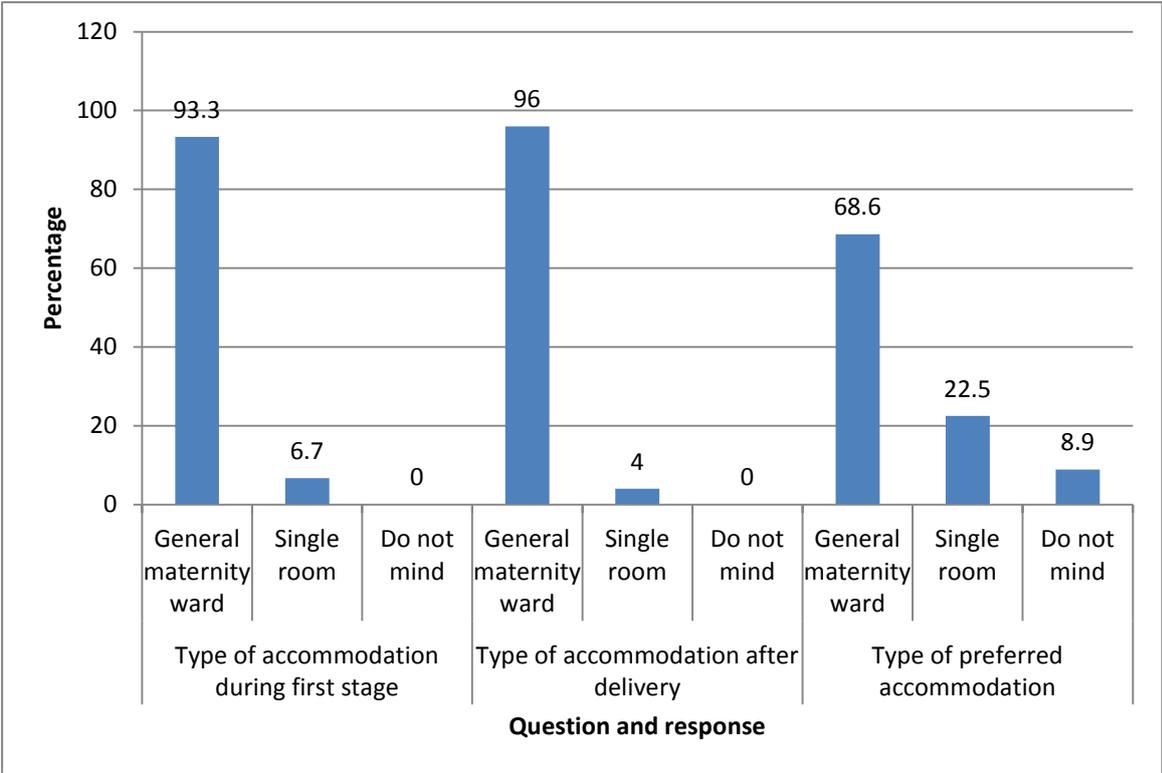


Figure 5.11 Finding on type of accommodation used during and after delivery and the type of accommodation preferred by women

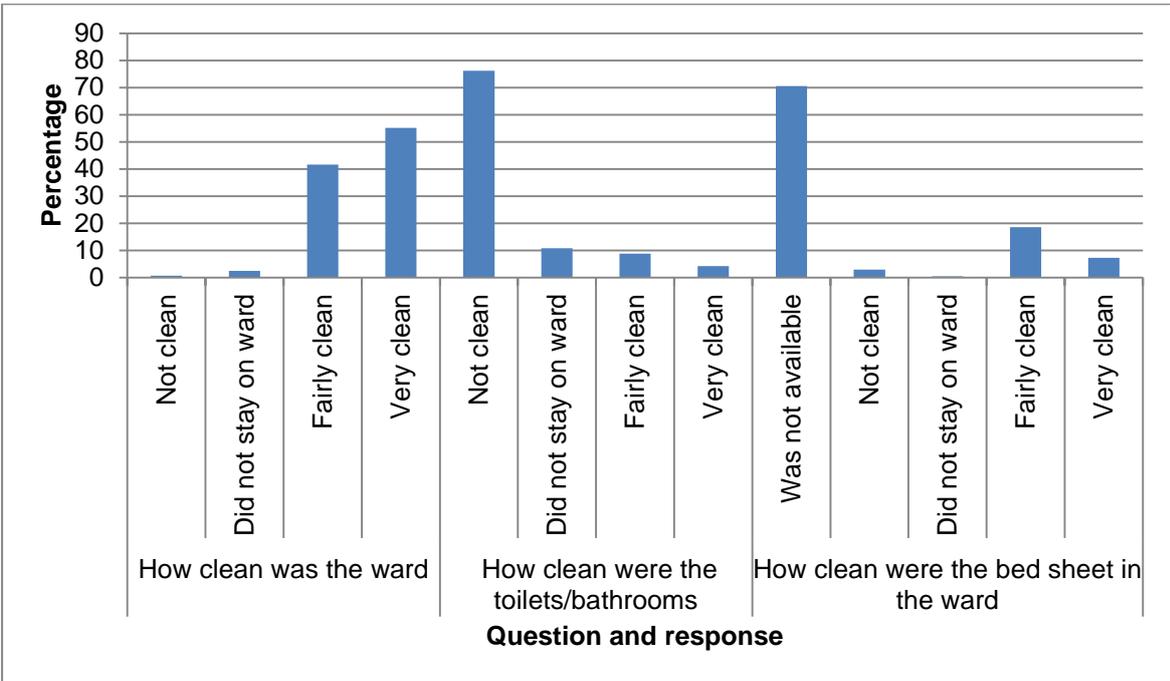


Figure 5.12 Findings on cleanliness of wards, washrooms and bedsheets

5.2.8 Findings on dimensions for client-centred care experience with childbirth

In relation to the distribution of dimensions of client-centred care experienced with childbirth, all the women indicated that support required during labour needs to be improved. Moreover, 95.8% were of the view that: informed choice, control, decision-making dimension need to be improved and 75.1% were not enthused about the length of stay in the hospital after delivery. Table 5.9 provides the details on the findings on the client-centred care dimensions.

The overall mean rating for: Arrival and Reception; Position of birth; Continuity of Care; and Communication and Education dimensions was excellent since their respective mean score exceeded 75.0% as shown in Table 5.10.

Table 5.9 Frequency distribution of dimensions for client experienced with childbirth

Dimensions for client-experienced with child birth	Client-centred care dimension scores		
	Number of women that responded	Excellent n (%)	Need improvement n (%)
Arrival and reception	754	483 (64)	271 (36)
Dignity, respect, courtesy and privacy	754	416 (55.2)	338 (44.8)
Informed choice, control, decision-making	754	32 (4.24)	722 (95.8)
Position of birth	754	632 (83.8)	122 (16.2)
Support in labour	754	0 (0.0)	754 (100.0)
Length of Stay	754	188 (24.9)	566 (75.1)
Communication and education	754	631 (83.7)	123 (16.3)
Continuity of care	754	715 (94.8)	39 (5.2)
Built environment	754	236 (31.3)	518 (68.7)

Table 5.10 The overall mean rating on dimensions for client-centred care experienced with childbirth

Dimensions for client-experienced with child birth	Mean rating				
	<i>Mean ± SD</i> (%)	Minimum (%)	Maximum (%)	95% CI	Average rating
Arrival and reception	82.0 ± 24.0	50.0	100.0	80.3-83.7	Excellent
Dignity, respect, courtesy and privacy	74.2 ± 13.1	41.2	100.0	73.3-75.2	Need improvement
Informed choice, control, decision-making	61.5 ± 7.3	33.3	87.9	60.9-62.0	Need improvement
Position of birth	81.7 ± 15.3	25.0	100.0	80.6-82.8	Excellent
Support in labour	57.2 ± 13.0	30.0	70.0	56.2-58.1	Need improvement
Length of Stay	59.7 ± 18.2	25.0	100.0	58.4-61.0	Need improvement
Communication and education	82.4 ± 8.1	57.8	100.0	81.9-83.0	Excellent
Continuity of Ccare	82.7 ± 8.4	58.3	100.0	82.1-83.3	Excellent
Built environment	69.7 ± 13.8	35.7	100.0	68.7-70.7	Need improvement

Note: SD represents sample standard deviation and CI is confidence interval

5.2.9 Findings on socio-demographic and other general variables correlates of excellent client-centred care experienced with childbirth using chi-square test of independence

The chi-square test of independence showed that type of facility; the number of weeks pregnant before baby was born; the first health professional seen at first visit to the health facility; the number of ante-natal check-ups; the type of health professionals seen during ante-natal check-ups; the type of pain relief method used during labour; the type of delivery; highest level of education; overall rating on ante-natal experience; overall rating on labour experience; overall rating on postnatal experience and host other factors were associated with excellent client-centred care experienced with childbirth ($p < 0.05$). Table 5.11 below presents the variables that were significant.

Table 5.11 Bivariate analysis of socio-demographic characteristics and other general variables and excellent client-centred care experienced with childbirth

Socio-demographic characteristics	Excellent client-centred care experienced with childbirth	χ^2 test	p-value
Type of facility			
Hospital B	151 (55.5)		
Hospital C	23 (25.3)	153.6	<0.0001
Hospital A	44 (11.3)		
Category of facility			
District Hospital	89 (24.5)		
Regional Hospital	10 (2.7)	79.6	<0.0001
B2: Number of weeks pregnant before baby was born			
Before I was 37 full weeks pregnant	54 (43.9)		
When I was 37 weeks pregnant or more	163 (26.0)	16.1	<0.0001
C1: The first health professional seen at first visited to the health facility			
Doctor	69 (42.9)		
Midwife/Nurse	147 (25.3)	18.9	<0.0001
Others (specify)	2 (28.6)		
C2: Number of weeks pregnant when first saw health professional about your pregnancy care			
Before I was 7 full weeks pregnant	44 (40.4)		

Socio-demographic characteristics	Excellent client-centred care experienced with childbirth	χ^2 test	p-value
When I was 7 to 12 weeks pregnant	89 (29.1)		
When I was more than 12 weeks pregnant	80 (25.7)	9.2	<0.026
Cannot remember	5 (20.8)		
C7: Number of ante-natal check-ups women had			
None	0 (0.0)		
1 to 6	112 (32.6)		
7 to 9	83 (32.2)		
10 to 14	15 (25.9)	23.4	<0.0001
15 or more	0 (0.0)		
Cannot remember	8 (9.9)		
C9: Types of health professionals seen during ante-natal check-ups			
Midwife/nurse	92 (21.7)		
Doctor	4 (30.8)		
Different categories of staff	122 (39.1)	26.8	<0.0001
Others (specify)	0 (0.0)		
D4: Type of pain relief method women planned to use during labour			
Natural methods (e.g. breathing, massage)	11 (25.0)		
Injection of pethidine or a similar painkiller	0 (0.0)	39.5	<0.0001
Epidural or similar (injection in your back)			
I did not intend to use any pain relief	112 (42.1)		
Cannot remember	74 (20.6)		
Other (specify)	1 (14.3)		
D8: Mode of delivery women had			
Normal vaginal delivery	141 (26.7)		
Assisted vaginal delivery	18 (47.4)		
Planned Caesarean delivery	39 (45.4)	23.2	<0.0001
Emergency Caesarean delivery	20 (19.6)		
D9: Health professional who assisted with the delivery of baby			
A doctor	7 (20.0)		
A midwife/nurse	142 (28.5)		
I do not know	6 (21.4)	8.5	<0.037
Other (specify)	4 (80.0)		
D18: Confidence and trust of women in health professionals			
Yes, definitely	166 (26.7)		
Yes, to some extent	37 (38.5)		
No	12 (50.0)	11.5	<0.009
Cannot remember	2 (20.0)		
D19: Preferred labour support person			

Socio-demographic characteristics	Excellent client-centred care experienced with childbirth	χ^2 test	p-value
Spouse/partner	79 (24.7)		
Family member/friend	130 (32.8)	6.0	0.050
Others (specify)	9 (24.3)		
E1: Length of stay in hospital after delivery			
Up to 12 hours	29 (49.2)		
More than 12 hours but less than 24 hours	20 (34.5)		
1 to 2 days	108 (26.8)	15.1	<0.004
3 to 4 days	31 (23.9)		
5 or more days	30 (29.1)		
I5: Highest level of education			
Never been to school	25 (27.2)		
Primary/Junior secondary	90 (25.1)		
Senior secondary/Vocational	63 (29.9)	12.4	<0.006
University degree/diploma and higher	39 (43.8)		
I7: Mode of payment of hospital fee			
Health Insurance	187 (27.3)		
Fee for services (out of pocket)	3 (23.1)	13.6	<0.004
Both Health Insurance and out of pocket	26 (51.0)		
I8: Paid money to health professional(s) not given an official receipt			
Yes	39 (18.9)		
No	175 (33.0)	15.0	<0.001
Overall rating for ante-natal			
Need improvement	170 (25.4)	35.4	<0.0001
Excellent	48 (56.5)		
Overall rating for labour			
Need improvement	168 (25.5)		
Excellent	50 (53.8)	31.8	<0.0001
Overall rating for postnatal			
Need improvement	0 (0.0)	31.9	<0.0001
Excellent	216 (31.9)		

5.2.10 Overall assessments

The mean (SD) score for overall satisfaction with care that comprises three key indicators (ante-natal, labour and postnatal experiences) was 63% (7.3). The number of women who had excellent ante-natal, labour and postnatal experiences was 85 (11.3%), 93 (12.4%) and 677 (90.5%) respectively. The mean (SD) satisfaction rating for ante-natal, labour and postnatal experiences was 68% (5.3), 68.2% (6.2) and 84.4% (7.4) respectively. This indicates that there is the need for improvement in relation to

ante-natal experience and labour experience since their mean scores were below the threshold point of (<75%). The mean (SD) overall satisfaction with care scores for those who waited and those who did not wait on arrival at health facility were estimated to be 72.1% (6.3) and 70.1% (4.9) respectively. This resulted in absolute mean difference of 2.0% that was statistically significant ($t=6.9$, $p<0.0001$).

Regarding client-centred care analysis, the proportion of women who had excellent client-centred care experience was 28.9% (95% CI: 25.7-32.2%). The mean (SD) score of excellent client-centred experience with childbirth was 71.5% (5.8). Since this figure does not exceed the expected threshold ($\geq 75\%$), there is a need to improve the overall client-centred care experienced with childbirth. The mean (SD) excellent client experienced with childbirth for those who waited and those who did not wait on arrival at health facility were estimated to be 69.9% (4.7) and 71.5% (5.8) respectively. This resulted in absolute mean difference of 1.6% that was statistically significant ($t=5.6$, $p<0.0001$).

5.2.11 Comparing excellent client-centred care experienced with childbirth among three facilities

The median (IQR) excellent client-centred care experienced with childbirth among the three facilities was as follows:

- Hospital A – 68.8% (7.3)
- Hospital B – 76.0% (5.8)
- Hospital C – 71.1% (7.6)

The Kruskal Wallis test showed a significant difference ($p<0.05$) in the median client-centred care score among the three facilities. The Posthoc test further showed that significant difference ($p<0.001$) existed between Hospital B and Hospital C, Hospital B and Hospital A, and finally Hospital A and Hospital C (see Figure 5.13 below).

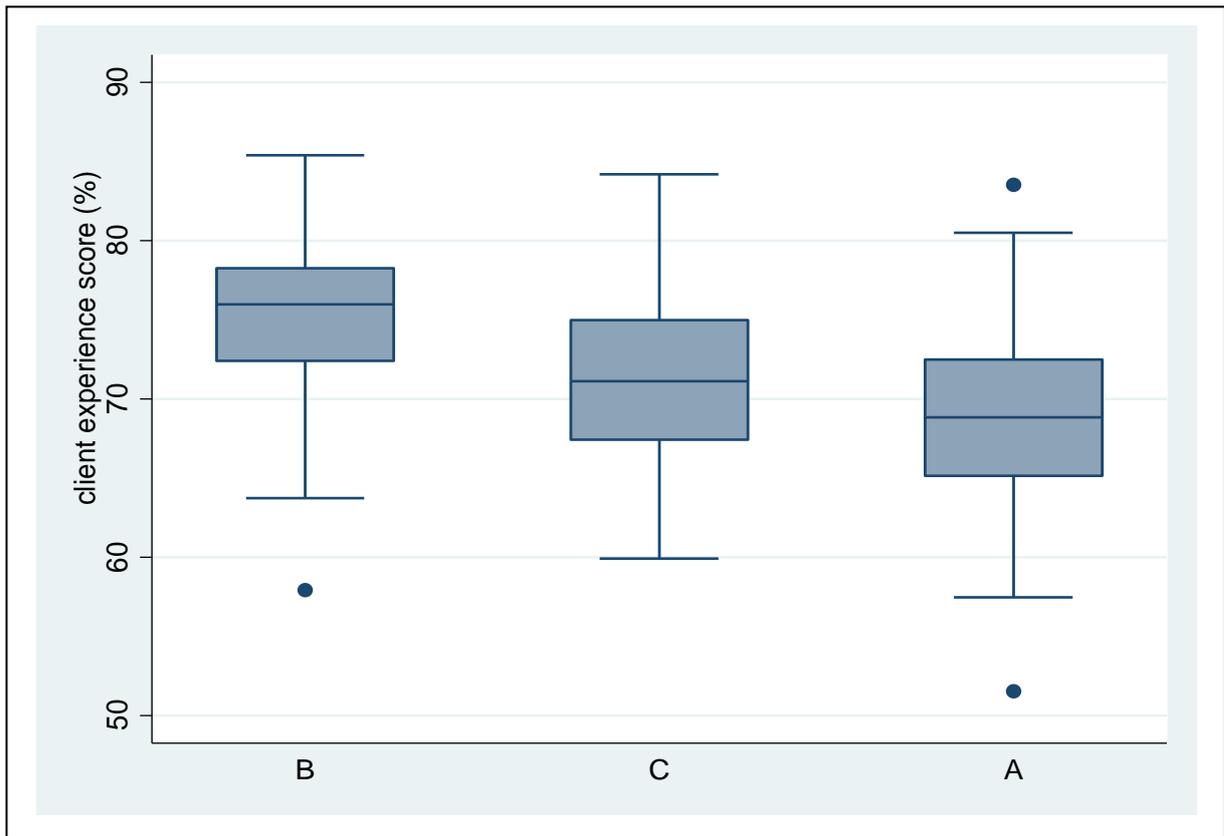


Figure 5.13 Comparative analysis of excellent client experience with care and location of facility

5.2.12 Multivariable analysis of factors associated with excellent client-centred care experienced with child birth based on the binary logistic regression

The binary logistic regression analysis in Table 5.12 indicates that the type of facility, the type of pain relief method used during labour, mode of delivery, professional who assisted with the delivery of the baby and length of stay in hospital after delivery were the factors associated with ‘excellent client-centred care’ experience with childbirth ($p < 0.05$). The odds of having ‘excellent client-centred care’ experience with childbirth is approximately 2.0 (95% CI: 0.98-3.98) times higher for women who had planned Caesarean delivery compared with women who had normal delivery controlling for all other factors accounted for in the model. The odds of having ‘excellent client-centred care’ experience for women who used Epidural as pain relief method during labour is 1.6 (95% CI: 0.60, 4.36) times higher compared to women who used natural methods controlling for other factors. Furthermore, the odds of having ‘excellent client-centred care’ experience for women who visited Hospital B is 3.7 (95% CI: 1.92-7.14) times

higher compared to women who visited the Hospital C controlling for other covariates as shown in Table 5.12.

Table 5.12 Multivariable analysis of factors associated excellent client-centred care experienced with childbirth

Item/variable	Excellent client-centred care experienced with childbirth		
	aOR	95%CI	p-value
Type of facility			
Hospital B	ref		
Hospital C	0.27	(0.14, 0.52)	<0.001
Hospital A	0.11	(0.07, 0.18)	
B2: Number of weeks pregnant before baby was born			
Before I was 37 full weeks pregnant	ref	(0.53, 1.36)	0.737
When I was 37 weeks pregnant or more	4.10	(0.52, 32.4)	
C1: First health professional seen at first ante-natal care visited			
Doctor	ref		
Midwife/Nurse	1.05	(0.64, 1.72)	0.533
C2: Number of weeks pregnant when first saw health professional about pregnancy care			
Before I was 7 full weeks pregnant	ref		0.718
When I was 7 to 12 weeks pregnant	0.86	(0.51, 1.44)	
When I was more than 12 weeks pregnant	0.85	(0.50, 1.45)	
C7: Number of ante-natal check-ups women had			
None	ref		
1 to 6	0.99	(0.66, 1.51)	0.468
7 to 9	0.82	(0.38, 1.79)	
10 to 14			
15 or more	0.60	(0.26, 1.38)	
9: Type of health professionals seen during ante-natal check-ups			
Midwife/nurse	ref		
Doctor	0.85	(0.30, 2.39)	0.777
Different categories of staff	0.84	(0.53, 1.32)	
D4: Type of pain relief method used during labour			
Natural methods (e.g. breathing, massage)	ref		
Injection of pethidine or a similar painkiller	1.23	(0.72, 2.12)	
Epidural or similar (injection in your back)	1.64	(0.60, 4.36)	<0.027
I did not intend to use any pain relief	0.86	(0.15, 4.78)	
D8: Mode of delivery women had			
Normal vaginal delivery	ref		

Item/variable	Excellent client-centred care experienced with childbirth		
	aOR	95%CI	p-value
Assisted vaginal delivery	1.20	(0.56, 2.63)	
Planned Caesarean delivery	1.98	(0.98, 3.98)	<0.022
Emergency Caesarean delivery	0.95	(0.45, 2.02)	
D9: Health professional who assisted you with the delivery of baby			
A doctor	ref		
A midwife/nurse	1.07	(0.40, 2.88)	0.018
D18: Confidence and trust of women in health professionals			
Yes, definitely	ref		
Yes, to some extent	1.20	(0.70, 2.12)	0.853
No	0.94	(0.17, 5.20)	
Cannot remember			
E1: Length of stay in hospital after delivery			
Up to 12 hours	ref		
More than 12 hours but less than 24 hours	1.34	(0.59, 3.07)	
1 to 2 days	1.21	(0.64, 2.30)	<0.033
3 to 4 days	1.05	(0.46, 2.39)	
5 or more days	0.79	(0.33, 1.87)	
I5: Highest level of education			
Never been to school	ref		
Primary/Junior secondary	1.11	(0.60, 2.07)	0.057
Senior secondary/Vocational	1.04	(0.54, 1.97)	
University degree/diploma and higher	1.67	(0.82, 3.42)	
I7: Mode of payment of hospital fee			
Health Insurance	ref		
Fee for services (out of pocket)	2.72	(0.57, 13.09)	0.294
Both Health Insurance and out of pocket	1.01	(0.52, 1.99)	
I8: Paid money to any of the health professional(s) that attended to you for which you were not given an official receipt			
Yes	ref		
No	1.14	(0.71, 1.84)	0.569

Note: Ref=reference category

5.2.13 Comments from participants

Participants were requested to comment on any other thing about their maternity care. One hundred and seventy seven (177) of the participants provided comments and some suggestions to improve the quality of childbirth services. Some participants mentioned

more than one issue. The findings from their comments were grouped into 11 thematic areas and are presented in Table 5.13 below.

Table 5.13 Comments and suggestions from participants

Thematic area	Summary of comments	Number that mentioned
Good work by staff	<ul style="list-style-type: none"> ANC services are good/ Staff are friendly and doing their best 	30
Communication and education	<ul style="list-style-type: none"> Offer ante-natal classes for women Provision of enough information to clients before they go home and insufficient explanation on some treatments 	6 13
Informed choice	<ul style="list-style-type: none"> Offer informed choice of birth attendant Staff not accepting opinion of women Staff should know the needs of clients 	10 2 9
Utilities	<ul style="list-style-type: none"> No/inadequate water in hospitals 	25
Infrastructure	<ul style="list-style-type: none"> Bath room and toilets not clean, Improve bathroom and toilet sanitation Poor ventilation Mosquitoes in the wards Inadequate space/overcrowding/some lying on the floor More single rooms 	68 15 12 44 5
Equipment and supplies	<ul style="list-style-type: none"> Inadequate resources to enhance service of staff Inadequate bed/ need to increase number of beds 	19 53
Staffing	<ul style="list-style-type: none"> More staff needed at maternity/pressure on staff High workload 	9 16
Staff attitude and interpersonal relationship	<ul style="list-style-type: none"> Some staff are impatient/ Service providers are very rude they should treat client with respect and courtesy- must learn to show kindness to clients/ Improve staff attitude and interpersonal relationship 	79
Attentiveness and comfort	<ul style="list-style-type: none"> Staff should respond to calls 	12
Diagnostic test services	<ul style="list-style-type: none"> Scan services take too long/lab staff to come for samples on the ward and not women to be taking it to them 	7
Payment	<ul style="list-style-type: none"> Insurance cards take long to process and without it we are not allowed to start ANC Payment without receipt 	4 4

5.3 PART 2: DISCUSSION OF FINDING ON FACTORS THAT INFLUENCE CLIENT-CENTRED CHILDBIRTH SERVICES

5.3.1 Introduction

Women's views on the quality of childbirth services are of great importance in determining aspects of care that need strengthening. This quantitative study was thus carried out to help provide a better understanding of the factors that influence client-centred care in hospitals and make recommendations for improvement. Using this approach is supported by Creswell (2003:21-22) who proposes that quantitative study is most useful if the aim of the study is to identify factors that influence an outcome such as client-centred care. Though the results of the study were in most part presented in line with the format of the questionnaire, the discussion of the findings was generally arranged according to the dimensions of client-centred care.

5.3.2 Demographic characteristics

The 754 women that participated in the study were drawn from three hospitals with similar socio-demographic characteristics. Participants from Hospital A constituted more than half of the study participants. This was not surprising as Hospital A is a regional referral hospital and is expected to have a higher service utilisation rate. The median (IQR) scores of all the hospitals depicted the need for improvement in client-centred care practices in all the study hospitals. It is worth noting that type of hospital was statistically significantly ($\chi^2=153.6$, $p<0.0001$) associated with excellent client-centred care of childbirth services. The Posthoc test further showed that significant difference ($p<0.001$) existed between the hospitals. Another indication of significant difference was observed in the binary logistic regression analysis. For example, the odds of having 'excellent client-centred care' experience for women who visited Hospital B is 3.7 (95% CI: 1.92-7.14) times higher compared to women who visited the Hospital C controlling for other covariates.

An association between type of institution and satisfaction with care was reported in Matejić, Milićević, Vasić and Djikanović (2014:4). Likewise, Mohammad, Shaban, Home and Creedy (2014:36) also found an association between hospital type and satisfaction and stated that birth in public hospital was associated with low satisfaction. All the study

hospitals in this study were public or government-owned institutions but comprised one regional hospital and two primary level ones. The differences in observations in the hospitals could be due to the existence of a real difference in the quality of service provided as Hospital A being a regional hospital often received more complicated cases. It must be indicated also that Hospital A tends to have more 'bad press' than the other hospitals and this could have influenced the views of women. This explanation is in line with views expressed in Bazant and Koenig (2009:83) who report that capacity of health facilities to effectively manage obstetric complications may influence satisfaction of women. Differences in expectations of women could also be a factor. Irrespective of the explanation, it would be beneficial for the root causes of the difference to be determined.

5.3.2.1 Socio- demographic characteristics of study participants

The age range of the women, 14 to 45 years with a mean of 29.1 years, as well as the distribution of number of deliveries the women had were similar to that of the general population of women in the reproductive age in the country (Ghana Statistical Services 2011:100). Likewise, the pattern of highest educational level where majority (55.7%) of the women had primary/junior secondary school stage as their highest level of education and the lowest percentage (8.4%) indicating university degree, diploma or higher certificate is supported in a report on the educational level of women in Ghana (GSS 2009:26). A statistically significant ($\chi^2=12.4$, $p<0.006$) association was found between level of education of women and client-centred childbirth but was only marginally significant on the binary logistic regression analysis. This finding is consistent with that reported in Ahmar and Tarraf (2014:604), Matejić et al (2014:4) and Saha, Arbelaez and Cooper (2003:1717) who found significant associated with level of education and satisfaction with care. Specifically, it has been noted that people with high educational level score higher on health seeking behaviour (Ihaji, Gerald & Ogwuche 2014:314). On the contrary, Mohammad et al (2014:36) found no association between women's educational level and satisfaction with intrapartum care. The inconsistencies on the influence of education on satisfaction with care calls for further research.

In contrast to the findings in Ahmar and Tarraf (2014:599), Bertucci et al (2012:270) and Neuman et al (2010:413-414) who reported that the age of the women is significantly

associated with childbirth preferences, this study found no association between age and client-centered childbirth experience; therefore supporting Mohammad et al (2014:36) finding of no association between women's age and satisfaction with care. This suggested that both older and younger women had similar perception regarding their experience with childbirth in the hospitals.

The evidence on the association of parity and client-centeredness of childbirth services appears to be inconsistent in the literature. For example, Matejić et al (2014:4) and William et al (2010:619) found that parity affected satisfaction with childbirth services. Ahmar and Tarraf (2014:591) pointed out that primiparous women dread the unfamiliar nature of the birth and the birth environment and that was a widespread subject matter running throughout first-time mothers as they do not know what to expect. Primiparous women are thus more likely to express low satisfaction with care compared with multiparous women. On the contrary, Mohammad et al (2014:36) and Neuman et al (2010:413-414) found no association between parity and childbirth satisfaction or preferences. This study found no association between the parity of women and client-centred care experience, indicating that both multiparous and primiparous had similar views on their experiences.

Regarding ante-natal check-up, most of the women reported for ante-natal care within the first 12 weeks of pregnancy but a good number of them also reported quite late when they were more than 12 week pregnant. The results showed a statistically significant ($\chi^2=9.2$, $p<0.02$) association between the number of weeks that women were pregnant when they first saw a health professionals about their pregnancy care and excellent client-centred care. It must be noted that no guideline document from the Ghana's Ministry of Health was found on the recommended start date for ante-natal care but it is generally expected that women would seek ante-natal care as soon as they realise that they are pregnant. The significant association observed on this item brings to the fore the relevance of this variable and the need to further examine the extent to which it influences satisfaction with care.

Prolonged labour has been found to be a predictor of lower satisfaction (Bélanger-Lévesque, Pasquier, Roy-Matton, Blouin & Pasquier 2014:3). Ahmar and Tarraf (2014:597) found that that the less time the female spent in labour, the more she was satisfied with the childbirth experience. It has also been reported that prolonged labour

especially for new mothers creates panic, and makes women feel helpless as if they have lost control (Nystedt, Högberg & Lundman 2006 cited in Ahmar & Tarraf 2014:592), a situation that could greatly impinge on their experience of care. Though no significant association was observed between duration of labour and having excellent client-centred care in this study, more attention needs to be paid to this aspect of care to help minimise the suffering of women.

The gestation of pregnancy before delivery and weight of the baby at delivery were examined to determine their influence on satisfaction of childbirth services. The study observed a statistically significant ($\chi^2=16.1$, $p<0001$) relationship between number of weeks women were pregnant before delivery and excellent client-centred experience on the bivariate analysis but not on the binary logistic regression analysis. The implication is that gestation of pregnancy before delivery has influence on the perception of client-centredness of childbirth service. Though the direction of the relationship was not assessed in this study, it is common knowledge that women who deliver term healthy babies tend to be more appreciative of their birth experience.

The impression is often created that location of residence influences satisfaction and that clients from urban areas tend to be more critical and dissatisfied with health services than those from the rural areas. No association was found between these variables and having excellent client-centred care.

5.3.2.2 Information on baby

It is worth mentioning that as much as 51.2% of the women could not tell or remember the birth weight of their baby. It could be that either the women were not provided with the information on the weight of their babies or they did not find the information relevant enough.

One of the globally recommended interventions to improve the health of infants is exclusive breastfeed. The World Health Organization (WHO) and many nations recommend timely initiation of breastfeeding for all newborns (WHO 2008; Ministry of Health, Ghana 2007; WHO 1991). This entails putting the new born to the breast either immediately or within an hour of birth. This is because early initiation of breastfeeding immediately after birth or few hours after birth has been found to be positively

associated with the well-being of the child (Fosu-Brefo & Arthur 2015:[6]). Indeed, Fosu-Brefo and Arthur (2015:[6]) postulate that the benefits to child health are higher for mothers who breast-feed their infants immediately after birth compared to those who breast-feed their infants hours after birth.

The majority of the women in this study stated that information regarding infant feeding was discussed with them. They stated that the information they had from care providers were consistent. It was therefore not surprising that majority of them breastfed their baby on only breastmilk after delivery. Many factors determined timely initiation of breastfeeding. These include place of residence, institutional delivery, post-natal advice on breast feeding and educational status (Setegn, Gerbaba & Belachew 2011:4). No statistical association was observed between having fed baby on breastmilk and having excellent client-centred care.

5.3.2.3 *Payment of hospital fees*

In terms of mode of payment of hospital fees, a statistically significant ($\chi^2=13.6$, $p<0.004$) association was observed between mode of payment of hospital fees, paying monies to health professionals without receipt ($\chi^2=15.0$, $p<0.001$) and client-centred experience but were not significant on the binary logistic regression analysis. These findings are of great importance as according to Moyer, McLaren, Adanu and Lantz (2013:226-229), financial access is a major hindrance to utilisation of services. Similarly, Tayelgn, Zegeye and Kebede (2011:[6]) found that cost incurred for service was associated with mothers' level of satisfaction. It is evident that despite the introduction of the National Insurance Scheme and an exemption policy for all pregnancy and delivery-related services, so women do not pay for service out-of-pocket (Kusi, Enemark, Hansen & Asante 2015:2). However, some of the women still made out-of-pocket payments for which receipt were not given. It is possible that these payments were for services or items that were either out of stock or not offered as part of the insurance package. The health facility managers would have to further investigate this practice considering the fact that it influences perception of client-centeredness of care.

Expectedly, most of the women resided in the urban or semi-urban areas. No association was also found between location of residence of women, who the women currently lived with and client-centred experience.

5.3.3 Arrival and reception during labour

The kind of reception a woman receives and waiting time have been found to influence childbirth experience. For example, Phillippi (2009:222) provides evidence that longer waiting time adversely affects satisfaction with childbirth services. Similarly, Phiri, Fykesnes, Ruano and Moland (2014:[6]) report that delay in receiving clinical attention especially during delivery makes women feel neglected and discourages use of health facility childbirth services. The findings in this study showed that the greater proportion of the women (85.9%) was attended to immediately on arrival during labour. In a similar vein, the overall mean rating for the Arrival and Reception dimension was deemed as excellent as the mean score exceeded 75.0% (95% CI: 80.3-83.7).

However, of note is that of the 106 women who had to wait on arrival, quite a substantial number 145 (53.5%) had to wait between 31 minutes to 1 hour before receiving attention. In general, apart from the negative finding on the friendliness of the front desk staff and about 26% of them not being provided with the reason why they had to wait, the women seemed to have had good waiting experience. The mean (SD) excellent client-centred care experienced with childbirth for those who waited and those who did not wait on arrival at health facility were estimated to be 69.9% (4.7) and 71.5% (5.8) respectively. This resulted in absolute mean difference of 1.6% which was statistically significant ($t=5.6, p<0.0001$). The observation of the statistical difference between those who waited and those who did not wait indicates that prompt treatment is important to women.

Friendliness, respect and feeling comfortable are important variables that have been found to be associated with higher level of satisfaction in health care (Netten, Francis, Jones & Bebbington 2004:28-29). The information obtained on the Arrival and Reception dimension lends credence to the fact that instituting measure to help reduce waiting time, improving the quality of waiting and addressing negative attitude of front desk staff can tremendously make the experience of women better.

5.3.4 Dignity, respect, courtesy and privacy

Women are particularly sensitive to the considerations and attention they receive during admission in the hospital and perceived quality of welcome correlated with a decreased perceived need for additional care and a more general faithful attitude towards health professional (Andrissi, Petraglia, Giuliani, Severi, Angioni, Valensise, Vannuccin, Comoretto & Tambone 2015:10). Despite efforts to improve customer care in health facilities (Ghana Health Service 2009a:14), the findings on issues regarding dignity, respect, courtesy and privacy were not very encouraging. For example, only 3.2% of the women indicated that all the staff that cared for them introduced themselves. Nevertheless, the majority (69.6%) of the women could not remember whether staff introduced themselves or not. Similarly, just a little more than half of the women felt that their concerns were taken seriously by the health staff and as much as 85.3% noted that they were not treated with kindness and understanding. The dimensional analysis showed that a little more than half (55.2%) of the women had excellent client-centred care experience while the experience of the remaining 44.8% needs to be improved. Expectedly, the overall mean rating of 74.2% (95% CI: 73.3-75.2) denoted that there is the need to improve issues that impinge on the experience of dignity, respect, courtesy and privacy of women.

These findings are similar to those reported in Mason et al (2015:6) and Phiri et al (2014:[6]) which indicate that inappropriate staff attitudes or behaviour constitutes a barrier to health facility delivery and makes women feel disrespected. It has also been found that the level of patient satisfaction normally stems from the relational style of individual professionals as well as how the organisation deals with relational issues (Andrissi et al 2015:2). Another study in Ghana (Awuah-Peprah 2014:104) indicated that empathetic behaviour seen through demonstration of respect, friendliness and care are related to satisfaction.

Though several factors may be responsible for this phenomenon, it is imperative that measures are put in place to curb disrespectful behaviour in health facilities. In this regard, putting in place measures to ensure that women are accorded the needed respect, there should be courtesy, privacy and dignity, which can enhance the satisfaction and childbirth experience of women. Staff should endeavour to: pay attention, value and appreciate each woman as an individual; demonstrate

understanding or try to understand women in his own terms and avoid making assumptions about them; and to care for women as well as act to satisfy their needs (Dillon 1992 cited in Ali 2011:74). This view is also supported in NICE (2008:7) which stipulates that women, their partners and their families should always be treated with kindness, respect and dignity.

5.3.5 Decision-making, control and informed choice

Jamas et al (2011:697) and William et al (2010:619) noted that women have preferences regarding having control over decisions on treatment; choice of place of birth, mode of birth and birth position, type of support during birth and comfort measures, labour pain management and length of stay after delivery. Similarly, Cook and Loomis (2012:166) and Simkin (1991:201) found a relationship between women having control over their birth plans and a more positive recollection of birth experiences and satisfaction. Generally, performance on items under decision-making, control and informed choice was low. The greater percentage of women in this study were not provided with information on the choices available to them regarding choice of place of birth, pain relief, birth attendant, mode of delivery, birth position and labour companion. The score on the informed choice, control and decision-making dimension was not encouraging as 96% of the responses fitted into the need for improvement category with an overall mean rating of 61.5% (95% CI: 60.9-62.0).

A number of studies (Holmes & Goldstein 2012:7; Kostick, Whitley & Bush 2010:529; Batte & Odoi-Adome 2006:12; Ministry of Health, Ghana 2004:19; IOM 2001:48-49) support the findings in this study. Though the current approach to care provision tends to advocate women having control over decision-making (Jomeen 2012:60; Cook & Loomis 2012:166), client participation in decision-making and experience of informed choice is often a low performance area. The IOM (2001:48-49) indicated that many patients expressed frustrations with their inability to participate in decision-making and were not able to obtain information they needed to participate in their care. Indeed, some clients especially in developing countries do not even know that they have the right to be involved in decisions-making regarding their care (Batte & Odoi-Adome 2006:12).

It has also been found that some clients do not consider involvement in decision-making important and would prefer to give such responsibilities to their care providers (Aro, Pietilä & Vehviläinen-Julkunen 2012:1855). For example, a study in South Africa noted that women were comfortable with their dependency on midwives regarding decision-making (Maputle & Hiss 2010:8). The findings implies that instituting systems to improve client involvement in decision-making and or providing explanation on care and treatment as well as promotion of informed choice could greatly enhance the experience of women during childbirth. Pre-requisite for achieving this objective include regular assessment of the information needs of women and families.

5.3.6 Communication and education

The importance of communication and education in health care delivery cannot be understated. Collins (2009:11) recounts several reasons why communication is important in health care and posits that among many other benefits, it is through communication that clients are: reassured; made to understand their illness; able to voice their concerns; empowered and motivated to follow medication regimen.

Contrary to studies (Martin & Robb (2013:6; Dzomeku 2011:32-34; Mattocks et al 2011:127) that indicated that women reported not having good experiences with communication and education, the overall mean rating of 82.4% (95% CI: 81.9-83.0) on the communication and education dimension found in this study depicts that majority of the women had excellent experiences on this dimension. In the same vein, more than half of the women had information on contraception, the emotional changes to expect after delivery and how to care for themselves. This finding is consistent with other results in the published literature (Constand, MacDermid, Bello-Haas & Law 2014:[8]; Tongue, Epps & Forese 2005:659) that demonstrate that adequate information giving and effective communication are important to women and greatly influences their experience.

However, it must be indicated that experiences of women regarding some of the individual items examined under this aspect of care were poor. For example, as much as 93.6% of the women stated that they were not spoken to in a way they could understand, 76.5% did not attend any formal ante-natal classes apart from the education provided during antenatal clinic attendance and the reasons for having scan

and laboratory tests were not explained to majority of the women. As expressed in Fowler et al (2011:699), it is imperative to fully explain every procedure, treatment, and test to women. Likewise, the OMA (2010:34-37) and Frampton, Guastello, Brady, Hale, Horowitz, Smith and Stone (2008:78) put forwards that patients who understand their providers are more likely to accept their health problems, understand their treatment options, modify their behaviour and adhere to follow-up instructions. The observations in the study shows that putting in place mechanisms to improve communication and education of women could lead to increase in overall satisfaction score. However, there is the need to further ascertain the specific information need of women as well as the modes of communication or information giving that is acceptable to women to guide the process.

5.3.7 Place of birth

Planning where to give birth is one of the most important decisions that women make during pregnancy, yet many care providers often take it for granted that most births will take place in health facilities (Coxon, Sandall & Fulop 2014:51). In this study, the majority (75%) of the women were clear in their minds that they would deliver in hospitals. Conversely, 23.7% of the women indicated that they had not decided on where to deliver their baby at the start of their pregnancy. In line with popular thinking, the preference of the women was consistent with the findings of Vedam et al (2012:601) and Overgaard et al (2012:978) as much as 96.3% of the women indicated hospitals and maternity homes as their preferred place of delivery. Crissman, Engmann, Adanu, Nimako, Crespo and Moyer (2013:20) also reported similar findings in a study in Ghana where all participants stated that they intended to deliver in a health care facility. Only a small percentage selected home or birth by a Traditional Birth Attendant (TBA) as their preferred places of delivery. Irrespective of the smallness of the percentage of women who preferred places of delivery outside the health facilities, the fact still remains that there are some women who would want to deliver their babies at home for which measure need to be put in place to assure safety and good birth experience.

It is generally known that a number of factors determine a woman's choice of place of birth. For instance, the Royal College of Midwives (2011b:11-20) asserts that inadequate information hinders women's ability to make decision on their choice of place of birth. Vedam et al (2012:601) state that some women choose to deliver at

home because of need: for more privacy; for comfort and convenience; to decrease their rate of interventions; for provide greater cultural and spiritual congruency; to change the provider-patient power dynamics; to facilitate family involvement; and for relaxed and peaceful atmosphere. Kkonde et al (2011:10-11) note that the decision on place of birth is influenced by factors such as distance, staff attitude, cost, spousal and significant others' influence. Yet still researches such as Guliani et al (2012:1185-1187) and Edmonds et al (2012:556-558) report that number of ante-natal visits, educational level, urban residence, increasing maternal age, parity and women's employment status were found to be associated with health facility birth. Though the reasons for the choice of place of birth were not determined in this quantitative study, the follow-up qualitative study offered some explanations.

The results also showed that 72.6% of the women that delivered in the study hospitals also used antenatal services in the hospitals. This finding is reassuring because though it is generally expected that women would use delivery services at the health facility in which they had their ante-natal care, anecdotal evidence in the past appeared to be on the contrary (that many women do not deliver in the hospitals where they go for ante-natal care). It must be noted that the study hospitals all served as referral hospitals, as such having as much as 27.4% of the women using only the delivery services in the hospitals was not unexpected. No association was found between having used ante-natal services in the study hospital and client-centred experience.

On the whole, the finding supports the view that women's preferences for place of birth vary (Vedam et al 2012:601; Overgaard et al 2012:978; Kempe et al 2010:133; Bazzano et al 2008:92). Increasing the proportion of births assisted by skilled personnel (Doctor, Nurse, Midwife, Auxiliary midwife, or Community health officer) is a central strategy for improving maternal and newborn survival in Ghana (Ministry of Health, Ghana 2011:42). The high percentage preference for health facility delivery could have been influenced by the intensification of programmes by the Ministry of Health and its agencies to increase skilled birth attendance in the country. Interestingly, the promotion of health facility delivery as against home birth in general increasingly fails to capture the nuances of women's experiences or the breadth of contextual influences that make women to choose home births. The major argument for this objective has been safety. As the country move forward in enhancing the experience of women, mechanism to assure the safety of home delivery by skilled birth attendants should be explored. Some

developed countries have instituted 'home-like' settings in maternity hospitals so women could feel at home and at the same time have easy access to life saving measures when required (Coxon et al 2014:53).

5.3.8 Birth attendant

About 63.1% of the women selected a midwife or nurse as their preferred health professional for delivery services. Midwives were the major care providers during pregnancy and delivery. Midwives were the first health professionals that most of the women saw on their first visit to the health facility for their pregnancy care and were also the major care providers through pregnancy to immediately after delivery. It is noteworthy that a number of variables examined on issues related to birth attendant were associated with excellent client-centered care on the analyses. It was noted that the category of health professional that attended to women was very important. This is because of the variables that were significant as four of them concerned issues of the health professional that attended to the woman. As expected, midwives were the most preferred health care providers. Statistically significant association was observed between the first health professional that women saw at their first visit to the health facility ($\chi^2=18.9$, $p<0.0001$), type of health professional seen during ante-natal check-ups ($\chi^2=26.8$, $p<0.0001$), health professional who assisted with the delivery of baby ($\chi^2=8.5$, $p<0.03$), and having confidence and trust in the staff that women during labour ($\chi^2=11.5$, $p<0.009$) and excellent client-centred care. It was also noted that the odds of having 'excellent client-centred care' experience for women who were assisted in delivery by midwives is 1.07 (95% CI: 0.40, 2.88) times higher compared to women who were assisted in delivery by doctors. These findings are of great importance to the design and implementation of childbirth services.

The results reported in Gamble et al (2007:117) are consistent with the finding on the preferred birth attendant in this study. On the contrary, Fairbrother, Stoll, Schummers and Carty (2012:11) and Bashour and Abdulsalam (2005:4) found that the majority of women in their study preferred to be attended by doctors compared to midwives. Participants in the study in Lekberg, Sundby, Jammeh and Fretheim (2014:41), had no preference among skilled care providers. Shiferaw et al (2013:[4-5]) wrote that families opted for TBAs as their first line care provider for delivery unless they believed that the labour is not normal. Though the extent to which women are able to exercise their right

to choose whom to assist them in labour depends on the structure of the health care delivery system, the findings of the study depict that the experiences of women could be enhanced if they are allowed the choices that lead to the receiving care from their preferred birth attendant.

5.3.9 Mode of delivery

Generally, many women regard vaginal birth to be the preferred mode of delivery in absence of medical indications for Caesarean section (Litorp, Mgya, Kidanto, Johndotter & Essén 2015:716). This study requested women to indicate the mode through which their baby was delivered. Predictably, most (75%) of them indicated that they had spontaneous vaginal delivery or assisted vaginal delivery. This finding is consistent with the report in Kudish, Mehta, Kruger, Russell and Sokol (2010:[3]) where a total of 85.7% of the women delivered vaginally as against 14.3% that had Caesarean section. The majority of the women in the study in Toohill, Fenwick, Gamble, Creedy, Buist and Ryding (2014:534) indicated they would prefer a vaginal birth. Though the preference of women was not assessed in this phase of the study, the finding could be explained by the high preference of vaginal delivery in the country (Danso et al 2009:30) and internationally as a whole (Faremi, Ibitoye, Olatubi, Koledoye & Ogbeye 2014:712; Liu et al 2013:3-4).

It is noteworthy that statistically significant association was observed between mode of delivery and excellent client-centred care. This implies that mode of delivery impacts the experience of childbirth care. This variable was also statistically significant on the binary logistic regression ($p < 0.022$). Inconsistencies have been reported in the relationship between the mode of delivery and the childbirth experience. Matejić et al (2014:4) reported an association between normal vaginal delivery and increased maternal satisfaction. Mohammad et al (2014:36) found that vaginal birth was associated with low satisfaction. Another study indicated that mode of delivery influences the perceived control, the characteristics of the emotional experience, and the first moments with the newborn, aspects of care, which are central for the construction of the delivery experience (Guittier, Cedraschi, Jamei, Boulvain & Guillemin 2014:6). To buttress this finding, Bryanton, Gagnon, Johnston and Hatem (2008:29) argue that the mode of delivery is a strong predictor of satisfaction with childbirth. In the view of Bryanton et al (2008:29), women who have a planned Caesarean section were less satisfied with their

childbirth compared with those who had vaginal or emergency Caesarean section delivery. On the contrary, Blomquist, Quiroz, Macmillan, McCullough and Handa (2011:4) found that women planning Caesarean section had more favourable ratings on all measures of maternal satisfaction compared with those planning vaginal birth. As outlined in Guittier et al (2014:6), the conflicting results highlight the complexities involved in studying the delivery experience of women, especially per quantitative methods necessitating the need for more qualitative investigations that are more amenable to unearthing the lived experiences of women.

5.3.10 Position during birth

Respecting the preference of women regarding birth position during labour is key to promoting the client-centredness of care. It was heart-warming to note that the women in this study felt that their preferences for birth position during the different stages of labour were respected. The majority of the women were able to move around during the first stage of labour and were also able to choose the position that made them most comfortable. The practice of walking around is consistent with current recommendations on position to assume during the first stage of labour (Lawrence, Lewis, Hofmeyr & Styles 2013:2) and should be encouraged.

On the contrary, despite the well-documented evidence on the benefits of upright positions during delivery over the lithotomy position (Lawrence et al 2013:2; Thilagavathy 2012:71), 92.2% of the women stated that their preferred delivery position was lithotomy. Moreover, 98.2% of those that had vaginal delivery assumed the dorsal or lithotomy position during the second stage of labour. This finding was not surprising as it is generally known that the lithotomy position is the routine in health facilities and that health professionals rarely permit women to assume other delivery positions. Consistent findings on the predominance of lithotomy position in health facilities were reported in (Lugina, Mlay & Smith 2004:4).

The dimensional analysis showed that 83.8% of the women had excellent client-centred care experience while the experience of 16.2% needs to be improved. The mean score on this dimension was 81.7% (95% CI: 80.6-82.8), also indicating excellent experience. It must be indicated that though most of the women in this study indicated preference for the dorsal or lithotomy position, their responses could have been influenced by

limited knowledge on the different types of birth position as well as the routines in the health facilities that limited choices.

5.3.11 Support in labour and immediately after birth

Ahmar and Tarraf (2014:588-592) noted that a number of socio-psychological factors affect women's satisfaction with care and childbirth experience. For that matter, women require physical, psychological, emotional as well as socio-cultural and spiritual support during pregnancy and birth. Indeed, a lack of support during this period may constitute a risk factor for women (Elsenbruch, Benson, Rücke, Rose, Dudenhausen, Pincus-Knackstedt, Klapp & Arck 2007:869). Literature (Gruber, Cupito & Dobson 2013:50; Boorman et al 2013:[4]; Jomeen & Martin 2008:393-394) highlight the value of women having support persons or labour companion especially during labour. On the whole, the experiences of women in this aspect of care were poor. The overall mean rating of 57.2% (95% CI: 56.2-58.1) denoted that there is the need to improve practices that impinge on the experience related to support for women. These findings are consistent with those in Mwangome et al (2012:6), Behruzi, Halem, Frazer, Goulet, Li and Misago (2010:[1]) and Gamble et al (2007:117) where many women expressed the lack of support during their labour.

Furthermore, though almost all the women expressed that their spouse or a family member was the preferred labour support person or companion and wished that they were with them during labour, none of them had a companion during labour. A greater percentage (64.4%) of the women also indicated though they were given information on how to feed their baby, the midwives and other carers did not give them enough support to help them effectively feed their baby. Boorman et al (2013:[4]) advance that pregnancy and childbirth are stressful events for many women while Jomeen and Martin (2008:393-394) also acknowledge that women often have strong moods and emotions during these periods for which they should be offered the needed assistance. The bivariate analysis demonstrated a statistically significant association between the item on preferred labour support person and having an excellent client-centred care experience, an indication that instituting measure to improve the experience of women in this area cannot be ignored.

5.3.12 Labour pain relief

Though research reports such as Daniel, Oyetunde and Eleri (2015:1) indicate that the ability to cope or the extent to which a woman's labour pain is managed is a key predictor of satisfaction, labour pain relief generally continues to remain poor in health facilities in many countries (Nilima, Kunder, Prakash & Ponniah 2012:197; Mugambe, Nel, Hiemstra & Steinberg 2007:16c; Batte & Odoi-Adome 2006:12). Most (91.3%) of the women in this study stated that they either did not plan to use any pain relief method or did not remember whether they intended to use labour pain relief or not. This finding is consistent with a number of studies that found instances where women preferred to deliver without any form of pain relief and or felt that pain relievers were not very important (Bamanikar & Amdani 2012:180; Bazzano et al 2008:92; Gamble et al 2007:117). In a related study, it was noted that women took great satisfaction not only in avoiding pain medications but also in appearing not to be in pain (Simkin 1991:210). In line with the findings in Ahmar and Tarraf (2014:597), it could also be said that women in this study felt that it was more satisfying to go through labour pain without any medication. Some studies have explained that the lack of knowledge of women on approaches to labour pain management could be a contributory factor to the limited use of pain reliefs (Nilima et al 2012:197; Mugambe et al 2007:16c).

The natural method of labour pain relief, use of injection Pethidine and epidural were the main forms of labour pain reliefs mentioned by the women who benefited from this service. These methods seemed to be the most commonly applied ones in health facilities. Others such as muscle relaxation, Lumbosacral region massage and taking a shower are rarely used. Some (13%) of the women who had pain reliefs were not even told the kind of pain relief that was given to them. Multivariable analysis of factors associated excellent client-centred care indicated that the type of pain relief method used during labour was associated ($p < 0.02$) with 'excellent client-centred care' experience with the odds of having 'excellent client-centred care' experience for women who used Epidural as pain relief method during labour being 1.6 (95% CI: 0.60, 4.36) times higher compared to women who used natural methods controlling for other factors. This finding demonstrates the importance of labour pain relief to the women in this study and the need to ensure that measures are put in place to offer this service. The finding is consistent with that of Ahmar and Tarraf (2014:597) where women who received epidural anaesthesia were found to be more satisfied with their childbirth

experience than those who did not. In a systematic review Anim-Somuah, Smyth and Jones (2011:1) concluded that Epidural analgesia was found to offer better pain relief. A relationship between labour pain management and satisfaction with care was also reported in Mohammad et al (2014:37) and Melese, Gebrehiwot, Bisetegna and Habte (2014:3) who found that women who received inadequate pain management were less satisfied with intrapartum care.

On the contrary, Ahmar and Tarraf (2014:597) indicted that women who experienced a higher amount of pain were more satisfied with the childbirth experience. Credence was given to this finding in Bélanger-Lévesque et al (2014:3) where it was stated that the use of epidural anaesthesia during vaginal birth was paradoxical with respect to parental satisfaction. In other words, having no anaesthesia to reduce labour pain was significantly associated with positive satisfaction. Attitude towards labour pain is subjective and is characterised by one's upbringing and many environmental influences (Leeman et al 2003:1109; Lowe 2002 cited in Madden et al 2013:1). While for some women labour pains would always be a source of worry others may not desire for it. Thus, it is imperative for health care organisations to have a good understanding of the needs and preferences of women as well as the contributory factors that facilitate or limit the effective management of labour pain for action.

5.3.13 Continuity of care

According to Price and Lau (2013:6-9) continuity of care consists of elements that ensure connectedness between providers, and between providers and the patient. Effective continuity promotes the feeling of more respectful treatment during pregnancy and birth (William et al 2010:619). The findings of the study showed that continuity of using the same carer during the ante-natal period was good as the majority of the women (84.3%) either saw the same midwife at every ante-natal visit or most of the time. This practice is one of the key tenets of the recommendations of the Focus Ante-natal Care approach that is being implemented by the Ghana Health Services to assure individualised care. The result supported in Government of Ghana (2011:49) where it was indicated that as much as 78% of health facilities indicated that they provided Focus Ante-natal Care. However, the finding does not only demonstrate some adherence to the guidelines on Focus Ante-natal Care but also shows that many women do get the opportunity to build close relationship with their midwives.

The relationship between women and their midwives is expected to be fostered by women having unlimited access and regular contact with a known midwife or the health team (Novick 2009:8). Unfortunately, findings on these aspects of continuity of care was not that encouraging as almost all the women gave responses that showed that they did not have the name and telephone numbers of midwives they could contact when they had concerns about their pregnancy and care. Therefore, it was not surprising that 82.74% of the women indicated that they did not contact a midwife about their concerns during pregnancy. Likewise, 98.4% of the women did not know or meet the staff at the labour ward prior to delivery. Jamas et al (2011:697) write that women prefer to have prior contact with care providers and the care environment before they get into labour. Newick, Vares, Dixon, Johnston and Guilliland (2013:8) further support this notion that women place more premium on the midwife knowing them, particularly, during delivery.

These notwithstanding, the overall score on continuity of care dimension was encouraging as 94.8% of the responses fitted into the 'excellent' care category with an overall mean rating of 82.7% (95% CI: 82.1-83.3). Good midwifery continuity of care helps to build women's confidence around coping strategies for pain and reduces anxiety and use of pain interventions in labour (Leep et al 2010:239-240). Though several factors could be responsible for the gaps observed in the provision of continuity of care, the findings in this study reinforce the importance of instituting systems to assist women have continuous access to their care providers to address their anxiety and questions.

5.3.14 Length of stay after delivery

However, more than half (53.5%) of women spent one to two days in hospital after normal delivery. This finding is consistent with the report of a survey carried out in Ghana (Government of Ghana 2011:52). Routinely, women that have vaginal delivery without complication are discharged within two days and those who had Caesarean section tend to stay longer. This finding is also consistent with recommendations by international bodies such as World Health Organization (WHO 2010:13) and other countries such as Australia, Canada, United Kingdom, United States and Sweden (Brown, Small, Argus, Davis & Krastev 2002:2). Relatedly, women are often not offered

the opportunity to discuss preferences and choices regarding length of stay after delivery. The decision is normally dependent on the attending health professional.

The dimensional analysis showed that almost a quarter (24.9%) of the women had excellent client-centred care experience on length of stay after delivery while the experience of the majority (75.1%) demonstrated needs for improvement. In a similar vein, the overall mean rating of 59.7% (95% CI: 58.4-61.0) denoted that there is the need to improve issues that impinge on the experience of length of stay after delivery. The relevance of this item to better client-centred care experience cannot be overemphasised as a statistically significant ($p < 0.004$) was observed between the length of stay after delivery and client-centred care experience on the bivariate analysis. The findings also showed that those who stay longer in the hospital are more likely to have a better childbirth experience. For example, the odds of having 'excellent client-centred care' experience with child birth is approximately 1.34 (95% CI: 0.98-3.98) times higher for women who stayed more than 12 hours to 14 hours compared with women who stayed up to 12 hours controlling for all other factors accounted for in the model.

The researcher did not come across any documented evidence on the preferences or views of women on length of stay after delivery in Ghana. Nevertheless, it appears that some women do have concerns about early discharge, especially in instances where they are compelled to go home for logistical reasons such as lack of bed. In other countries such as the United States of America, concern about possible adverse outcomes of early discharge led Congress to pass legislation in 1996 mandating that private insurers cover postnatal stays of at least 48 hours after a vaginal birth and 96 hours after a Caesarean section (Brown et al 2002:2). For the fact that an association was observed between the length of stay after delivery and having excellent client-centred care lends support for a closer look at the practices in this area.

5.3.15 Built environment

Evidence shows that the design and ambiance of health facility rooms contribute to the lived experience of patients (Olansson et al 2013:239-240). Furthermore, some studies have established a relationship between physical design of health facilities and factors such as health care associated infections, medical errors, falls, pain, stress, privacy, communication and patient satisfaction are well-known (Hammond et al 2013:3-4; Ulrich

et al 2008:63-111). This study thus examined the views of women regarding the type of accommodation preferred and what they had as well as the availability of beddings and cleanliness of the environment. Almost all the women spent their stay in the hospital in general wards. The experience of the women was in line with their preferences as majority of them indicated preference for same type of accommodation. It must be indicated that, though a good percentage of women (22.5%) preferred single or private rooms, only a few (4%) had the opportunity to spend the first stage of labour in a single room and even a lesser percentage had single rooms after delivery.

Bromley (2012:1057) noted that there are calls for health facilities with features that provide space, homely environment and hotel-like services in many developed countries. It has also been documented that having access to personal belongings and small items associated with one's own home relieves the patients' suffering (Olansson et al 2013:241). A number of women expressed their displeasure with conditions related to the built environment in this study. Key among these were: inadequacy of space and bed; poor ventilation; and overcrowding. Some women had to resort to lying on benches or the floor with their babies. Inadequacy of water supply was also noted. The finding on the availability of bedsheets was also not encouraging. About 70.6% of the women indicated that bedsheets were not available. These findings are consistent with the observations in Tuncalp et al (2012:3-6) where women expressed concerns about lack of physical resources such as mosquito net and delivery beds. These findings may be similar to those in many developing countries like Ghana but it will be prudent to re-look at some of the concerns expressed in this study not only to create an enabling environment for women but also to foster the work of care providers.

With the exception of a few, most of the women were happy with the cleanliness of the bed area of wards but expressed many concerns about the cleanliness of the toilets and bathrooms. The poor condition of the toilets and washroom was highlighted in the comments provided on the open-ended question. Women want a pleasant atmosphere go give birth (Jamas et al 2011:697) and as recommended by the Department of Health, United Kingdom (Department of Health, United Kingdom 2013:1), the health care setting must be safe and should permit women to exercise choice and control.

5.3.16 Overall assessments

Srivastava, Avan, Bajhangshi and Bhattacharyyas (2015:5) observed that most studies report women's satisfaction with maternity services in terms of the proportion of women expressing satisfaction with their maternity care. A similar approach was adopted in this study where women were requested to rate their overall satisfaction with ante-natal, labour and postnatal services. Very high ratings were given by most of the women on the items on overall satisfaction ratings. For example, almost all (98.39%) the women rated their ante-natal care as 'good', 'very good' and 'excellent'. This finding supported other studies that also noted that ratings of this nature are usually high (Srivastava et al 2015:5). The mean (SD) score for overall rating on satisfaction with ante-natal, labour and postnatal care was 68% (5.3), 68.2% (6.2) and 84.4% (7.4) respectively, while the mean (SD) score for overall rating on satisfaction with care rating was 63% (7.3). This indicates that though there is the need for general improvement in care, much more emphasis needs to be placed on improving antenatal and labour care.

Despite the high ratings provided by the women on the overall satisfaction with care, the analysis of the scores obtained on the individual items that determined the actual experience of women showed that the proportion of women who had excellent client-centred care experience was 28.9% (95% CI: 25.7-32.2%). The client-centred care score portrays that many of the women in actual fact may not have had very good experiences. To buttress this fact, the mean (SD) score of excellent client-centred experience with childbirth was 71.5% (5.8), a score that falls in the category of 'need for improvement'. A statistically significant association was observed between the overall satisfaction rating on antenatal experience ($\chi^2=35.4$, $p<0.0001$), overall satisfaction rating on labour experience ($\chi^2=31.8$, $p<0.0001$), and overall satisfaction rating on postnatal care experience ($\chi^2=31.9$, $p<0.0001$) and excellent client-centred care.

It has been noted that patients do not readily express dissatisfaction with the actual care received for fear of reprisal or because of feeling empathy for those providing frontline care (Williams 1994 cited in Beattie, Lauder, Atherton & Murphy 2014:2) and that a more accurate account of quality of care can be captured if questionnaires are designed around what patients have actually experienced, as opposed to asking patients to rate their care using general evaluation categories such as excellent, very good, good, fair, and poor (Coulter et al 2009:8-10). This difference in methods of assessing overall

satisfaction and client-centred care experience could be responsible for the difference observed in the rating on overall satisfaction with care and the scores obtained on client-centred care experience. In recognition of this, there have been calls to distinguish between instruments measuring patient experience and those measuring satisfaction (Beattie, Lauder, Atherton & Murphy 2014:2).

5.4 CONCLUSION

This study was specifically designed to identify factors that influenced the client-centredness of childbirth services. The findings demonstrate that statistically significant difference exists in the client-centeredness of childbirth services in the hospitals. A number of the items examined under demographic characteristics, ante-natal, labour and postnatal care were significantly associated with the experience of excellent client-centred care. This give credence to the conceptual framework for the study which indicated that demographic variables of women are important attributes of client-centred care. On the whole, though improvements are required in all aspects of care, more focus should be placed on enhancing the experiences of women during the antenatal and labour periods. It must be noted however that additional investigations would have to be carried out to better understand the experiences of women and to generate information that will help focus improvement actions.

CHAPTER 6

FINDINGS AND DISCUSSION OF IN-DEPTH INTERVIEWS WITH WOMEN ON THEIR VIEWS AND EXPERIENCES WITH CHILDBIRTH

6.1 INTRODUCTION

Chapter 5 presented the results of the quantitative study on factors that influence client-centred childbirth. This chapter provides the findings and discusses the in-depth interviews with women. This qualitative study was imperative because though the quantitative study offered very useful responses, it was deemed necessary to obtain details on how women actually experienced their care so as to make a more holistic assessment (Drain 2004:W4-6-7). The interviews generated information relating to women's relationship with health workers, issues related to offering support for women during childbirth, decision-making and informed choice, continuity of care, barriers, overall assessment by women and recommendations for improving childbirth experiences. Findings on women's views of and experiences with choice of: place of birth; birth attendant; mode of birth; birth position and mobility; support in labour; labour pain relief; and length of stay after delivery are also presented. Table 6.2 outlines the categories and themes that originated from the data.

6.2 DEMOGRAPHIC CHARACTERISTICS

Fifteen (15) women with age range of 21 to 37 years and mean age of 28 years participated in the study. Table 6.1 presents the demographic characteristic of the women. One (7%) participant had never been to school and one (7%) had primary school level education. The highest level of education for eight (53%) was Junior Secondary School (JSS), while three (20%) and two (13%) had Senior High School (SHS) and university level as their highest level of education respectively. The mean number of children (alive or dead) that the women had was two (2) with the minimum being one (1) and maximum four (4) children. The number of children included the current child to which they had given birth. Majority (73%) of the women had delivered before and only four (27%) were first time mothers. Nine (9) (60%) women had used delivery services in the hospital before and for seven (40%) of them this was their first time. All of them used ante-natal services in the hospital in which they delivered.

Table 6.1 Frequency and percent frequency distribution of demographic characteristics of women who participated in the qualitative study

Demographic characteristics	Frequency	Percentage
Age		
20 – 30	10	67
31 – 40	5	33
Number of children		
1	5	33
2	2	13
3	7	47
4	1	7
Highest educational level attained		
None	1	7
Primary	1	7
Junior Secondary School (JSS)	8	53
Senior Secondary School (SHS)	3	20
University	2	13
Prior delivery at the hospital		
Yes	11	73
No	4	27
Location of residence		
Urban	15	100
Person living with		
Husband	12	80
Mother	3	20
Mode of payment of delivery bill		
National Health Insurance	15	100

Two (13%) had Caesarean section and thirteen (87%) had spontaneous vaginal delivery. All the women had live births. Regarding residential location, all the women lived in the urban setting. Twelve (12) (80%) lived with their husbands while three (20%) lived with their mothers. All (100%) the women paid their bills through the National Insurance Scheme. Some of them had to pay cash for other items such as mackintosh that were provided by the health facility staff.

The demographic characteristics of the study participants are very similar to that of the study region. The age range and pattern of number of children is supported by the national demographic data of women in the childbearing age as well as the fertility data (Ghana Statistical Services 2011:100). According to the 2010 census report by Ghana Statistical Services 2011:100), fertility is higher in the rural areas than the urban often

due to differences in education and other value-systems. For example, rural girls marry early; hence tend to have more children.

Similarly, the literacy level of the participants is supported by the demographic data where women in the Greater Accra region are more likely to have completed secondary or higher education (GSS, GHS & MII 2009:26). It was not surprising that all the women lived in the urban area as Greater Accra is about 90% urban.

In terms of payment system, the Government of Ghana introduced the National Insurance Scheme and an exemption policy for all pregnancy and delivery services; as such, women do not have to pay for service out-of-pocket (Kusi et al 2015:2). This notwithstanding, it is evident from the study that some of the women made out-of-pocket payments for which some of them were not given any receipt. Considering the fact that financial access is a major hindrance to utilisation of services (Moyer et al 2013:226-229), this practice may require further investigation for redress.

Table 6.2 Categories and themes of finding of interviews with women

Category/theme	Number that responded
Relationship with health care workers	
<ul style="list-style-type: none"> • Respect, courtesy and privacy • Communication and information giving 	15 15
Support during childbirth	
<ul style="list-style-type: none"> • Socio-cultural and spiritual • Psychological and emotional • Physical (e.g. significant others, husband) 	15 7 15
Decision-making, control and informed choice	
<ul style="list-style-type: none"> • Health professional as decision-making • Views on and experiences with informed choice in childbirth 	10 15
Continuity of care	
<ul style="list-style-type: none"> • Knowing your staff 	15
Overall assessment	
<ul style="list-style-type: none"> • Satisfaction 	14
Barriers from women’s perspectives	
<ul style="list-style-type: none"> • Too many clients • Inadequate staff 	13 5

Category/theme	Number that responded
<ul style="list-style-type: none"> • Non-availability of some services • Unacceptable staff attitude • Lack of cooperation from other clients 	15 6 7
Recommendations from women	
<ul style="list-style-type: none"> • Health workers to have patience • Need for open communication • Friendliness and good relationship • Health workers to be attentive • Re-organisation of some services 	15 7 10 5 14

6.3 RELATIONSHIP WITH HEALTH CARE WORKERS

The relationship between mothers and their care providers during childbirth is one of the important factors that determine the quality of childbirth experience. Relationship permeates all facets of activities and is one of the major influential factors that impinge on women's satisfaction with care (Srivastava et al 2015:8). The individual health professional's relational style as well as how the organisation deals with relational issues are all very important in client-centred care (Andrissi et al 2015:2). Three themes were identified under this category:

- Respect, courtesy and privacy
- Informing and explaining
- Communication and education

6.3.1 Respect, courtesy and privacy (N=15)

Respect, courtesy, privacy and dignity are interrelated words used interchangeably the literature. In health care, respect for patients is described in Beach et al (2007:692) as recognition of the unconditional value of patients as persons and recognising their autonomy. In addition, Beach et al (2007:692) further explained that respect in the health sector should be accorded equally to all patients independent of their personal characteristics. According to Dillon (1992) cited in Ali (2011:74), respect has three dimensions: attention and valuing of the particularity (appreciating and cherishing each person as an unrepeatable individual), understanding (trying to understand a person in his own terms and avoiding making assumptions about others) and responsibility (caring for a person in the sense of helping them to pursue their end, acting to promote

their goods and assisting them to satisfy their needs and wants). Respect is valued highly and is expected in everyday interactions even with health professionals (Dickert & Kass 2009:[1]).

Participants referred to both positive and negative occurrences regarding issues of respect and courtesy in their stay in the health facilities. On the positive side, many instances of being addressed politely, nicely and being 'talked to well' were mentioned. These examples were described at different times of the journey of the participants from ante-natal to delivery. Some of the views were:

'Oh, I would say when I came to deliver. Then I didn't know anyone. I didn't know anyone but they had patience and respect for me' (Wp3).

'...they spoke courteously to me. When I came here, each person who attended to me, spoke politely to me. I, when I delivered, the nurses that bathed the babies, was bathing some babies. I then told her that my baby has not been bathed yet. She replied that she would do so in a polite manner. The midwife that was on duty was good and respectful. For instance when I delivered, she took proper care of me and my baby. She looked after us properly. She even spoke courteously to my husband when he arrived' (Wp12)

The participants felt respected even when a care provider carried out basic activities such as assisting mothers to bath their babies, laying on their bed and fetching water for them to drink. Dzomeku (2011:32) noted that participants deemed caregiver attitudes to be positive if the care giver did not shout at clients, was kind and had a sense of humour. Similar results were reported in another study (Lekberg et al 2014:40) where it was noted that when women were asked whether health providers treat them with respect, almost all, (95%) agreed that doctors treat women with respect because they addressed them well, but a slightly lower percentage (88%) agreed when asked if nurses treat women respectfully.

On the contrary, other reports indicate that many women experience disrespectful and abusive treatment during childbirth. WHO (2014b) provides accounts of such treatments that do not only violate the rights of women to respectful care, but also threaten their

rights to life, health, bodily integrity, and freedom from discrimination. Examples of women's account of disrespectful behaviour in this study included the following:

'...because sometimes they scream at us too much. For them, they are not midwife, they are not doctors, so if they then nurses should have patience, sometimes if it's something you even going to ask for, they wouldn't give you the chance to' (Wp4).

'...some of the midwives, the way they attend to us really disturb us because when the pregnancy was aching me, the thing was happening to me, the pregnancy was matured and I was in labour, they made me climb the bed myself, with all due respect, even my private [toilet], they made me collect everything myself, first time, second time. They didn't do well at all. Because that time the pregnancy was aching me and I was in labour, with the drip on me, they made me got down from the bed, held the drip and cleaned everything from the bed. That was what disturbed me' (Wp14).

Every woman has the right to the highest attainable standard of health, which includes the right to dignified and respectful health care (WHO 2014b). The participants felt disregarded, humiliated and abused. There were accounts of being ignored, verbal abuse, neglect, being left on benches for hours while in labour and left to deliver unassisted by a health professional. In a study in Ghana, Dzomeku (2011:32) also found similar issues of neglect - not attending to clients promptly and not involving client in the care. Other reports of disrespectful and abusive treatment during childbirth in the literature include outright physical abuse, profound humiliation and verbal abuse, lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay (Bowser & Hill 2010:3-8). Disrespect makes health care providers to give sub-standard care and may make patients not to adhere to medical advice (Blanchard & Lurie 2004:727). Blanchard and Lurie (2004:727) again put forward that patients who have negative perceptions of the patient-provider relationship would be less likely to seek care. It is hoped that further investigations will be conducted into these observations and the factors that contribute to them so they could be addressed.

Similar to the findings on respect and courtesy, different views were also expressed about how privacy was assured. Few women described the extent to which care providers at times went to assure privacy, but majority were very unhappy with the situation. Issues raised related to visual and auditory privacy. The excerpts below present the two views:

'...if they want to talk to you or attend to you, they call me privately' (Wp2).

'They do not shout but, their talking too is not under tone, but it is not undertone for somebody sitting next to be able to hear. If you are next you will hear. As for the delivery room, we are just there. It's just a table and a chair like this. No curtains, no screens' (Wp11).

'...if they agree with me such that men wouldn't go into delivery room anyhow because the other time, a lady was bring forth when some men came in there to see some people there, and I was displeased with that. But the nurses sacked them over and again, which they didn't understand why they should leave till the lady brought forth, which was not the best. So am pleading that for the labour ward, men shouldn't be allowed to go there anyhow' (Wp15).

Some participants were not comfortable with the general wards due to lack of privacy. For example, physical examinations were done for some of the women without appropriate screening of the area and information was given out to some of them to the hearing of others. The participants suggested that it should be possible for them to discuss confidential personal issues with staff without others hearing and also that they should be assured of visual privacy during procedures. In addressing a similar challenge, Lin, Lee, Kuo, Cheng, Lin, Lin, Chen and Lin (2013:4-7), in an evaluation study, observed that significant improvements in patient privacy and satisfaction could be achieved through implementation of work space and process modifications in health facilities. According to Lin et al (2013:4-7), redesigning work spaces or procedure rooms to be away from patient waiting areas, reviewing procedures for access control for visitors, bystanders and staff transiting through the ward as well as putting in measures (for example, training) of health workers to change their attitude and behaviour to be more sensitive and respectful of patient privacy and confidentiality are useful strategies to consider. As was reported in this study where staff had to talk in low tone, Lin et al (2013:4-7) also suggest that staff should be encouraged to lower voice tone when

discussing treatment options with patients, and should avoid discussing patient information in treatment areas or open workstations where others could eavesdrop their conversation. If possible, private rooms could be provided.

6.3.2 Communication and information giving (N=15)

Communication is seen as the bedrock of almost all activities that goes on between the client and care provider. In recent years, communication between health professionals and women in maternity care has received much attention at official and professional levels (Dudley & Wiysonge 2009:1). Through communication, the uncertainties that surround health care can be made known to clients (Peters, Hibbard, Slovic & Dieckmann 2007:743). It is still through communication that patients can: be reassured; be taken seriously; understand their illness more fully; voice their concerns; feel empowered; be motivated to follow a medication regimen; express a desire to have treatment (or not); and be given time and treated with respect (Collins 2009:11). The literature notes that receiving childbirth education and information is linked to reduction of reported pain during labour and delivery, decreased use of analgesics and anaesthetics during labour, reduction of anxiety or tension during labour, decreased incidence of forceps use, and a more positive birth experience (Riedmann 2008). Generally, people desire information for various reasons. In health care, some may desire information to understand illness and others to prevent disease (Brashers et al 2002:259). In pregnancy and delivery, women often have many expectations for which they may require information.

Communication and information giving was one of the themes that emerged from the data. The major source of information for the participants appeared to be health professionals, but some also mentioned having obtained information from family and friends. For example, a comment from one participant who felt that she learnt more from the health staff but who also indicated that she heard about epidural analgesia from the sister is as follows:

'Yes, because I was a new mother. Even though my Mummy is around, but I will say things are changing now. So they [health workers] taught us a, a, new ways of trying to handle issues and all that...I have a sister abroad and when I was about to deliver, she told me about epidural section, whereby they will inject in. But they

say it requires the services of a midwife who will always be by your side to attend to you' (Wp11).

It is generally known that women receive information on their pregnancy and birth from various sources. Malata and Chirwa (2011:44) found that though the women in their study had educational sessions in health facilities, they also obtained information from traditional counsellors, family and friends regarding actions which prolong labour, actions which influence poor outcome for baby and actions which enhance labour. To achieve their information need, women use variety of sources, including their family members and mass media to gain information (Martin & Robb 2013:2-6; Belizan et al 2007:850). While some women report preference for paper-based and electronic media such as Television, online programmes, leaflets and bulletins as their main source of information (Metzler et al 2012:264), others rely heavily on health professionals for such information (Akin-Otiko & Bhengu 2012:e895-e896). There are yet some women who express preference for provision of information through home visits by health professionals and use of parenting groups (Metzler et al (2012:264). Irrespective of which form it takes, the information must be evidence-based and should be culturally appropriate and tailored to the woman's and relevant family member's needs (NICE 2008:7). The marital status, culture, religion, parity, trimester, and educational level should all be taken into consideration in planning what information to provide when designing and deciding on what and how to give information to women (Riedmann 2008).

In discussing issues about communication and information giving, participants narrated both positive and negative experiences. Major part of the narratives related to the intrapartum and post-partum periods. Some participants were appreciative of the information provided and felt that the staff were open and discussed issues freely with them. A number of the participants were able to recall even technical issues provided on how their pregnancy was fairing and the plan for management.

'Yes, we are happy with it, some of the nurses they are quite open. If you ask them anything, they have the time to explain to you...' (Wp15).

'...whatever they were supposed to do before referring me to the labour ward, they did everything and told me. When he [doctor] diagnosed me, he saw

everything and said the child's head is turned upside down but it is the umbilical cord, they couldn't cut. So he told me, he will prescribe some drugs to go and buy and take. May be by that week, the cords will be flexible, so I could deliver. So I agreed for him to write it for me and he wrote it for me, fine' (Wp14).

Kessels (2003:219) submits that when important decisions are to be made, as was the case in the expression of participants in this study, the patient must receive detailed information on the illness, treatment options and prognosis. For some of the interviewees, the information given to them was adequate. Contrarily, there were quite a number of women who reported instances where no information or explanation was given for actions by care providers. One participant said:

'...they didn't tell me anything but the people are many so they just told me to go and sit down small...after she attended to me till I was just about to deliver, the child wasn't coming. The time was also up. She just took me to the doctor and didn't explain to me why she sent me. She just told me to go and see the doctor and when I came she didn't take care of me again. She said she is finished with her part and have given me to them. That was where I didn't understand so well' (Wp7).

Other participants in similar ways described situations where they even verbalised their concerns regarding the lack of information but were ignored. The women strongly felt that health professionals need to be patient to listen to them. Blackford, Richardson and Grieve (2000) cited in Malata and Chirwa (2011:42) identified comparable challenges and stated that most mothers received insufficient and inappropriate information about pregnancy and birth in their study. A study in Ghana also found inadequate flow of information from health care providers to the women concerning ante-natal ultrasounds that they did (Mensah, Nkyekyer & Mensah 2014:35). According to Mensah et al (2014:35), more than 45% of the women did not have any explanations concerning the reasons for the ultrasound request, 55% did not have the results explained to them by their doctors or midwives, just as the sonographer did not communicate the findings to majority of the women. In another study conducted in Ghana, Dzomeku (2011:32) reported that reasons for client's dissatisfaction with caregivers included not receiving explanation and being ignored. Ministry of Health, Ghana (2004:19) reports of a study where patients and their relatives/carers were not involved in planning care and that as much as 90% of the patients interviewed were either unaware of having a care plan or

said did not know they could be involved in the planning of their care; 80% of the patients did not know details of their clinical care management; neither did their next of kin know. The involvement of relatives/carers in the planning of patient care only consisted of performing such tasks as washing, emptying of bedpans and feeding (Ministry of Health, Ghana 2004:19). Another study in Uganda reported that though some participants in the study felt that the staff listened to their concerns, less than 15% of them were told reasons for performing any procedure or treatment and possible side effects of treatments (Kigenyi, Tefera, Nabiwemba & Orach 2013:5). Similarly, less than 15 % were given the opportunity to ask questions. According to Kigenyi et al (2013:5), this attitude greatly contributed to non-usage of health facility services.

The interviewees in this study further talked about the approaches to communication and health education, the topics discussed, language use and some challenges. The major part of client education takes place at the prenatal stage. On a typical clinic day, a prayer session was held often led by a staff member. This was followed by group educational session. Health topics were pre-determined by the staff and were the same message for all. One-on-one sessions are expected to be held with personal midwives in individual cubicles to further educate and provide explanations where necessary. Some descriptions of the process were as follows:

'Sometimes, they we have talks, and that is as a group, and when you get into your cubicles too, yes and she [midwife] also have a little chat with you' (Wp11).

'When we come, it is in a group format. I think that if it is also done inside, it will be of benefit, because there could be someone who cannot ask a particular question due to its nature, in a group. So if she can ask on an individual basis, it will be ok' (Wp9).

It could be deduced from the second statement above that not all clients were offered additional education when they meet their midwives. This was attributed to the high number of clients by some of the participants. Some participants were also hindered from asking questions because of the group sessions. Some felt that it would be waste of the health professionals' time. A similar finding was reported in Bazzano et al (2008:92) where some women did not want to waste nurses' time by asking questions.

Regarding satisfaction with the approach to information giving and education, interviewees stated diverse views. Some were happy with the group method:

'...if they do it in a group, it is good. Someone may express her opinion and you also learn from it and add to yours' (Wp7).

'I like it, the group one, as it a group, someone might ask a question you couldn't ask, and by that you get the answer' (Wp13).

Others would have preferred individual sessions:

'It was general, it was group. All those who came, they give us the talk. I would have preferred the individual one' (Wp6).

'...educated one-on-one, eh, that will be fine, oh they can't do that so if they do it in general that's all it should be done in general because we are many' (Wp8).

These findings are supported by an earlier study in Ghana that found that not all women appreciate the group method of education that is offered in health facilities (Akin-Otiko & Bhengu 2012:e895-e896). Considering that the benefits can accrue from having an effective educational section (Riedmann 2008), health professionals would have to examine how they can meet the needs of women by limiting factors that hinder learning. Additionally, it must be indicated that education and information needs vary among women (Martin & Robb 2013:3). While most clients expect to be given information about their condition and the treatment options, and want care providers to take account of their preferences (Akin-Otiko & Bhengu's 2012:e895-e896; Coulter & Ellins 2006:57), there are others who do not want to know much in advance about the experience of delivery (Belizan et al 2007:850). Information need in pregnancy also varies according to trimester (Martin & Robb 2013:3). These factors need to be considered in the design of method of education and communication. Offering pregnant women the same information may not be beneficial to some.

It has been said that the underlying purpose of communication and education for pregnant women is to provide prenatal preparation for pregnancy, labour, and birth (Koehn 2002:10). Understanding whatever is thought is therefore imperative. Comments were raised on the medium of communication and ability to understand

messages. The language of communication varied greatly at all stages. As there were no professional interpreters, other clients were often called upon to interpret messages to their colleagues. It is noteworthy that, almost all the participant experienced situations where somebody had to explain things to them because they did not understand what was said. The view below represents what most of the participants felt:

'To me, they speak languages I understand and I don't know about the others. Yes, for me, sometimes when they speak English and I don't understand, I tell them to explain in Twi or Ga that I understand. And with that they ask that we speak Twi and I agree. The English they speak, I tell them I don't understand. I don't hide it. They do really well with that. Because when they are talking to us, they ask who is an Ewe, who is a Hausa, who understands what am saying? All of you do you understand this language? Someone might say, I don't understand. Then she would call someone [a client] and say please explain this to the other person' (Wp4).

Some women were not comfortable with other clients interpreting messages and suggested that health facility managers identify midwives who speak the different local languages to do the interpretation. Some participants were hindered from asking questions due to the language barrier. Despite these shortcomings, most participants were happy with what they learnt.

'...how to keep our self-clean with the baby and what to eat during pregnancy they told us not to give them water and food for some time only breast milk they also talked about family planning just as I said they talked to us that we should take good care of ourselves and we should give the child food some of us if we weren't told that, we would have given the child food after one month if the child is crying but since we were told I did one and it was okay' (WP8).

'It's, it's very beneficial. When we even come, they teach us so many things. From ante-natal, they teach us what food to eat, how to care for ourselves. We also ask questions, so it was very good. Sometimes, you don't know, so when you come in, you are taught. When we visit, they teach us the danger signs in pregnancy. So they stated that when we see those signs, we should come to them' (Wp9).

A comment from a participant on the need for additional information on the choices available was:

'Like the, the choices we have during childbirth. I believe they should give; they should discuss that with you. You have a choice to go for Caesarean section and you have the choice whether to go the natural way and all that. But, it seems they don't' (Wp11).

Some studies have also reported significant differences between the information that clients need and what is offered by their information providers. Freda, Anderson, Damus and Merkatz (1993) cited in Chirwa and Chirwa (2011:42) stated that women reported great interest in topics such as foetal development, nutrition, vitamins, travel, bottle feeding, danger signs during pregnancy, when to go to the hospital, medicines in labour, how to know when labour starts, effects of stress on pregnancy, rest and activities, discomforts in pregnancy, anaesthesia, natural childbirth, birth defects, bleeding in pregnancy and breast feeding. On the other hand, health care providers felt clients would be more interested in topics such as use of forceps, breast-feeding, family violence and when to go to the hospital (Freda et al 1993 cited in Malata & Chirwa 2011:42). Differences were also observed in the topic in which primiparous and multiparous women were interested (Freda et al 1993 cited in Malata & Chirwa 2011:42).

In an exploratory descriptive qualitative design study to determine Malawian women's childbirth information needs, the women indicated that though they were given information on several topics such as signs of onset of labour, preparation for labour and birth, need for rest and exercise, positions during labour and breastfeed, the focus was more on signs of onset of labour other topics were poorly covered (Malata & Chirwa 2011:44). According to Malata and Chirwa (2011:44), the women were more interested to know about their rights during labour and birth, the process of labour and birth, what could go wrong during labour and birth, indications for interventions with focus on Caesarean birth, and pain relieving measures. First time mothers wanted to know how the newborn baby looks like and what the baby is capable of doing. In another study, more than half of the pregnant women indicated a need for information related to medicine use during pregnancy (Hämeen-Anttila, Jyrkkä, Enlund, Nordeng,

Lupattelli & Kokki 2013:4). Therefore, it is imperative to regularly determine the information need of women to guide practice.

It is well documented that several factors facilitate or hinder the processes of communication and information giving to client in health care (Martin & Robb 2013:3; Akin-Otiko & Bhengu's 2012:e895-e896; Coulter & Ellins 2006:57). These contextual and individual staff factors include: staff shortages; poor conditions of work; low job satisfaction of staff; and lack of equipment which all impinge on how work is organised (Cockcroft, Milne, Oelofsen, Karim & Andersson 2011:[4]). Cockcroft et al (2011:[5]) further noted that though doctors in the study had the skills to talk to patients, they were hindered to do so in government facilities because of the poor working conditions and high patient loads. According to Cockcroft et al (2011:[5]), one of the participants in the study even suggested that it was only literate patients who really expected or needed an explanation about their condition and that most patients just needed treatment with sympathy. Furthermore, it has been noted that health staff at times may hold on to information in consideration of issues such as client's age, anxiety and distress level, perceived importance of the information and client-educational level (Brashers et al 2002:259).

Effective communication and information giving to clients and families will mean facilitating and supporting them to reflect on their experience in an environment characterised by psychological safety, warmth, collaboration and respect (Anderson & Arbor 2010:8). The lack of effective interaction with patients and families affects the quality of care (Cockcroft et al 2011:[5]). Effective engagement as is required in client-centred care calls for identifying innovative ways of providing information. According to Patel and Rajasingam (2013:599), this may require a significant change in the traditional health care professional-patient relationship and professional culture. Creating this culture, especially in maternity care, will take a broad effort at every level of the health system (Romano 2010:50).

6.4 SUPPORT DURING CHILDBIRTH

Providing support for women during pregnancy and birth is multifaceted and a long established practice. During these periods, women tend to require more physical, psychological and emotional as well as socio-cultural and spiritual support. A lack of these constitutes a risk factor for the mother (Elsenbruch et al 2007:869). Continuous one-to-one support is linked to: having a spontaneous vaginal birth; less need for intrapartum analgesia or to report of dissatisfaction; shorter labour; and less birth interventions (Hodnett et al 2012:15). Continuous support is most beneficial if provided by a person who is present solely to provide support, is not a member of the woman's social network, is experienced in providing labour support, and has at least a modest amount of training (Hodnett, Gates, Hofmeyr & Sakala 2013:2). It is recommended that all health facilities implement programmes that offer continuous support to women especially during labour (Amorim & Katz 2012).

Three themes were identified under this category from the interviews. These were:

- socio-cultural and spiritual support
- psychological and emotional support
- physical support

6.4.1 Socio-cultural and spiritual support (N=15)

Socio-cultural factors such as family support, religion, traditional beliefs, values and norm significantly influence sexual and reproductive health behaviour (UNFPA 2011:8-14). As stated in Crowther and Hall (2015:1), in recent times spiritual issues have also become so important in childbirth experience that leaving these undervalued or uncared for may have negative effect on women and significant others. Dako-Gyeke, Aikins, Aryeetey, Mccough and Adongo (2013:4) indicate that, in Ghana, several women view pregnancy as a biological phenomenon, also widely perceive pregnancy and delivery as a condition characterised with spiritual and social threats.

Issues of socio-cultural and spiritual well-being were raised by the participants during the discussion. Many expected their spiritual needs to be fulfilled even when on admission and felt that this should be fully supported by care providers. However,

regarding traditional cultural beliefs, values and practices interviewees were of the notion that rituals should not be allowed in the health facility but could be performed prior to admission. Some of the comments were:

'Please what I would want them to do is that, the thing is, if you are coming to deliver, if you have any ritual to do, do it home before coming here. Because if anything happens it would be their [health professional's] fault, so don't come here before saying, they are going to do something for me before I give birth. You cannot come and waste the nurse's time at the expense of something else happening, which they could be blamed' (Wp4).

'...I came here and I had a scan and they told me the baby is not well in the womb so I went to my pastor, and my pastor said that I should pray and he will also support me in prayers that it will turn after I had had the main scan. So after I went for the main scan, then the person there told me that everything is okay. Me, I think the nurses, we have spiritual things and physical things and I don't think these people [health professionals] can deal with the spiritual things so if someone comes with spiritual things, just allow the person to deal with the spiritual things to go through whatever she will go through and after that, you will do your part because, if anything at all will happen, the person will tell you that, because you didn't allow me to go through this that's why I went through this thing. So allow the people and you too, do your part' (Wp6).

While some participants felt that performance of rituals will be a waste of the care provider's time, others thought otherwise. Strong expressions of belief in spiritual issues were made. All the participants gave examples of how one pastor or a spiritual head had contributed to their wellbeing. Some indicated that they often apply 'Anointing oil' on their abdomen or body during labour. It was proposed that the hospital should have resident spiritual persons for example, pastor or imam to offer such services. It must be indicated that it was a routine to have morning prayers sessions in almost all the units.

In terms of social support, some participants noted that staff demonstrated concern not only for them but also for their families. When needed, the staff delves into their social life to support. These women were appreciative of these overtures. One participants' comment was;

'This, when we get here they ask if there is anything bothering me, I say no or is your husband troubling you at home. Is anything troubling you? Sometimes once you get here and they see the look on your face, they ask you. And I tell them no. if there is anything troubling you or if your husband is bothering you, she could find a way of getting to communicate with your husband' (Wp3).

International and local research gives credence to these findings. The phenomenon of spirituality is well ingrained in pregnancy, childbirth experience and midwifery practices (Crowther & Hall 2015:3). A study in Ghana reported that the period of pregnancy, delivery and postpartum is perceived as a potentially dangerous era requiring diverse forms of support, which includes spiritual, psychosocial and medicinal (Dako-Gyeke et al 2013:6-7). Dako-Gyeke et al (2013:6-7) observed that pregnant women were seen to be vulnerable to spiritual attacks that can lead to the destruction of the pregnancy such as miscarriages and other maternity complications. For that matter, the women need spiritual protection that ranged from a simple act of personal prayer through attending regular prayer sessions to participation in specially organised prayer camps.

Chirwa and Chirwa (2011:44) also report expression of cultural beliefs related to actions that prolong labour such as standing or sitting at the door, walking in the forward direction all the time while in labour and a sneak look through the window by their participants. Chirwa and Chirwa (2011:44) noted that these actions were considered to have a negative effect on the progress of labour; so, women were encouraged to avoid anything that would delay labour. On the other hand, the actions which enhance labour were: taking traditional medicines which were believed to facilitate onset of labour. Women take the drug at home before they get to the hospital to facilitate labour but are advised not to reveal to hospital staff for fear of being chastised. The UNFPA (2011:8-14) suggests that norms and positive values derived from or influenced by religious and cultural traditions need to be properly understood so that they can be used as creative tools to promote sexual and reproductive health awareness.

6.4.2 Psychological and emotional support (N=7)

Pregnancy and childbirth are stressful events for many women (Boorman et al (2013:[4])). Jomeen and Martin (2008:393-394) report that women do have strong moods and emotions, and worry about issues such as going to hospital, giving birth and

coping with a new baby as well as going through childbirth interventions. Women and their spouses often seek psychosocial and emotional support from various sources to help manage these pregnancy-related fears and anxieties (Dako-Gyeke et al 2013:7). Indeed during labour, one of the key objectives of having labour companion or doulas is for them to among other things offer the needed psychosocial and emotional support throughout labour (Gruber et al 2013:50).

Views on the experience of emotional support were generally mixed. Some participants had both positive and negative experiences to share. However, the majority noted that they were able to discuss their fears and worries with their care providers. For example, one participant described how she was supported when the decision was made to send her to the theatre for Caesarean section as:

'...most of them speak softly to us. Not to mention, when I was to be taken to the theatre, how they treated me, I was pleased. I was afraid to go to the theatre but one of the nurses, before they took me, I was crying and a nurse came to talk to me, advised me that because of God, I would go and come back alive then I was at ease. Even in the theatre, how they took good care of me and I was really pleased. Before I didn't want to do it; I was very scared. How they spoke to me made me do it and I had my health and my baby. I would have liked my husband to be by my side. Yes, it was like I was sad and I wept and one midwife asked why I was crying, what was worrying me. I explained to her what was troubling me so she also advised me. So she encouraged me and they both encouraged me and that's what helped me go' (Wp15).

As was noted under the discussion on socio-cultural and spiritual support, spirituality also featured greatly in offering psychological and emotional support. The participants often found consolation in their belief that 'God is in control'. Being able to discuss concerns with care providers was seen as very important to the participants. Experiences in this regard appeared to be encouraging at the ante-natal stage. Majority indicated that the staff often enquired from them whether they had any concerns and encouraged them to open up. For the ante-natal stage, the main worries of clients were about their physical health and when they were told that the foetus was not doing well. A few expressed worries about the difficulties they encounter when they come for ante-natal visits due to delays. Most participants did not feel hindered to discuss issues with the staff, especially their personal midwives.

'...when I use to come for ante-natal, and had anything worrying me, I told her [personal midwife] whatever the problem was I tell her how I feel...'.(Wp4).

'...she told us from the beginning that if we have any problem we should tell them and she ask me as well I didn't have any problem but if I have body pain she tells me what to do' (Wp10).

On the contrary, many of them presented instances where they felt that their psychological and emotional needs were ignored during delivery. One participant described how some unkind words were used to address her when she was in labour:

'...those who attended to us in the morning, they were a bit, I will say harsh. If you come in and cry, I don't care. It is painful. The crying will not have any positive effect on you. So what should I do, when you cry. Like, some of them said something like that. But those in the night, were, were nicer' (Wp11).

It appeared that clients had better interactions with their midwives during the ante-natal period, because majority of the negative experiences were during labour. Major factors that generated fears and worries during labour included having to go for surgery, low progress of labour, being left unattended and just wishing the labour would end. Some wished they had a family member with them. With the exception of few, most participants expressed positive emotions after birth.

In a related study, Dako-Gyeke et al (2013:7) wrote that perceptions of pregnancy as a threatening experience generate fear among several pregnant women. Dako-Gyeke et al (2013:7) continued that pregnant women sought psychosocial support from non-conventional providers like spiritualists particularly when they were experiencing maternity complications and fears. The causes of these fears are either linked to biological conditions, including overdue pregnancy and Caesarean section, or knowledge of other women's negative childbirth experiences.

Women also reported thoughts of mental defeat and of wanting labour to end, poor understanding of what was going on, worry, dissociation, thoughts of death, distorted perception of time, thoughts about the baby, decision-making, disbelief, and evaluation of labour as some of the emotional and psychological issues that they had to contend

with during childbirth (Ayers 2007:255-259). Aryer's (2007:259-260) study indicated that both positive emotions (for example, feeling happy, pleased, glad, calm, excited, surprised, amazed, relieved, and grateful) and negative ones (for example, feelings cared, frightened, panicky, stressed, worried, upset, apprehensive, anxious, nervous, disappointed, helpless, depressed, bored, frustrated, irritable, annoyed, and angry or aggressive) were expressed by the women irrespective of birth outcome. It is important that women are supported through these trying periods by instituting support systems tailored to their needs and preferences.

6.4.3 Physical support (N=15)

Amorim and Katz (2012) outlined that the benefits of continuous labour support in terms of maternal and perinatal outcomes are clear and consistent across all settings, despite differences in obstetrical routines, hospital policies and conditions, and qualifications of the individuals who provide the support. Physical support in this context refers to having somebody physically present at the woman's bedside throughout labour to provide emotional, psychological and other non-technical medical services such as comfort and encouragement. When continuous labour support is provided, women have more spontaneous vaginal birth, shorter duration of labour, less use of labour analgesia, fewer Caesarean sections and instrumental deliveries and fewer babies with low Apgar scores and most importantly, they express more satisfaction with birth experience (Amorim & Katz 2012).

In discussing their views and experience on having a labour support person or companion physically present during labour, it was not surprising that all the participants stated that no one stayed with them. They noted that the health professional were around but their interaction with them was mainly to carry their activities.

'No one was there. My husband came but left for home I was there with the nurses' (Wp3).

'...my husband brought me but I would say I was the only one there' (Wp8).

It was common knowledge among the participants that once you are in labour you have to come to the health facility with someone. So, all of them came along with somebody. These people were family members who stayed in the hospitals premises and provided basic services like fetching water, bringing food and washing items, but were not allowed to stay in the labour ward. One participant explained the routines as follows:

'...and for you, if you know, when you are in labour, you shouldn't come alone. You should come with someone because you don't know what could happen, so I come with someone' (Wp5).

However, the interviewees expressed what they would have preferred. Majority of the participants wished their husbands were around to support them. A few mentioned their mother or sister. A few also felt there was no need for a family member to be around. One excerpt was:

'...I believe the appropriate people [to provide support] to be our husbands. They should be closer to see what we go through. But here, they don't give them the chance. It's because the place is small. You don't go in alone. In fact, when it was my turn, that night, we were inside two, two and the midwives were two. So would, should my husband, come and you see we are always, we are naked too. If it is me alone, he can come but, the nature of the place, will not permit him to get closer. My mum was there, but not closer. They asked her to go. As for that time, I would have wished my husband was there' (Wp11).

The interviewees gave reasons why they could not have their family members with them. These included: hospital regulations; inadequate space; and need for privacy. They also felt that the midwives were few and the patients were many so they could not have enough time for them. It is common in Ghana for midwives to attend to many women in labour simultaneously, compromising personalised care. Probably because of the absence of support persons and the staff being 'very busy', there were a number of descriptions of neglect, not to mention the disrespectful attitudes that some of them experienced. The excerpt below is one incident in the labour ward where a first time mother delivered without support.

'...if you sit like this for long, maybe she is not ready to attend to you. The other time someone delivered just by my side. She hadn't delivered before so she came

to sit with me while the baby was coming and asked if I had ever delivered and I told her yes. I asked why and she said there was something beneath her. So before I could open my mouth, the baby had come, she had brought forth into the cloth. I even had to use my hands to hold the cloth and the nurses saw to her and removed it for her' (Wp15).

Patients at health facilities in Ghana normally rely on a support person; most often it is a family member, to bring them food, water, clothing, bedding and any other items they may need during their stay at the health facility (Crissman et al 2013:22). On the same vein, Ministry of Health, Ghana (2004:19) found similar issues as were observed in this study where the involvement of relatives or carers in the planning of patient care only consisted of performing such tasks as washing, emptying of bedpans and feeding. Bhattacharyya, Srivastava and Avan (2013:5) found that the presence of family members is one of the key aspects that women believe constitutes good care. According to traditional culture, generally, a female family member, either mother or mother-in-law, accompanies the woman during childbirth. Unlike the experiences of women in this study where nobody stayed with them, in the report in Bhattacharyya et al (2013:5), a community health worker was often present in the delivery room along with the woman's family members, which was highly appreciated as it provided emotional support.

The following literature also supports the observations in the study. Not having a companion during hospitalisation was seen as barrier to client-centred care in the study by (Behruzi et al 2010:[1]). The report also mentioned that women showed great preference for a longer amount of time spent with their chosen companion. Gamble et al (2007:117) reported that almost all (70%) women in their study described support after birth as mediocre, or hard to access. In another study, Howarth et al (2012:490-492) stipulated that most women were unable to establish good personal relationship with the midwives during childbirth even when the opportunity was there, making their delivery stressful. Mwangome et al (2012:6) indicate that both medical personnel and community members in their study recognised the mothers' preference for social support during delivery. However, hospital regulations did not allow the presence of family members in the delivery room, and mothers were required to remain on the hospital delivery bed throughout their labour. Despite awareness of the negative community perceptions of

these regulations, medical personnel followed hospital protocol rather than meeting the mothers' social and other care needs.

In contrast to the limited support that was received during labour, many of the participants stated that they were happy with the help that they had after delivery.

'...after I delivered, one of the midwives prepared some tea for me and another elderly nurse also came that, we are going down and they collected all my things and held the child also for me' (Wp2).

'...the nurses took care of the baby and wrote drugs for me to buy but they sent someone to buy the drugs for me so I was happy about that' (Wp8).

'...if they are to move you to another room, they will pick your bag and send there, which also show respect and is fine. How they also come to take the baby and go and clean the baby and bath him' (Wp7).

Several women perceived that the care received after delivery was good, sometimes on the basis of staff having carried out basic activities such as laying the bed, bathing the baby or attending to some physiological and medical needs. Similar results were reported in Simwaka, De Kok and Chilemba (2014:10) where most of the women in Malawi perceived that the care received was of good quality because health workers addressed their physiological and medical need, empathised with them, and provided explanations on health care issues.

In an effort to address some of the challenge with provision of support for women, health institutions in many nations have resorted to the use of doulas due to the challenges of having adequate numbers of staff to offer effective support for mothers in labour. Majority of the participants in this study would prefer their husbands to be with them. However, as noted in Amorim and Katz (2012), it may be very difficult to determine the "ideal" form of continuous intrapartum support, but benefits seem to be the greatest when labour support is provided by a doula. If this is not practicable, any continuous non-staff caregiver (friends, family members or the baby's father) can provide labour support.

6.5 DECISION-MAKING, CONTROL AND INFORMED CHOICE

Childbearing women have preferences regarding many issues such as: having control over decisions on treatment and care (Jamas et al 2011:697; William et al 2010:619). In this study, women's views and experiences with decision-making and control as well as informed choice regarding: place of birth; birth attendant; mode of birth; birth position; support during labour; labour pain management; and length of stay after delivery were examined. The major themes that emerged from the discussion were as follows:

- Health professional as decision-making
- Views on and experiences with informed choice in childbirth

6.5.1 Health professional as decision-making (N=10)

The current childbirth care environment advocates control and choice for women and promotes women's active involvement in decisions so as to improve quality (Jomeen 2012:60; Kostick, Whitley & Bush 2010:530; IOM 2001:48-49). This notion is based on the association of positive experience in childbirth to the amount of control experienced by the mother (Snowden et al 2011:9; Goldberg 2009:38). For example, Cook and Loomis (2012:166) found a relationship between women having control over plans for their birth and a more positive recollection of birth experiences. There are other reports that have observed contrary views that some patients do not consider important to be involved in decision-making (Aro et al 2012:1855). In view of these inconsistencies, views and experiences of childbearing women were examined to guide interventions.

Though the participants expressed varied opinions on who should be in control of decision regarding their pregnancy and birth, majority of the women would prefer the medical officer or midwife to be the key or final decision makers. Few would give that responsibility to their husbands or parents. Only a few of the participants indicated that they should be in control of key decisions. The following are some of the sentiments:

'...should say the midwife, because they always attend to us. It is when you have a problem that you will be referred to the, a doctor. Yes, but you always come to see the midwife, she should be the key decision-maker' (Wp11).

'...[control], yes, I don't think I was having any. I think, we, then, then they should help us. They have to help us because, some of the things, we don't know. They have to help us' (Wp9).

'...the doctors and midwives, because they know best and they know what is good for me, they know what is good for me' (Wp13).

Comment from a participant who felt the mother should be in-charge of decisions was:

'For me, the nurses I don't know them, I'm somehow a visitor here so I don't know then that well, so maybe my mum who came with me, she would be the one I would say that could talk about it with the nurses' (Wp15).

One participant felt strongly that she should be responsible for taking decisions and said:

'I think, it is, am the one who is supposed to, because am the one going to deliver. I will say that, mostly about 80%, yes because if you say something and it's good, it suits with them, they just respond to you, but if it's dangerous to your health, they will tell you it's dangerous to your health' (Wp6).

The impression deduced from the discussion was that often the staff would make the decision and that they only come to 'tell' or inform them about what was going to happen. There was an instance where the staff refused to care for a client because she was not in agreement with frequent vaginal examination. The best evidence-based practice from the literature recommends that patient should be actively involved in decision-making and given the final say (Martin & Robb 2013:2). This implies a two-way communication where information is not only provided but also ensuring that the information is understood and that the woman is capable of making the decision (Noseworthy et al 2013:e43; McKenzie 2009:171). The findings from this study showed that the participants generally would leave decisions for their care providers, as they felt that they did not have adequate knowledge and that the health professionals knew best. A related finding was reported in Batte and Odoi-Adome (2006:12) who stated that often patients believed that they do not have enough knowledge to choose interventions even when offered the opportunity and so they leave the decision to the health professionals. In another study, 52% of the participants preferred to leave final decision to their

physicians (Levinson, Kao, Kuby & Thisted 2005:532). Levinson et al (2005:533) explained that these results are consistent with the paternalistic attitudes observed in many health facilities, but cautioned that the health professional directed approach to decision-making often observed in studies is in contrast with international discourse on patients being in control of decisions in childbirth.

In an assessment in Ghana, patients and their relatives and carers were not involved in planning care (Ministry of Health, Ghana 2004:19). Ninety percent (90%) of the patients interviewed were either unaware of having a care plan or said they did not know they could be involved in the planning of their care. Belizan et al (2007:848) further support the findings in the study that few women who attend public hospital express the desire to be actively involved in decisions concerning procedures or treatment. Additionally, one study in South Africa noted that women were comfortable with their dependency on midwives regarding decision-making (Maputle & Hiss 2010:8). It has also been noted that even relatively affluent and well-educated patients at times feel compelled to conform to socially sanctioned roles and defer decision-making to physicians during clinical consultations (Frosch et al 2012:1032).

Shared decision-making, as is being promoted locally and internationally is a complex intervention, and its implementation in health care will need multifaceted strategies coupled with culture change among professionals, health organisations, and patients (Stiggelbout et al 2012:[3]). Effectiveness of the process will require facilitating and supporting patients to reflect on their experience in an environment characterised by psychological safety, warmth, collaboration and respect (Anderson & Arbor 2010:8) which is often difficult to achieve in many health care settings, especially in developing countries. Epstein and Street (2011:101), in commenting on this difficulty, noted that one reason could be that helping patients to be more active in their care process changes centuries of physician-dominated dialogues that exist in the health sector. Creating this culture especially in maternity care will entail concerted and sustained effort at every level of the health system.

6.5.2 Views on and experiences with informed choice in childbirth

Choice and control are intimately connected for women with regard to pregnancy and their childbirth experience (Snowden et al 2011:[1]). In other words, the opportunity for

greater choice over care allows more involvement with decision-making which ultimately impacts on birth experience. Choice among other things, entails having enough information and detailed discussion from a care provider for the woman and the care provider to make a choice together (O’Cathain, Thomas, Walters, Nicholl & Kirkham 2002 cited in Hindley and Thomson 2005:306-307).

The participants were requested to discuss their views on and experiences with the practices of informed choice in the following aspects of care:

- place of birth
- birth attendant
- mode of birth
- birth position and mobility
- support in labour
- labour pain relief
- length of stay after delivery

It should be noted that the aspect of support in labour has been extensively discussed in the previous sections.

Generally, implementation of informed choice was low. With the exception of providing information on the payment systems, almost all the women were not given information on the choices available to them regarding the aspects examined. Little or no reference or discussion was made on these issues during the ante-natal stage. Likewise, even when some women requested for options that were not routinely offered during labour, they were denied. Regarding the payment systems, the staff probably had to discuss this because of the implementation of the free delivery policy and the high priority National Health Insurance issues have assumed in the provision of health care in the country. On the whole, most of the women did not even know that there were options and that they could choose. One participant made the comment below during the interview:

‘From the questions you asked and the answers were no. I will say yes, we were not given the options. So, I, I, I wasn’t really involved much in...’ (Wp11).

This finding is generally supported in the literature on informed choice, especially in developing countries. For example, the IOM (2001:49) stated that the rights of patients to be informed decision makers is well accepted, but not always well implemented.

Women want to be involved in care and want to be given information on options available. It has been reported that for some women, the one who conducted the delivery or which intervention was carried out was not as important to their experience as having choice and control over the process (Cook & Loomis 2012:166). Levinson et al (2005:532) indicated that a whopping 90% of the participants in their study answered positively when asked whether they would prefer to be offered choices and to be asked their opinion by their doctors.

6.5.2.1 Women's view on and experiences with choice of place of birth

With the exception of those who were referred due to their health condition, all the women made their own decision as to where to go for ante-natal care. Some had previously used delivery services in the health facilities and were happy with the services as depicted in the quote below:

'The first time I came here. The first time I came here, I was well attended to. I was well attended to. The Madame in room 3, the midwife was the one who attended to me. She took great care of me, so I was happy. This propelled me to continue coming here, always' (Wp12).

Other participants made the decision based on recommendations from friends or family members.

'I delivered my first child at Korle-Bu but my sisters said how they attended to them when they came to deliver here made them happy, so that has made them like this place so let me also try and come to this place...'. (Wp7).

There were few who based their choice on proximity. Some of the comments were:

'Well, this hospital is closer to my residence. That's why I chose this place. That is the main reason why I came here' (Wp11).

The two most frequently mentioned reasons were proximity and positive testimonies from others who have used services in the health facilities. Almost all the participants indicated that preference for place of birth was government hospital. Only a few of the participants mentioned preference for private hospitals. Reasons for choice of government hospitals included low cost of care and availability of different types of services. One participant mentioned that '*...normally, when complications do come, they do refer to the public hospitals*' (Wp5), and that she preferred public hospitals.

The results are related to other findings on reasons for choice of place of birth. In the report in Crissman et al (2013:20), all participants in a study in Ghana stated that they intended to delivery in a health care facility and verbalised a strong determination to actualise their intentions. They also noted that community leaders, husbands and mothers of pregnant women who in the past impeded women from accessing health facility delivery services appeared to be changing their preferences. The majority of the women in another study stated that an important facilitating factors for the use of health services for childbirth among participants were the perception that health care workers had the ability to handle complications, and that they possessed the necessary equipment and skills (Lekberg et al 2014:41).

The general preference for hospital delivery could have been influenced by the intensification of programmes by the Ministry of Health to increase skilled birth attendance in the country (Ministry of Health, Ghana 2011b:42). Delivery at home in Ghana is discouraged (Ministry of Health, Ghana 2011b:42). Hadjigeorgiou, Kouta, Papadopoulos and Martenson (2011:10) state that women's choice of birthplace is often limited by the assumption that it is only safe to give birth in hospital. This view is most probably due to the recommendation by WHO and other partners for all pregnancies and deliveries to be attended by a skilled birth attendant (WHO, ICM & FICO 2004:1). Therefore, it was not surprising that many of the participants in this study preferred hospital delivery. Different women may want different things at different times, and normally what they want is often heavily influenced by what they are told by their caregivers, family and friends, and by the media (Green 2012:2). As well, what women want may change based on their personal experience. Hadjigeorgiou et al (2011:10) suggest that though the extent to which women are able to exercise their right to choose where and with whom to give birth may differ due to the structure of the health care

system, women should be given the required information and allowed to weigh up the pro and cons to arrive at how their preferred birthplace can best meet their needs.

6.5.2.2 Women's views on and experiences with choice of birth attendant

Generally, in many formal health systems choosing a place of birth is synonymous to choosing the type of birth attendant. However, even in the formal health system, women may have preferences for the category (doctor or midwife) of staff that should attend to them. Though not given the opportunity to choose their birth attendants, participants stated their preference for categories of staff that should take care of them during pregnancy and birth. Most of them indicated that they would prefer a midwife. Some of the reasons for their preferences are described in the comments below:

'I will choose the midwife. I know that with them, it a service they have specialised in, so they have many ideas. It's the midwife who conducted my delivery' (Wp9).

'I have three children who were all delivered by midwives; so I assume midwives are the ones who conduct delivery' (Wp12).

The comment from one participant who preferred a doctor was:

'Well, maybe I, I, will choose a doctor because I feel it's a bit professional in, in his or her field. He is also higher than the midwife. I should think so. Yes, it was the midwife who attended to me and nothing really happened' (Wp11).

A few of the interviewees indicated that they do not have any preference and that any qualified health professional assigned could attend to them during pregnancy and delivery. Regarding their experiences, all of them were assigned midwives for their pre-natal care. Occasionally, they were referred to see a medical officer when health issues that were beyond the scope of care of the midwives emerged. In terms of delivery care, all except a few of the participants that had Caesarean section were assisted in delivery by a midwife. Comments such as *'they are more professional in their work'* and *'the doctor is superior to the midwife'* were given for choosing a doctor. The comments from those who prefer midwives comprised: *'...they are specialist...'*, and *'midwives are for*

that purpose'. Some of the women expressed the view that they wished their personal midwives assisted them during the delivery.

Preferences for birth attendants vary in the literature. Gamble et al (2007:117) note that the preferred birth attendant for women in their study was a midwife who had medical backup. In contrast, in a study conducted in Syria, Bashour and Abdulsalam (2005:4) found that 60.4% of women in their study preferred to be attended by doctors compared with midwives (21.2%), while more than 85% of them preferred the obstetrician to be a female. In another study conducted in Canada, 51.8% of female participants selected obstetrician as one of their preferred care providers, 40.1% selected family physician and 30.1% selected registered midwife (Fairbrother et al 2012:11). The most common reasons for choice of birth attendant were: desires for safe care: care of a specialist or expert in maternity care: and a quality relationship with the care provider (Fairbrother et al 2012:11). The participant in the study by Lekberg et al (2014:41), had no preference as over 80% of the women that participated in the study only mentioned that they prefer to give birth attended by a skilled provider.

6.5.2.3 Women's views on and experiences with choice of mode of birth

While some prefer to delivery per Caesarean section (Karaku & Sahin 2011:61; Karlstrom, Nystedt, Johansson & Ingegerd 2011:624), there are others who indicate strong preference for vaginal delivery (Liu et al 2013:3-4; Danso et al 2009:30). In this study, with the exception of few participants that had Caesarean section due to health reasons, all the other women had vaginal deliveries. Women overwhelmingly expressed their preference for vaginal delivery as their first choice. Even those who had Caesarean birth indicated that they would prefer spontaneous vaginal delivery (SVD) in subsequent deliveries. Explanations for preference of SVD included: because it is safe; that is how it must be you safer before bringing forth; that is the easy one; that is the arrangement of God; and it's natural. There were some who expressed strong feeling against Caesarean section. One of such as expressed was:

'I don't know why I don't want it but I just don't want to be cut. I would want to push. I want them to know I am a woman so I would want to bring forth myself'
(Wp4).

Other interviewees, in recognising labour may not progress smoothly all the time indicated that they are open to Caesarean section if it becomes necessary. Some of the views were:

'I would prefer to deliver by myself [SVD], the reason why I would want to deliver by myself is that, that is the arrangement of God but if you are going to deliver and you can't, the child isn't coming, that one, you don't have to force yourself, you have to allow them to remove the baby for you but if they think I could deliver by myself, fine' (Wp7).

The following literature is presented in support of these findings. Danso et al (2009:30) reported that majority of participants (55.2%) in a study they carried out in Ghana noted that they prefer vaginal delivery to Caesarean delivery. The most frequent comment for preferring vaginal delivery was 'vaginal delivery is best'. In another study, an overwhelming majority (91.5%) of the women preferred vaginal delivery (Ajeet, Jaydeep, Nandkishore & Nisha 2011:247). Ajeet et al (2011:247) further noted that most women preferred vaginal delivery as they felt it was safer and the natural way to deliver. They also noted that women who preferred vaginal delivery generally felt that Caesarean sections were more dangerous and painful.

Faremi et al (2014:712) presented results from a study in Nigeria which showed that 93.1% of the participants felt that vaginal delivery was the natural and acceptable mode of delivery. Reasons for their preference included: seeing one's baby immediately after delivery which was pleasurable; mothers regained their health status faster after vaginal delivery; vaginal delivery has more pleasant outcomes; vaginal delivery gives the woman confidence in her ability to give birth; and provides an important life experience. A related survey conducted among Italian women also reported that 4 out of 5 preferred to deliver vaginally (Torloni, Betrán, Montilla, Scolaro, Seuc, Mazzoni, Althabe, Merzagora, Donzelli & Merialdi 2013:5). The main reasons for preferring a vaginal delivery were: not wanting to miss the first hours of life of the baby, a shorter hospital stay and faster postpartum recovery. For those who preferred Caesarean section, their reasons were: fear of pain, convenience to schedule the delivery, and because it was perceived as being less traumatic for the baby. In a qualitative study conducted in Argentina, Liu et al (2013:3-4) report that most of the women preferred vaginal delivery and cited emotional and other psychological benefits of this mode of birth. It is obvious

that women have different reasons for their choice of mode of birth, and knowledge of these should guide measure to improve health care.

6.5.2.4 Women's views on and experiences with choice of birth position and mobility

The benefits of especially the upright positions in birth over the lithotomy position have been highlighted in the literature (Thilagavathy 2012:71). Lawrence et al (2013:2) indicated that there is clear evidence that walking and upright positions in the first stage of labour reduces the duration of labour, the risk of Caesarean birth, the need for epidural, and does not seem to be associated with increased intervention or negative effects on mothers' and babies' well-being. They thus propose that women in low-risk labour should be informed of the benefits of upright positions, and encouraged and assisted to assume whatever positions they choose.

Some positive and negative views were articulated on the topic of birth position and mobility. In terms of mobility during the first stage of labour, the general sentiment by the participants was that they were not hindered by the staff from moving around but most of them felt that the best position was to be in bed. Most of the women expressed comments that indicated that they had little or no knowledge of the benefits of movement during labour. Some of the comments portrayed fear and concern about safety. It was interesting to note that even without being informed about the benefits of mobility, the mothers that had the opportunity walk around felt that their pain lessened when they walked. The quotes explaining these views are as follows:

'For me I would lie down, when you walk around, you wouldn't know what might come from below you but if you lying down and there's something coming from below you, below you, it's safe, so everything can just be on the bed on which you lying' (Wp4).

'Well, when I came, they said 4 cm, my baby's head was down. So I'm supposed to lie on my left for it to come fast. But I wasn't able to do so. I was walking up and down. But I really don't know any importance of walking. All I know, what I can say is, as a pregnant woman, you need to exercise, yes. But for labour, I don't, I can't really tell why you have to move or I can't even say anything about that' (Wp11).

The following comment relates to those who felt that movement reduced perception of pain:

'...I will prefer to be walking because when you sleep at one place, the pain is more severe. So when I am walking, it is good for me' (Wp7).

'...yes when you are walking around it reduces the pain but here they tell you to lie down' (Wp8).

In terms of preference for birth position during the second stage, the most consistent perspective that emerged was the supine (that is, dorsal lithotomy) position. Only one participant stated that she preferred the squatting position. The following are some excerpts:

'Oh, for me, when I give birth, I lie down so I can't say I can sit and this and that. For my two births, I laid down so I can't. I don't know whether I could sit or not' (Wp3).

'I would want to lie down [lithotomy], because I know that it's good when you lie down and give birth. When you squat, the baby's head could hit the floor by that you killing your baby. So it's better you lie down and push the baby to come by that you save the baby's life' (Wp4).

Reasons for choosing the dorsal position were: it is the normal one; that is what I know; I do not know whether I can sit; it is safe for the baby; and that is what the nurses want. It appeared that most of the women knew of only the lithotomy position. However, some concerns were raised about the height of the delivery bed and how women had to dress themselves as follows:

'Honestly that bed there is too high, so if can sit like this, I believe that one, because you will have to climb. Nobody will help you to climb. They will ask you to do everything yourself. You will go and lay your, your, your, the rubber on, the delivery sheet on the bed, the cloth, you will climb. You will do everything yourself. Nobody will help you. So if it's a chair like this, and I believe you can sit on. That one will even ease our pain a bit' (Wp11).

The practices observed in this study appear not to be limited to Ghana. A study in Tanzania reported that mobility during labour was not widely practised in hospitals, and that some women who laboured in bed in the labour ward said they would have preferred to be mobile (Lugina et al 2004:4). In same study, where women were asked to indicate their preferred position during labour, more than 80% of them said they would choose supine position in the second stage, only a few chose to deliver in a sitting position (Lugina et al 2004:4). Lugina et al (2004:4) continued that supine position was the routine at all the study hospitals and that sitting upright and squatting positions were used very infrequently.

In promoting client-centred childbirth, the National Institute of Health and Care Excellence (2014:23) recommends that health professionals should encourage and help the woman to move and adopt whatever positions they find most comfortable throughout labour. The benefits are enormous and have been clearly articulated in the international literature (Lawrence et al 2013:2). The findings in this study suggest that mothers have little knowledge about the types and usefulness of mobility and birth positions. These issues could be factored into pre-natal training programmes.

6.5.2.5 Women's views on and experiences with choice of pain

Erskine, Morley and Pearce (1990) cited in Tinti, Schmidt and Businaro (2011:1) said, labour pain is different from illness or trauma-related pain; it is not an indicator that something is going wrong but signals that labour is proceeding and its expected outcome is generally considered as positive. The literature provides a number of accounts where the ability to cope or the extent to which a woman's labour pain is managed is seen as a key predictor of satisfaction (Daniel et al 2015:1). For many developing countries, knowledge of and labour pain relief remains a poorly managed aspect of childbirth (Nilima et al 2012:197), thus, understanding women's perspective and their needs during childbirth can provide vital information to improve their experience.

The study explored the opinions of women on pain management. Generally, knowledge or awareness on labour pain relief was very low. All of them indicated that labour pain management was not discussed during their ante-natal stage. Whatever knowledge

they had seemed to have emanated from other sources such as: friend, family members and from previous birth experiences. The statement by one participant was:

'...I have a sister abroad and when I was about to deliver, she told me she said, she is going for epidural section, whereby they will inject in. But they say it requires the services of a midwife who will always be by your side to attend to you. Because you will not feel the pain, but you will have to check to see if the baby is coming and all that, but I realise, here is not like that. We are even many than the midwives. So who will have time to sit by me, if I go to do the epidural section and then. So I decided to go natural. That epidural session I asked her [midwife] and she laughed. And the problem was, it's not one midwife to a mother. So, it, it can't be possible' (Wp11).

There were participants that did not even know that measures were available to reduce labour pain. Some quotes were:

'...if there were to be medicine there to prevent the pains, I think that would help a lot' (Wp6).

'...If there is such an aid, I, I will prefer the aid' (Wp9).

'...they should just show me what to do to reduce the pain' (Wp10).

'For me, first when I deliver myself there were no medicines, so this I don't know. I didn't even know that when I come here, even drip I have never been given. All I know is that when you come to deliver it will pain you so when coming, I know that it will be painful. So I make up my mind to come and deliver but I would want them to give me things' (Wp3).

Most of the women in this study wished they had some support to relieve their pain, but it appeared that either the lack of knowledge or non-availability of the methods was a major limiting factor. Nilima et al (2012:197) indicate that a lack of knowledge regarding the birth process can influence a woman's attitude to pain relief. They continued that a knowledgeable woman may understand the pain leading to birth, and view her pain as positive and as a good sign of progress. Nilima et al (2012:197) again noted that half of the participants in their study were in favour of labour pain relief but very few (35.29%)

could guess the beneficial effects of relieving pain and stress. Their report also stated that the lack of knowledge influenced the poor response for plans to use labour analgesia. In a related study, Mugambe et al (2007:16c) indicated that more than half the women were aware of labour pain relief methods. Most of the women had gained knowledge of pain relief from previous experience or from friends and relatives, with only a few gaining knowledge from media and textbooks. Batte and Odoi-Adome (2006:12) reported that some of the participants in their study felt that women were not aware of some of the pain relief options and so could not make a choice. They also observed that even though many patients in their study reported receiving enough information, the information might have been too lacking to facilitate an informed and shared decision-making process.

Unlike the findings in this study where women were not informed about pain relief methods, Ogboli-Nwasor and Adaji (2014:S22-S23) observed that majority (87%) of the participants in their study had information about pain relief in labour largely from their health care providers. Therefore, it was not surprising that they found high level of awareness on pain reliefs in the study. However, in terms of utilisation Ogboli-Nwasor and Adaji (2014:S23) found that only a small proportion of the mothers (4.1%) could recall ever using any of the labour relief agents or methods. Of the five women who recalled using pain relief, three recalled use of parenteral Pethidine and one used epidural analgesia.

There were other participants that mentioned or described the types of pain relief they would have liked to have. Those mentioned were the injectables like Pethidine and epidural analgesia. Two of such comments were:

'...I would prefer the drug to numb me because before the child comes when it turns, it is very painful' (Wp4).

'...yes if they see the pain you are going through and can give you some injection to reduce the pain. I would like injection because I felt pains a lot' (Wp8).

None of the women mentioned other forms of pain relief or non-pharmacological methods such as respiratory exercises, muscle relaxation, Lumbosacral region massage and having a shower. It appeared that these were not routinely used in health

facilities. In support of these findings, Mugambe et al 2007:16c) noted that women were mostly aware of pain relief given as an injection in the thigh, presumably an opiate like Pethidine. They also maintained that their finding was not surprising, as Pethidine was the most commonly given form of labour pain relief. Similarly, none of the women in their study mentioned inhalation techniques or non-pharmacological methods, except the few who knew about breathing exercises.

Only a few of the participants expressed the view that they did not require any pain medication. In their view, it was normal to go through labour pains. Their views were stated as:

'oo, I don't prefer any medicine, because when the pain comes, it subsides. It makes me breath fine, before it comes again. So it is normal, so for medications no' (Wp7).

'Taking medications are not good. When you deliver by yourself, it is better than taking medications for the pains to subside' (Wp14).

Similar findings were reported in one study in Brunei Darussalam in which most (74%) of the women preferred to give birth without any anaesthesia (Bamanikar & Amdani 2012:180). Reasons for their choice included: need to feel the pain; previous unfavourable experience of anaesthesia; and fear of allergies. In the same vein, participants in the studies by Gamble et al (2007:117) and Bazzano et al (2008:92) said pain relievers were not very important. Some women also believe that labour pain should be tolerated (Mugambe et al 2007:16c)

It is well-known that attitude to pain is subjective and characterised by one's upbringing and many environmental influences (Leeman et al 2003:1109; Lowe 2002 cited in Madden et al 2013:1). In this regard, it is important to have a good knowledge of the socio-cultural context within which care is being provided. Some evidence on this was provided in Christiaens et al (2010:9) who found that labour pain acceptance and how childbearing women cope with labour pain is country specific. For example, regarding Dutch women, they found that the use of pain medication is lowest if women have a positive attitude towards labour pain and when they also experience control over the reception of pain medication. Equally important is the kind of coaching that women

receive during both the pre-natal and labour period. Ogboli-Nwasor and Adaji (2014:S22-S23) provides evidence indicating that positive coaching during the pre-natal period helps women to go through labour better. Furthermore, the support that women obtain from their care providers and labour companions during labour also helps better coping. For example, Kuo et al (2010:452-454) contend that women in their study mentioned that support provided by the midwives helped them to handle labour pain better. In addition, Tinti, Schmidt and Businaro (2011:5) note that positive emotions may be very important in reducing pain intensity during delivery and that if women could be prepared at the pre-natal stage on strategies to reduce negative emotions but also to enhance positive emotions their birth experience will be enhanced. Tinti et al (2011:5) suggest that during both the pre-natal and labour stage, promotion of positive emotions can be achieved through provision of constant information which give women a sense of personal empowerment and control to cope with events. The findings in this study demonstrate that there is more work to do to make an impact on how mothers feel concerning labour pain relief.

6.5.2.6 Women's views on and experiences with choice of length of stay after delivery

Internationally, the length of time women spend in hospital after childbirth has reduced significantly. In Ghana, though the research did not identify any documentary evidence on the average length of stay after delivery, the general practice is from 24 to 48 hours. This appears to be similar to some international practices and recommendations in WHO (2010:13). Anecdotal evidence indicates that concerns have been raised about early discharge of women and their newborns but a systematic review report Brown et al (2002:2) showed that early postnatal discharge of healthy mothers and term infants does not appear to have adverse effects on breastfeeding or maternal depression and that there is need for further studies to determine the impact of early discharge.

In keeping with the tenets of client-centredness, the views and experiences of participants were obtained on their involvement in deciding on the length of stay after delivery. On the whole, none of the women had any discussion with care providers on the length of stay after delivery. This neither happened during the ante-natal stage nor during their admission. How long a woman should stay was determined by the medical officer. With the exception of a few, the participants were happy with the length of stay.

The length of stay for SVD ranged 24 hours to three (3) days while that for those who had Caesarean section ranged three (3) to four (4) days. The interviews were aware of the reason for the length of stay and vividly provided explanations. It appeared the reasons were provided by health professionals thought this was not expressed explicitly. Some of the remarks were:

'...I liked it [length of stay] because my blood pressure was high so they saw to that, they said that the blood pressure had to come down before so liked it' (Wp1).

'I came here on Thursday and left on Friday so it was two days, if I don't feel any pain then I would like to go home, I can even decide to go the same day because I didn't feel any pain' (Wp8).

I delivered on Saturday, I was discharged on Sunday. So I spent a day here, oh, am okay with it. My reason being that they used that time to study the health to the baby, to check if there is a problem, because if you are discharged it could happen that things will not turn out well. That is why they keep you here overnight to observe you and the baby for least a day after your discharge. That is why I liked to have stay for a day' (Wp4).

However, it must be stated that some of the women felt compelled to leave early due to some logistical and infrastructural constraints in the hospitals. There were a few of the participants who felt that some categories of mothers like primiparas should have been allowed to stay a bit longer so they could be provided with information on how to effectively cater for their baby and themselves. The following expressions outline these views:

'...I went home the following after I delivered; yes, it is good for me, because, there are not enough beds here; it is good for me that, I delivered safely and went home. My friends would also get a place. I will say that, rooms and beds are what and beds are what we need, so that, when someone delivers and still weak, she would have a place to sleep and be taken good care of, before she goes home' (Wp14).

'I believe since there are other complications, after birth, I believe a new mother should be attended to properly. So at least spending about three days there, if there are enough beds and enough space even to really cause anything for the

nurse to check, then if you are ok, then you move, but you deliver, you go home, honestly I'm not so happy about it' (Wp11).

Anecdotal evidence seems to support this view in Ghana that some women and families are dissatisfied with the length of stay, especially, for the first time mothers. Similar findings were reported even in some developed countries. For example, the length of postnatal hospital stay for an uncomplicated vaginal birth in Australia, Canada, United Kingdom, United States and Sweden is around two to three days or less (Brown et al 2002:2). However, Klingner, Solberg, Knudson, Schumacher and Carlson (1999:253) said that efforts to reduce length of stay after vaginal delivery are meeting with increasing resistance from patient groups and their political representatives. For example, the Minnesota State Legislature passed a bill in March 1996 that required all health plans to provide coverage for hospital maternity care for 48 hours after vaginal delivery. The bill included a provision for home care coverage for patients with shorter stays. The Ministry of Health, Ghana may have to take a closer look at the practices on length of stay after delivery to offer some documented guidelines.

6.6 CONTINUITY OF CARE

There are different definitions of continuity of care (Price & Lau 2013:6-9; Haggerty et al 2003:1221). Haggerty et al (2003:1221) define continuity of care as the degree to which a series of discrete health care events are experienced as coherent, connected and consistent with the patient's medical needs and personal context. Continuity of care helps women to build personal relationship with their care providers and also promotes the feeling of more respectful treatment during pregnancy and birth (William et al 2010:619). Consequently, many health services have now changed their model of care to incorporate a system that focused on improving the experience for each woman by enabling continuity of care from a known midwife (Editorial 2009:47).

One main theme was generated from the discussion on continuity of care. This was 'knowing your staff'.

6.6.1 Knowing your staff (N=15)

The Ghana Health Service (2014:15) states that focused ante-natal care is geared towards promoting individualised, client-centred and comprehensive services. It also means that service provider should focus on assessment and actions needed to make prompt decisions and provide quality care tailored to meet each woman's need as an individual. Inherent in this objective is to facilitate the process of women knowing their care providers. Interviewees in describing their experiences with antenatal and delivery care made a number of submissions related to continuity of care. In their submissions and from the field notes, it was observed that women were usually assigned to one or two midwives who attend to them during the ante-natal period. They are not given the opportunity to choose. Indeed, in a metropolis like Accra where the study was carried out, it would have been difficult for them to choose as they would not have known the care providers prior to coming to the health facility. The midwives assigned become their personal care provider. Presented below are two descriptions of the process:

'When I first came here, a certain man who came to talk about health insurance first and the reason why we should partake in that health insurance,... they brought a red card that, they told us everything what we should do when we get there various rooms [cubicles] that they gave us,...after that they allowed us to sit for the nurses to see to us' (Wp6).

'When you come and when they [front desk staff] want you to see a doctor or midwife, she didn't tell us the reason, she just tell us that number one or two should go there' (Wp10).

It is said that the fundamental aspect of continuity is the midwife-woman relationship (Editorial 2009:47). Despite being assigned to midwives, most of the women expressed positive views about the care that they received from 'their midwife'. The following are some of the comments:

'For me, the midwife I know, maybe the others other people go to but mine is okay. The way she talks to me is okay, the other time I felt sick and came here, the doctor who attended to me, spoke to me well. He speaks well. I like it very much' (Wp3).

'As for me, the room I went, the midwife was very friendly, she talked to me about even the things that is not part but needed to be taught. She taught me' (Wp6).

Having a personal relationship with or knowing their midwife was very important to the women. However, for the majority, more than one midwife attended to them during the ante-natal period. Some stated that their midwife was transferred, while others noted that they travelled. On some occasions they were seen by medical officers to address some medical problems. Sometimes they were accompanied by their midwives to see the officers to which they referred them. One participant said:

'It was a midwife who attended to me. Yes, when I come and there is something she can't handle, then she refers me to a doctor. At first, when I felt sick and came, she gave me medicine but it wasn't well. Second time, when I came, she told me she couldn't handle it so she referred me to the doctor and I went' (Wp3).

Per the tents of the focus antennal care programme, as much as possible women were to be given orientation (a tour) of the labour and introduced to the midwives there prior to labour. The personal midwife could also arrange to conduct the delivery for her client. Unfortunately, almost all the participants did not have the opportunity to visit the labour ward or to be introduced to the midwives. The women did not know that anything of that sort could be done. One participant narrated a situation where they had to go round the hospital on arrival during labour to locate the labour ward. Majority expressed to desire for this to be done. Below are some of the sentiments expressed:

'I don't know them would it be good to be introduced to the midwives at the labour ward because for instance, I didn't even know the labour room so we searched a lot before getting there when I came in labour' (Wp8).

'Yes, because I, I, read, sometimes when you come for ante-natal, that they are supposed to take us to the labour wards. Yes, go and show us things over there especially the new ones. But nothing of that sort was done' (Wp11).

'I didn't know anyone Left to me, I would want them to introduce us to the nurses and midwife before, so you could say this nurse is my god mother or something of that sort, so that if anything you could call on her and she would help you because with here, they are quite a lot' (W15).

Women also expressed the need to be given prior information if their personal midwife would not be available during their visit and also to be properly introduced or handed over if they are to be assigned to a new midwife. Another aspect of continuity that the participants alluded to was intrapartum continuity and the importance of knowing or at least being introduced to the midwives or other staff that cater for them during the different shifts. Women had both positive and negative experience in this aspect of care. One of the participants that had a positive experience on being handed over during intrapartum said:

'...they come to tell us they are leaving you for this particular Aunty. So they will take care of you, then they show our folder to them, then they mention our names to show how they should attend to us. So if they come, this is how they should continue. They hand over to them so they would follow that trend' (Wp4).

Another participant who did not feel very happy about how the staff dealt with continuity during the intrapartum period stated that:

'For us they didn't tell us anything. But it seems they have a way of doing it. They handed over to the nurses, but they didn't tell us they were handing me over to this, the morning nurses and all that. They didn't tell us. But they did it between themselves' (Wp11).

Interestingly, none of the participants talked about knowing or being introduced to their care providers during the post-natal period. From the findings on continuity, it can be deduced that it is very imperative for health care organisations to know women's preferences and needs so that they can be factored in service designs. None of the participants talked about knowing or being introduced to their care providers during the postnatal period.

The findings in this study are support by the following literature. There are different models of continuity (Sandall et al 2013:3; NSW Health 2003:11). As to which model women prefer, Hundley and Ryan (2004:555) wrote that women prefer to have a midwife who they had met during their pregnancy and who would be present throughout labour and delivery. Other studies reported that women preferred a single provider or at

least better coordination of care with multiple providers (Novick 2009:8). In addition, Jamas et al (2011:697) found that women preferred to have prior contact with care providers and the care environment before they get into labour. Other findings indicate that some women are not too much concerned about having the same care provider attend to them throughout childbirth. However, they do value having a midwife that they have seen during the prenatal period attend to them at the time of delivery (Rodriguez & Rivieres-Pigeon 2007:9-10). A similar finding was observed by Gamble et al (2007:117) where majority of the participants reported that they felt very comfortable having the same person providing care for them during pregnancy, birth and postnatal.

In a formal health care environment as the one existing in the health facilities in this study, it may be difficult to consistently assure continuity of carer. However, as stated in Frampton et al (2008:112), measures should be put in place for care to be delivered in a manner that is well-coordinated among the numerous caregivers, the patient and the family.

6.7 OVERALL ASSESSMENT BY WOMEN

Having had in-depth discussions with the women, it was just fair to request that they give an overall assessment of the services that they received from pregnancy through delivery to being discharged. Local and international bodies have long determined that not only should childbirth take the individuals needs and preferences of the woman into account but it should also be designed to meet their expectations and satisfaction (Australian College of Nursing 2014:1; Department of Health, United Kingdom 2010). The theme that emerged under this category was 'satisfaction'.

6.7.1 Satisfaction with care

The concept of patient satisfaction has been extensively researched in the medical literature. Despite the lack of agreement on its definition, patient satisfaction can be seen as an individual's "personal evaluation of health care services and providers" (Ware, Snyder, Wright & Davies 1983:247 cited in Sawyer, Ayers, Abbott, Gyte, Rabe & Duley 2013:1). Patient satisfaction is also seen as "the degree to which the individual regards the health care as useful, effective and beneficial" (Lebow 1983 cited in Ahmad, Nawaz & Ud Din 2011:37). It has also been argued that patients' satisfaction in health

care services is influenced by the individuals' social environment and that patients measure the satisfaction they derive from health care services against the perceived comfort or discomfort they feel with respect to the services (Fitzpatrick & Hopkins 1983 cited in Ofili 2014:27). To obtain information from clients, they could be asked after discharge to report their perceptions of what happened during their stay, rate their perceptions of the quality of care and service they received, or to indicate how satisfied they were with the care and service (Drain 2004:W4-6).

Women's assessment of quality of services they received was fairly mixed. Though majority articulated satisfaction with services, a good number of them were not so happy. It was interesting to observe that some women were appreciative of services even when staff carried out their routine activities or helped them with some basic personal care activities. Their assessment also was influenced by the relationship they had with care providers. Some of the reasons for being satisfied were:

'Yes, I got help; there is a nurse here, who really takes good care of me. If I want sachet water she gets it for me. Yes, and really like her it's a good hospital that anyone can visit. But for me, when I came to deliver, my time wasn't due and they helped me so if they could do same for others then it would help' (Wp3).

'...the reason why I said I was happy is that when we come, when I came how the ante-natal unit, how they attended to me in the ante-natal ward and how they taught me and all which I adhered to, all helped me very much. That is why I said I was happy' (Wp4).

Interestingly, even some participants also narrated very unpleasant occurrences during the interview at the end expressed satisfaction with the services. When asked about her assessment, one participant noted the following:

'I wouldn't want to give a mark. I am not happy though, but I wouldn't want to blame them, because we are many. Today like this, we are many. I came here since morning, and then it's, it's past twelve and I'm still here. And then even the, the, the lady, the woman attending to us too, you could see she is tired. So even if I'm, if I'm not happy. If maybe they are many and then they attend to us on, one is to one basis, I believe that maybe the work would have been faster. But because we are many, you come and then you spend all your time here' (Wp11).

In a similar study in Ghana, women in describing their satisfaction with services also talked about experiences with their labour, how staff took care of them and their accounts depicted both positive and negative encounters with staff (D'Ambruoso, Abbey & Hussein 2005:5). It has also been documented that patients' reports of the hospital satisfaction appear to be significantly better when they are treated with courtesy and respect (Shaller 2007:7). However, in another study in Malawi a number of women pointed to substandard care during or after birth in terms of physical or psychological aspects (Simwaka et al 2014:10). Simwaka et al (2014:10) also outlined that some participants expressed dissatisfaction with the nursing care provided while others commented on the positive aspects of nursing despite their dissatisfaction. Simwaka et al (2014:10) reported that the reasons for dissatisfaction were neglect of the emotional needs of women and that the participants complained that nurses did not spend much time with them or offered no words of encouragement to the mothers. Reports from some developed countries indicate that the quality of care scores was higher when women knew their care provider, when they gave birth at home and when they are assisted by their own midwives (Weigers 2009:8).

Similar findings where clients expressed high ratings of satisfaction with services even when some aspects of care appeared to be of poor quality have been reported in the literature. For example, Shaller (2007:6) stated that though patients may rate their care providers highly, this might not be reflective of their actual experience. Similar observations were reported in Ferguson, Ward, Card, Sheppard and McMurtry (2013:284) where it was acknowledged that although patient satisfaction surveys continue to demonstrate high satisfaction with the quality of care, many patients continue to have concerns about the care they receive. In view of this, Creel, Sass and Yinger (2002:4) cautioned that client satisfaction may not necessarily mean that the quality is good; it may only indicate that the expectations are low. The observation in this study where even after some clients expressed so much dissatisfaction with aspects of care but still graded the service as very good tend to support the assertion in Creel et al (2002:4) that probably expectations were low. In a systematic review of studies on satisfaction in developing countries, it was concluded that satisfaction ratings by women were high across most studies and that this could be because of lack of awareness and exposure in the largely low literacy context in developing countries (Srivastava et al 2015:8).

Despite these shortcomings of patient satisfaction surveys, it is still seen as very useful tool in obtaining information and feedback from clients on aspect of services.

6.8 BARRIERS IDENTIFIED BY WOMEN

In 2013, a total of 1021 women died in health facilities in Ghana (Ghana Health Service 2014:38-42). A globally accepted strategy to minimise these deaths and its accompanying complications is to ensure skilled care at birth and immediately thereafter. Providing quality childbirth care is an important intervention that can help to make women utilise skilled facility-based services. The participants in this study talked about a number of organisational and individual health worker factors that in their view constituted barriers to the provision, utilisation and unacceptable experiences during childbirth. Five (5) major themes were identified from their comments. These were as follows:

- Too many clients
- Inadequate staff
- Non-availability of some services
- Unacceptable staff attitude
- Lack of cooperation from other clients

6.8.1 Too many clients (N=13)

The influence of high workload on quality of care, and most especially, on the effectiveness of client-centred care has been well documented (Kostick et al 2010:528; Mead & Brower 2000:1103-1104). Inadequate number of midwives and high number of women in labour contributes to low satisfaction with services (Mohammad et al (2014:37). It was interesting that participants in this study identified too many clients as a barrier as this variable is not often mentioned by service users as a barrier. The high number of clients and attempts by some of them to jump queues often generated conflicts and dissatisfaction among the women. Women felt that the inability of staff to deliver quality care could partly be due to the high number of patients. The high number of clients contributed to long waiting time during labour, inadequate staff time to attend to clients and even affected availability of beds and space. At the prenatal stage, some

participants said that they had to leave their home very early on their antenatal clinic days to avoid the long delays due to the high patient numbers. The venue for prenatal care was small, the seats were not enough and some had to stand for hours. Comment from one participant was:

'...the point is we are many sometimes, and it's like sometimes, we quarrel among ourselves because of the queue. You are in front of me, I'm behind you, and all that. That's what brings about quarrel, getting to the Holy Saturday, we were many. And honestly I will applaud the nurses who attended to us that day, because, we were many and in fact they come and they go. People come to give birth and they go and there are some also there wailing and all that. And we were many; so when you come you will have to wait. There were no beds. You will be asked to sit. Me like this I was asked to lie there, because there were no beds. So I laid on the floor there. As I said earlier on, it's because we are many than them. We are much. So, she is always tired. So if you come and then you want to prove stubborn a bit and she would have to just say something to you, in order to attend to the next person. And also if you need some assistance too, because there is somebody on the waiting list too, when she is done with you, you have to go for somebody else to come. So we are many. So if they would also address that' (Wp11).

Clients indicated that they could notice that the staff were tired and stressed and were at times hindered from making demands from them. The Choices and Challenges in Changing Childbirth Research Network (2005:[5]) indicates that there are a number of challenges that need to be overcome in order to change practices and implement evidence-based maternity care. The high workload and the understaffing in hospitals among others constitute major challenges and barriers to change. They further stated that there are instances where health facilities are not able to effectively accommodate women and newborns as was the situation in this study where some women had to lie on the floor. Challenges with high workload were also identified in Assibi et al (2013:768-810) and Bradley et al (2015:4). In the Assibi et al's (2013:768-810) study in Ghana, high work load was seen as a major cause of stress among health workers; so, it was concluded that measures should be put in place to address the high workload and critical shortage of staff.

6.8.2 Inadequate staff (N=5)

Closely linked to the issues of too many clients is inadequate number of staff. Staff shortages, poor conditions of work, low job satisfaction of staff, and lack of medicines and equipment all limited service delivery (Cockcroft et al 2011:[4]). Staff shortages led to increase in waiting time and overcrowding and lack of space in health facilities in the findings reported in (Amnesty International 2014:33). It is said that the health human resources challenges in many low income countries continues to hamper efforts to provide quality care and reduce maternal mortality. In describing their experiences, the interviewees noted that the low number of staff caused too much delays and inability of the staff to have time for the clients. One participant narrated an instance where a client had some complications because the staff did not have enough time to effectively care for her. Her narrative and another from a participant on the staff issues are as follows:

'...the client that came that day were many and the mid-wives were only two so they didn't have time at all, a friend of mine came to deliver and after delivering they didn't have time to remove unnecessary things from her because another client was in so I saw that the client were more than the workers just as I said, the nurses at the labour ward should be more' (Wp8).

'Every time, I want a doctor available for consultation. Sometimes when you come in there is no doctor. The last time, for instance, I came in to conduct a scan. I sat there for a long time, because there were many people all accessing services. I joined the queue for a long time, secondly the doctor was not around. So I wish that there is a doctor around always for consultation' (Wp12).

In support of these findings, Ly, Kouanda and Ridde (2014:6-7) reported that they found severe shortage of perinatal care workers (nurses and midwives) and stated that staff shortage can have devastating impact on care as they would have less time to attend to clients resulting in obstetrical complications and high maternal mortality. In a related study, where data were collected from 15 health facilities in Eastern Uganda, the results indicated that there was an overall health worker shortage with medical officers and midwives in limited supply (Tetui et al 2012:7). Fagbamigbe and Idemudia (2015:6) noted that 25.5% of women indicated that they did not go for ante-natal care because the clinics did not have skilled health workers.

6.8.3 Non-availability of some services (N=15)

Dudley and Garner (2011:2-3) report that in many low- and middle-income countries, clients' and their families often experience health care services that are characterised by fragmentation, duplication and care gaps. Clients want a health care system that is seamless, smooth and easy to navigate (Waddington & Egger 2008:5). In other words, clients want a coordinated service which minimises both the number of stages in an appointment and the number of separate visits required to a health facility.

The participants in this study seemed to be echoing the agenda that they do not want to be going to different place to obtain services. This barrier related mainly to sonography and other laboratory tests and to some extent pharmaceutical services. The women found the process of having to go to different government, private laboratories and diagnostic centres often outside their primary health facility premises for different tests was cumbersome and waste of time. Some interviews did not understand why they had to do a scan on every prenatal visit and also expressed frustrations where they were only informed of these diagnostic tests when they arrive in the health facility. The following were some of their sentiments:

'As for that, it is a major problem, because when you come in, they say go over there and have it done [scan or other laboratory]. By the time you get there, for instance, the personnel at that hospital facility are not working. When that occurs, it becomes a bit troubling. So they have to put all those facilities in place so that, when we come in to access facilities, we don't have to cross the road to a different place. If we had all at the same place, it would be helpful, they should have the tests available, so that when we come in, everything would be done here in a continuous fashion. We don't have to do it elsewhere, so it creates confusion (Wp9).

'...the lab [laboratory], I first did the first here, and whenever I go there, they tell me that they don't have the medicine for that lab, so the first one I went there, they told me they don't have the medicine. Since then, I didn't go there again. I would have loved that any medicine needed should be presented to them. So that when we go there they wouldn't tell us stories' (Wp6).

The National Partnership for Women and Families (2014) reports that high quality maternity care is one that is seamless and effectively coordinated across settings, and disciplines to maximise safety and efficiency as well as reduce waste. As different women have different needs in relation to pregnancy and childbirth, care should be planned in such a way that they can anticipate requirement and prepare accordingly (NSW Department of Health 2008:6). Models of care, as far as possible, should provide a range of options at the same time. The service should also be designed to meet the needs of mothers and their significant others through effective teamwork, communication and coordinated management of care plans (National Partnership for Women and Families 2014). Women prefer a multi-disciplinary health facility to a traditional fragmented one (Hall & Van Teijlingen 2006:9).

6.8.4 Unacceptable staff attitude (N=6)

Unacceptable staff attitudes have been found to be a major barrier to health facility delivery (Mason et al 2015:6). A number of studies have cited poor health worker attitude as a major contributory factor to low utilisation of maternity services (Fagbamigbe & Idemudia 2015:6; Amnesty International 2014:23; Crissman et al 2013:20-21). Earlier discussion on sections such as respect, courtesy and privacy articulated some of the disrespectful and unacceptable attitudes of health workers that women experienced during their childbirth. Quite a number of the participants considered some of the staff attitudes they observed or experienced, as a barrier. One participant described her experience as follows:

'...so when I got to the top, no one attended to me. It was a certain girl that they said she's at 7cm, so they were standing at her, and I was suffering so I get to the down, I brought chamber pot so I was "wee-wee" [urinating]...it pour down on the floor, I asked a certain nurse that, what should I use [to clean it], the nurse told me if I brought T-roll I should use it. So I was using the T-roll when a certain nurse came to tell me that, me, I have "poo-pooed" [defecated] on myself, I have defecated on myself and am using a T-roll. The way I have done myself, do I think cleanliness will come to me? Meanwhile, the bay [washroom] was just here; I haven't delivered before so I didn't see. I was not happy. So I was on the bed, I was suffering but then my mother told me that if I come, I shouldn't shout else whenever am delivering I will be shouting. So I didn't show anything show sign, so I was on the bed when a certain nurse came to me. After checking all the women

in the room, she came to me that moment she said the baby, she said "get up, get up, let's go" (Wp6).

Many factors could have contributed to the unacceptable attitude of staff, but it is equally unacceptable to subject labouring women to inhuman and demeaning behaviour. Fagbamigbe and Idemudia (2015:6) reported a similar finding in which health facility-related factors consisting of unavailability of skilled health workers, poor attitude and unprofessional conduct of the health workers was mentioned by 27.5% of the participants as the reasons why pregnant women did not come for prenatal services. The participants in the study conducted by Crissman et al (2013:20-21) described harsh treatment and other forms of maltreatment by midwives as major barriers to utilising health facility delivery services. They also noted that many participants described witnessing or hearing stories of midwives shouting at women, being harsh, impatient, or unhelpful. Byford-Richardson, Walker, Muckle, Sprague, Fergus, White and Dick (2013:128) found that a common sentiment among mothers was fear of harsh treatment from the nursing staff at health facilities and that few mothers expressed this fear for themselves, while others provided it as an explanation for others' decisions to deliver at home. In some cases, this fear acted as a direct barrier to seeking health care for delivery. Amnesty International (2014:23) gives credence to this result by reporting that practices at clinics and the behaviour of health care workers in some health facilities in South Africa seriously compromised the utilisation of maternal health services.

6.8.5 Lack of cooperation from other clients (N=7)

Another barrier to provision of client-centred care that was mentioned was the lack of cooperation from some clients. Some participants were of the view that the behaviour of some clients provoked the health workers. In their view, it is imperative for clients to show respect and adhere to advice by staff. Their comments included the following:

'...some people [clients] come with different behaviours from their homes. Some are just annoying so when there is any misunderstanding, it's the fault of those who come here, the way they talk. Sometimes, they only need to be patient but they rather make noise' (Wp1).

'...if you come here and behave like you are "too known", then they would be angry at you. They would talk against you so if you come with patience for them, they would also be patient with you. So when I come they don't do any of that to me' (Wp3).

'...we normally provoke them because when we come and they tell us to sit at a particular place, we should obey them. They teach us. You will see some people walking about, if you do that, they shout at you, they won't be angry but will shout at you. They have made us to also know that they are training us. So it is good' (Wp7).

No literature was identified to support this finding. However, it must be noted that per the training of health professionals, they should have the qualities to effectively handle some clients that display the kind of behaviours described above in a more professional manner.

6.9 RECOMMENDATIONS FROM WOMEN

To improve the quality of childbirth services, it is essential that health organisations study and understand how women think and feel about services so that they can factor their inputs in improvement strategies. The themes that were generated from the recommendations by the women were as follows:

- Health workers to have patience
- Need for open communication
- Friendliness and good relationship
- Health workers to be attentive
- Re-organisation of services

6.9.1 Health workers to have patience (N=15)

For centuries, the philosophy and foundation of nursing and midwifery stressed that the attributes of the nurse or midwife should be those of dedication, kindness, compassion, patience, trustworthiness, self-control, discretion, humility, perseverance, courtesy, the obedience of loyalty and respect (Bradshaw 1998:438). According to Bradshaw (1998),

a nurse and for that matter health professionals could not be good practitioners without a virtuous character. Women in this study overwhelmingly felt that there was the need for health worker to have and exercise patience when dealing with clients. Every individual participant mentioned this need. One participant had this to say:

'Well, I, I, believe labour itself is something that makes people go mad. And it seems our nurses are used to. So when you come and you are screaming, it's like it is normal. So they don't care. But I would entreat if they can be a bit patient, because some of them have been through. So if they can be a bit patient with us, because it's not so easy. So when you come and you are, at least they should say something nice. But it's like, and they will be like, there is nothing I can do about it, in spite of your shouting. I say lie down, go and lie down. And at least if you say "sorry, it will be over soon" and all that. That is a bit good. But if you are telling me it's painful and all that, you are rather adding salt to my injury' (Wp11).

Being kind, compassionate and patient are virtues that cannot be overemphasised in health care. The findings are supported by literature. For instance, Ashraf, Rahman and Khan (2012:1845) articulated that some mothers in the study they conducted also expressed their dissatisfaction with attitude of health professions and had concerns about some of them not having time to listen to them. Patient or client-centred care is respective care that treats the individual client humanly and with empathy (Picker Institute Europe 2004:9-10). It known that the factors that contribute to some of these unpleasant behaviours are multifaceted (Reis, Deller, Carr & Smith 2012:4; Brower & Hill 2010:3-8). However, as outlined in Bradshaw (1998:438), the attributes of a good health professional such as patience, friendliness, being nice and being empathetic have been spelt out in guidance documents since the 20th century. It is important that health professionals imbibe these qualities.

6.9.2 Need for open communication (N=7)

Peters et al (2007:743) posit that uncertainty abounds in health care settings, and successful communication of uncertain information to all patients is critical. Clients want to receive information on their care (Creel et al 2002:5), especially in childbirth where there appears to be a lot of uncertainties. Tinti et al (2011:5) acknowledge that open communication and provision of constant information helps to allay the fears of women

during pregnancy and labour give them a sense of personal empowerment and control to cope with events of the birth process.

Women expressed the value of health workers sharing information with them in an open and truthful manner. The participants noted that if they are involved in discussions they may have some suggestions to assist in their care. One of such comments was:

'When a patient or a pregnant woman comes and they are attending to them, they must be chatting [talking] with them, so that maybe, the ailment disturbing the person, maybe she has some efforts [suggestions] that could help her better. Oh do this, do that for her but when you are not happy with them chatting with them, you alone, you may not know where exactly the problem is and you will be struggling searching for it. Maybe, when you ask her [woman], she can tell you' (Wp14).

Øvretveit (2012:30) postulates that health care providers often fail to create an environment and relationship that allows effective communication with patients, but as has been shown in this study, patients want to know about their care plan and for that matter care providers may have to find way to effectively engage them. It is said that effective communication must begin with active listening characterised by empathically attuning to both the patient's medical and non-medical needs (Greene, Tuzzio & Cherkin 2012:52). The communication should not be directed to the patient alone, but it is important to involve the patient's friends, family, and/or caregivers especially in times of stress or when family support is important for achieving clinical goals (Greene et al 2012:52).

6.9.3 Friendliness and good relationship (N=10)

The relationship between the service user and health worker is pivotal to the experience of good quality person-centred care and support (Innes, Macpherson & McCabe 2006:33-35) and health care organisation must strive to institute measures to promote it. Several happenings in this study have clearly demonstrated how women value the relationship that they had with their care providers or how they would like the relationship to be. Therefore, it was not surprising that the participants felt that staff need to be friendly and also establish good relationship with them. Put in another way,

women want to be one with their care providers so they can feel safe. One participant noted that:

'I would want to have a good relationship with them because for doctors and nurses, God has chosen them as our gods, you understand? So if you come and are not in a good relationship with them, it could happen that you would lose your life. If you come and don't obey them and respect, they could ignore you and you might lose your life. So we have to, left to me alone, give them our respect and obey them' (Wp15).

The women expressed the notion that poor relationship can have adverse effect on them. In support of these findings, another research that examined poor interpersonal relationship between the clients and health care providers in Nigeria reported that all participants agreed that poor interpersonal relationship has adverse effect on quality patient care (Aiyedun, Chukwu & Musa 2014:6-7). Poor inter-personal relationships also creates a communication barrier that prevents health professionals from giving women the information they need for their care and health, and should this happen during labour can cause women to experience a loss of sense of control which can result in later emotional and psychological problems (Holmes & Goldstein 2012:7). As succinctly put in Shumba, Atukunda and Memiah (2013:78), a good technical skill is of no value if not accompanied with good interpersonal skills. Women in this study were well aware of this difficulty and have thus called for measures to improve relationships.

6.9.4 Health workers to be attentive (N=5)

Andrissi et al (2015:10) asset that women are particularly sensitive to the considerations and attention they receive during admission in the hospital, and the quality of human relations with individuals. In the view of Andrissi et al (2015:10), the perceived quality of welcome, including attentiveness that women received during their stay in the health facility, correlated with a decreased perceived need for additional care and a more general faithful attitude towards the health professional. The following are some of the views that the women in this study provided on the need for the staff and for that matter, the health system as a whole to pay more attention to their needs and preferences:

'...when you come, they should be quick to attend to you' (Wp2).

'Okay, what I would say is that some come early in the morning, like we come early. Upon getting here, they do not see to you. Some [staff] who know where you work, when they get there then they see to them. I don't like that and it worries me. I would want that when we all come, we all be seen to, according to the time we get here' (Wp3).

'...the only thing is may be the late attendance of nurses to work that is the little problem. May be you come and they say, the one to attend to you is not in yet. So you would have to wait for the person, that is our only problem' (Wp7).

In ascribing reasons for poor attention, the participants described events depicting concerns about favouritism and other clients being allowed to jump the queue. Late reporting to work by health workers was noted. Others stated that the high number of clients was a contributory factor but their plea was that authorities should find ways to help provide prompt attention. Promptness of care is a key criterion of perceived good care and the lack of it may discourage use of health facility childbirth services (Bhattacharyya et al (2013:5-6). Similar views were reported in Phiri et al (2014:[6]) where they reiterated that the lack of prompt attention discourages use of health facility childbirth services and that the participants in their study who experienced delays in receiving clinical attention within delivery room and felt neglected.

6.9.5 Re-organisation of services (N=14)

The calls for re-organisation of services were in three aspects of care. The first care area was a re-look at the opening hours at the pre-natal clinic. In the view of women, there is a need to review this process so it can address their concerns of long delays. The view of one participant concerning the change that should be instituted at the antenatal clinic was:

'...here if you are coming for ante-natal, you have to wake up early and come. Honestly, around 5:00 am, because we are many. So anytime it gets to my turn and I need to come to ante-natal, when I sleep I'm not able to sleep. You have to wake up, come early. You have to come and sit and wait for them also. And if that [the working hours] would be changed, I would love that, yes, because as early as 5 am, as early as 4:30 am, you come here, you meet pregnant women sitting down, just because they want to come early and go early...' (Wp11).

The second aspect was providing a better coordinated care where all services will be sourced in their primary hospital. Suggestions were made for the health facility authorities to provide the necessary equipment and logistic for laboratory and diagnostic tests. The third key area was putting in measures to formalise the orientation of women to the labour ward so they could familiarise themselves with what goes on at the ward prior to labour. If possible, the participants would prefer a system where they could be assigned to a primary delivery care midwife in the labour ward.

6.10 CONCLUSION

The findings of the present study from the women's perspective portray a system of varied modes of providing care. While some participants were happy with the relationship that they had with their care providers, some expressed distressing experiences. The provision of socio-cultural and spiritual, psychological and emotional, as well as physical support during pregnancy and labour generally showed the need for measures for improvement. Furthermore, it was noted that women would prefer to leave major part of decisions for health workers to take. As such, there was very little or no engagement of some of women regarding the choices available on the aspects of childbirth examined. Despite the efforts by the health care organisations to improve care, there still exist considerable opportunities to improve childbirth services to meet the needs and preferences of women.

CHAPTER 7

FINDINGS AND DISCUSSION OF IN-DEPTH INTERVIEWS WITH DOCTORS AND MIDWIVES

7.1 INTRODUCTION

Client-centred care is regarded as one of the best practice approach to health care quality improvement. The focus on client-centred care is based on the emerging evidence that a health care system that is patient-centred is likely to provide higher quality health care with greater efficiency and also improve client's experience (Christensen et al 2013:136; Clif 2012:88; Joint Commission 2010:1). However, it is recommended that for effective operationalisation of client-centred care all stakeholders, most especially, those who provide direct patient care in the health organisation must have a common understanding of the concept and what it takes to implement it (IAPO:5; Jayadevappa et al 2011:16).

The in-depth interviews with doctors and midwives generated information relating to understanding of client-centred care, its related attributes, the qualities and or behaviour expected of health care workers, and the organisational factors that facilitate and or hinder effective implementation of client-centred childbirth. The data also provided information related to views and experiences of doctors and nurses on decision-making in pregnancy and childbirth and promotion of informed choice related to: place of birth; birth attendant; mode of birth; birth position; support during labour and after delivery; labour pain relief; and length of stay after delivery. Table 7.1 presents the categories and themes.

7.2 DEMOGRAPHIC AND BACKGROUND CHARACTERISTICS

Doctors and midwives were interviewed in an office located on the premises of the hospitals that they worked. Of the twenty five (25) of them that agreed to participate in the study, nineteen (19) were interviewed as theoretical saturation was achieved at that stage. The nineteen (19) were made up of two (2) medical officers and seventeen (17) midwives of different grades. The minimum age was 23 years and the maximum 60

years. Thirteen (13) had worked between one (1) to four (4) years while the remaining six (6) had between five (5) to eight (8) years work experience at the current hospital.

All the participants were working at different unit at the maternity unit of the hospitals. It was observed that six (6) worked at the labour ward, four (4) at the ante-natal unit, five (5) at the postnatal section and two (2) at the obstetrics and gynaecological units. One (1) participant worked at the gynaecological and labour unit while another one (1) said that she worked at all the units as a supervisor. The data also indicated that midwives were rotated every three (3) months and assigned to different units of the maternity department. This gave them the opportunity to regularly practice knowledge and skills at the different sections.

Table 7.1 Categories and themes of finding of interviews with health professionals

Category/theme	Number that responded
Meaning and attributes of client-centred care	
• Focused individualised care	19
• Involving clients and families in health care	8
• Open communication	10
• Personal and interpersonal relationship with care provider	19
• Continuity of care	11
• Dignity, respect and privacy	17
Qualities and behaviour expected of health care workers	
• Patience	13
• Tolerant	6
• Empathy	10
• Nice and friendly	12
• Confidentiality	10
Organisational factors that positively influenced implementation of client-centred care	
• Leadership influence	17
• Training	19
• Guidelines	19
• Provision of resources	8
• Monitoring and feedback	16
Control over decision-making and informed choice	
• Shared decision-making	17
• Decision must be taken with husband or family	5
• Health professional dominance in certain situations	11
Client factors limit implementation of client-centred care	
• Client lack of knowledge	7
• Client cultural and spiritual issues	10
• Lack of cooperation from clients	8

Category/theme	Number that responded
• Client financial challenges	5
Health care worker factors that limit implementation of client-centred care	
• Inadequate knowledge and skills on some delivery options	15
• Poor staff attitude	5
Organisational barriers that limit implementation of client-centred care	
• Facility rules and routines	18
• Lack of equipment and logistics	17
• Infrastructure and space	19
• In adequate staff	19
• Work organisation	19
• High workload	18
Recommendations by doctors and midwives	
• Training of staff	17
• Recruitment or provision of additional staff	19
• Provision of equipment and logistics	16
• Improve infrastructure	19
• Re-organisation of services	10
• Improve communication and education of mothers and the public	15

For the doctors, apart from those who were doing their housemanship (internship after graduating), they could be assigned to any unit of the hospital at any point in time based on need. The two doctors who participated in the study were working at the maternity unit at the time of the study. With regards to work arrangement, the midwives run 6-8 hours or even 12 hours daily shift system depending on the staffing situation. Those doing day shift normally take one day off-duty per week. Those on night duties work four nights per week and take three days off. Doctors could be on duty 24 hours or more as and when required. Table 4.2 outlines the details of the demographic characteristics.

Table 7.2 Presentation of demographic characteristics of health professionals

Demographic characteristics	Frequency	Percentage
Age		
23 – 40	10	53
41 – 60	9	47
Professional grade		
Medical Officer	2	11
Midwifery Officer	1	5
Principal Midwifery Officer	1	5
Staff Midwife	7	37
Senior Staff Midwife	5	26
Senior Midwife	3	16
Duration of work at current work place		
1 – 4 years	13	68
5 – 8 years	6	32
Key area of work		
Ante-natal unit	4	21
Gynaecology/Labour ward	1	5
All areas in the maternity ward	1	5
Obstetrics and Gynaecology	2	11
Labour ward	6	32
Post-natal unit	5	26

7.3 THE MEANING AND UNDERSTANDING OF CLIENT-CENTRED CARE

A number of themes emanated from discussion in the study regarding the meaning of and attributed of client-centred care. See Table 7.1. The themes were as follows:

- Focused individualised care
- Involving clients and families in health care
- Personal relationship over time with care provider
- Open communication
- Dignity, respect and privacy
- Interpersonal relationship
- Continuity of care

7.3.1 Focused individualised care (N=19)

Brookman et al (2011:19) and Mead and Bower (2000:1102) state that client-centred care is a term used to describe the approach to health care delivery that puts the client

or patient at the centre of care. The IOM (2001:40) outlines patient-centred care as 'providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions'. The institute further noted that this type of care responds to each patient's wants, needs, and preferences and offers them the opportunity to actively participate in the medical decision-making process designed to improve their health (IOM 2001:49).

All the participants alluded to a 'focused or individualised care' for the client during the interview when discussing the meaning of client-centred care. The participants saw individualising care as core to patient-centred care. The following excerpts explained the meaning of individualised care in the study:

'When you talk client-centred care or client focus care, it means, we everything is focused on the client. You want to know the client preferences then you also know how our services can help the client we don't impose things on the clients wishes and then her preferences' (Hp11).

'...to meet the need of the patient is to take that patient as a unique individual and approach the care in that direction. There can be about one, two, three or four patients. We don't lump them that they are patients. Ama's needs are different from Kodjo's needs, so we should take Ama as an individual patient who has come to you, for you to give care. So you must ascertain whatever the problems are, whatever the interventions are on individualised basis' (Hp9).

The views expressed by the participants demonstrated their acknowledgment of the importance of paying attention to the person as a whole. The above views are similar to those outlines in the literature. Ferguson et al (2013:283) noted that most health care workers indicated that one of their goals was to provide care that is tailored to the specific needs of the individual patient. In relation to childbirth service delivery, a joint statement endorsed by seven professional organisations described patient-centred care as a system of practice within which health care providers accept that the values, culture, choices, and preferences of a woman and her family are relevant within the context of promoting optimal health outcomes (AWHONN 2012:151). The statement further noted that the overarching principles of client-centred childbirth include treating all childbearing women with kindness, respect, dignity, and cultural sensitivity throughout their maternity care experiences.

7.3.2 Involving clients and families in care (N=8)

Patient collaboration, patient involvement, partnership, patient empowerment, patient engagement are terms used interchangeably in the literature in relation to how clients should be involved in their health care delivery (Longtin, Sax, Leape, Sheridan, Donaldson & Pittet 2010:53). Client and family involvement is seen as the process and state of being engaged, informed, collaborative, committed to one's health care and tolerant or resilient to uncertainties in treatment outcomes (Johnson et al 2012:1). It is also deemed to be "the mutual exchange of information and ideas between the caregiver and patient resulting in the emphatic, trusted relationship which benefits the experience of the user" (Patel & Rajasingam 2013:597). In general terms, patient involvement refers to an enabling process through which individuals or communities take control of their lives and their environment.

The doctors and midwives expressed views indicating the importance of involving clients and their families in health care. In their submission, they noted that involving and explaining issues help patients to have idea of what is happening and that help to get their cooperation. The interviewee below commented on the significance of involving the client and the family in care said that:

'...I don't think when you are treated or you are dealing with the client, you should only be the client. It should be the family as well or somebody the client or somebody that means well to the client because, let's say for instance, at times you need a client to consent to something. But she might need to consult somebody she trusts more. In cases of CS, let's say for instance, maybe the pastor will be somebody closer to the client...If the client would allow the husband to be part of the procedure or whatever you are doing for the client, you let the husband be around to support them. If they have any concerns and then you address them. So when you combine all these people together, you achieve a greater health care to the client herself' (Hp2).

Involving clients in care is a well-recognised strategy in health care provision (Ferguson et al 2013:283) but there is evidence that this is often not accomplished effectively. Mitchell et al (2009:543-553) in their study reports that providing care that is focused not only on the client but also on the family is a strong predictor for family centred care. In

childbirth, the importance of involving the social network of the client becomes even more imperative as the childbirth experience does not include the patient alone but a host of other family and health care team (AWHONN 2012:151). Furthermore, it is acknowledged that patients and their families are now better educated and informed about their health (IOM 2001:48), and by making them part of the team they can provide vital support and information throughout the care process (Shumba et al 2013:79; Pelzang 2010:915).

While some research reports on good collaboration between parents and staff (Gill, Pascoe, Monterosso, Young, Burr, Tanner & Shields 2014:322), in others many clients suffer negative health consequences when they do not agree to assessment and treatment plans in a collaborative way with their care providers (Øvretveit 2012:7). In a focus group study conducted among child welfare workers, Michalopoulos, Ahn, Shaw and O'Connor (2012:661) reported that participants frequently stated that engaging families was a constant struggle. In another study to assess the level of patient involvement in care from the provider's perspective, Shumba et al (2013:78) found that only 11% of the health facilities had scores that indicated high level patients' involvement, majority of the health facilities lack approaches that systematically planned and prioritised involvement of patients in health care. A study that used the Patient-Practitioner Orientation Scale and other tools to measure perception and competence in technical and communication skills regarding two dimensions of patient-centred care (caring and sharing) among 525 student nurses and 108 nurse showed that staff were less supportive in sharing information and in involving patients in the decision-making process (Grilo et al 2013:38). Empowered patients may be perceived as difficult or demanding by providers resulting in some of them withholding requests for medical tests, additional opinions, or the pursuit of alternative treatment approaches (Johnson et al 2012:6).

Relationships in health care as well as in any setting do not exist and evolve in isolation but are strongly influenced by the context(s) within which they take place (Pedersen et al 2013:6). Hermansson and Martensson (2011:815) indicated that the antecedents to effective involvement of client and families in midwifery are the willingness of the woman or significant others to: allow choices among available tools and resources to facilitate participation in decision-making; set goals; and to accept behaviours that encourage empowerment. Additionally, care providers need to possess and use

professional skills and knowledge as well as assure an enabling environment that is characterised by trust, openness, honesty, authenticity, acceptance of people as they are, and regarding clients as equals. Self-understanding, courage, respect for others' values and choices, awareness and understanding of patients limitations are important in the process.

The participants also expressed some concerns about certain client factors that hinder their effective involvement in care. These included low level education and lack of cooperation. Some participants stated that the high number of client and lack of time also hinders effective communication with client. One participants' comment was:

'...but at times it is difficult. I am thinking, if they were to be educated well enough, even JSS [Junior Secondary School] is good. But the way they hold themselves, at times, excuse me to say, you wouldn't appreciate it that they have even gone to the stage of JSS, SSS. So this is the way they have to hold themselves. Somebody for example, would be sick within this whole municipality, but would decide to stay at home for days. I believe, once you are not fine, why not come back to us...is it the educational background? You at this age, I do believe that if you are pregnant, you are losing liquor, you wouldn't stay at home for three, four days...' (Hp12).

The above comments clearly demonstrate some of the challenges that doctors and midwives encounter. As indicated by Pedersen et al (2013:6) and Hermansson and Martensson (2011:815), patients, families as well as the health professionals have an important role in making the involvement process effective. Likewise, the contextual factors that promote such processes should also be in place.

The results demonstrate that many of the participants are open to actively engage client in their care; however, how this is actually implemented in practice needs to be determined. Good quality care can be achieved if there is a coordinated systematic support for patients' involvement (Shumba et al 2013:79; Shaller 2007:10). At the individual client-service provider level, health workers can foster good engagement through effective communication that clearly explain care processes in a manner that is simple and understanding to the clientele. In addition, training physicians, and other health workers need to be more mindful, informative, and empathic and this will help to

transform their role from one characterised by authority to one that has the goals of partnership, solidarity, empathy, and collaboration (Epstein & Street 2011:101). At the organisational level, engaging patient, families and community representatives in the management or at the decision-making level such as involvement in quality improvement committees, increasing contact and feedback from patients' support groups, and encouraging them to actively participate patient satisfaction surveys will be beneficial (Shumba et al 2013:79; Epstein & Street 2011:101). As noted in Shaller (2007:10) and Michalopoulos et al (2012:662), if patients are to be truly involved, so must their families, close friends and significant others so that they would understand their roles.

7.3.3 Open communication and education (N=10)

Good communication between health care professionals and women is essential. Tongue et al (2005:659) support this assertion by stating that good communication between physicians and patients is the bedrock of quality medical care. Patients value achieving effective communication and partnership (Constand et al 2014:[8]). These are but few comments that indicate how important communication and education is in client-centred care. Open communication and education which are closely related to patient involvement were highlighted as a key attributes of client-centred care. In discussing issues of communication and education, the participants underscored the importance of good communication and education in the following expressions:

'That one if you communicate well with them. You explain every procedure to them, they tends to even go more to an extent of even bringing other problems, which will help you in diagnosing the patient. That one, if you do it and do it well, the patient put their trust or confide in you everything they will tell you. And even when they go home and like you call them, you give them a call, everything, if they are encountering any problem, they tell you. So, that you tell them the appropriate place to attend' (Hp5).

'..yes, education It goes a long way to promote. Because, if woman woman should know like that's health education, that's the communication. If a woman should know that when I'm pregnant I'm supposed not to see blood at any day and she sees bold at every other woman of childbearing age, know this. Because the education has gone far, so many women who sees that, she knows it is not

normal even if she is healthy she has to rush in. Anybody's waters breaking before term or even at term and you are still not in the hospital, you quickly rush' (Hp13).

The doctors and midwives noted that good communication and education make clients to open up and discuss their problems. It also fosters a trusting relationship that enables client to confine in them. According to the participants, effective education helps women to identify complications and seek early treatment. Many health care acts and regulations, as well as professional guidelines clearly state that every pregnant woman has the right to base her maternity care decisions on accurate, up-to-date and comprehensible information (Goldberg 2009:35). Patient-centred care communication among other things, demands that every procedure, treatment, and test ordered should meet the patients' goals for care while fully informing and involving the patient in the decision-making process (Fowler et al 2011:699). Patients who understand their health providers are more likely to accept their health problems, understand their treatment options, modify their behaviour and adhere to follow-up instructions (OMA 2010:34-37; Frampton et al 2008:78).

According to Frampton et al (2008:78), communicating effectively with patients and families, is the cornerstone of providing quality health care and the manner in which the information is communicated to the patient is as important as the information being conveyed. Participant interviewing in this study included aspects on approaches to communication and education in the hospitals.

The views expressed showed that the participants expected most of the health education to be done at the ante-natal stage. One participant stated that:

'... these things [education] should be done ante-natally before getting here [labour ward] but we don't do them, when they come before they opt for it and sometimes, we also use our discretion...' (Hp19).

And another also commented that:

'Most of the education goes on at the ante-natal clinic, before the patient come. That one, even though, even though I'm not there, I know they educate them a lot' (Hp18).

The findings showed that both group and one-on-one approaches were used at different times in the encounter with women. At the antenatal, group health talks were given at the start of the days' work then when the mother get into the cubicles to meet their personal midwives reinforcements or other issues are discussed on one-on-one basis. The women who have access to the phone numbers of their personal midwives also call for further information when necessary. The following were some of the statements from the participants:

'Health education is at the ante-natal, for the maternal cases. The maternal cases at the ante-natal, they give, some health education are given in general (groups). When you come to the... room [cubicles], where you see the midwife. The specific ones are addressed, based on the findings of the midwife. And when you come on admission too, you do the same. You do it, everybody one-to-one' (Hp13).

'... we do give the education. We give talks [group education]. So when she comes [into the cubicle], "Madame, what did you learn today?" if she is unable to explain, I will tell you. Then you have to go over. Today we talked about this, that, that. If it is well- balanced, or signs and symptoms of labour, then you have to explain, Madame, today we talked about signs and symptoms of labour. So what do you know or what did you hear? Then she will tell you some. If she has forgotten, then you add, then you then ask for feedback' (Hp14).

This findings are supported in Akin-Otiko and Bhengu (2012:e895-e896) who found in a study in Ghana that educational talks were mainly given in groups in the open without the use of any information, education and communication materials, consequently, women rarely asked questions. The views on teaching aids availability were as follows:

'The dilatation board, then sometimes we shows them the particular, we have one pasted in the labour ward that have been plotted. Sometimes too, we try to use that one to educate them, how the partograph would be. Then the dilatation, how

the dilatation would be if you are primiparous, we try to give you the assumption, how the labour will be. So we use those ones too to educate them. And updating them, the progress of labour' (Hp3).

One participant's lamentation about the inadequacy of the teaching and learning aids was:

'...for the doctors for now we are doing the talking, we don't support it with any, any document. I know even elsewhere there are you know, anatomy charts, then they show the women the birth canal, how the whole process, labour is and all that, you know. I haven't even my former place, the doctors have not even, midwives who during their ante-natal, would take them through all those things. Show them pictures. Yes, but I don't see anything wrong with doctors if you have that. We also need that, we can also do that. So, it's a matter of we having access to those aids and teaching aids...honestly speaking our setting doesn't help a lot with that...we have to sketch or draw for then on sheets of paper. Where we have the diagrams or the pictures to show, sometimes we do show it but then, I'd say that we don't always have these resources, invariably it's by word, we tell them this, this and that, we try to explain to the best of our abilities in the local languages if it's possible' (Hp17).

According to the participants, the absence of these learning and teaching materials negatively affected the effectiveness of the communication and education processes. Therefore, it was not surprising that the participants expressed misgivings about the adequacy of communication and education that was given to mothers. The interviewees also cited a number of factors that hinder the effectiveness of communication. One of such comments was:

'At times we are able to, sometimes we are not. Because if let's say the midwives there is. It's normally, it's the midwife who will communicate if the patient are more. Maybe you will communicate, but not fully. Just give, Maame your child, maybe does not look well, I am taking him to NICU [Neonatal Intensive Care Unit]. But, he is not healthy, what happened, we should be able to explain it to and what is wrong with her, that. But you should be able to explain everything, to, to them...it's not enough. We are doing it, but it's not enough. Because the, they are a lot and you want to see to all of them. So we just communicate a little and then, go to the next person. It's the, it's the number. The number, it's still about the

number. The number that. Because sometimes, we share the work. There is one person at the triage. The first examination, there is one midwife there, but if, if the patient sitting down there to be examined are a lot, the communication will not be effective. Sometimes, you can't even communicate with some of them. And some too have the opportunity to be communicated to. Especially if it is an emergency. Maame when I looked at you, this and this and that, so maybe you will go we will have an operation on you, because your babies' rate of breathing or the legs are sticking out. But if it is normal, you say that your cervix is opened, only 2, 2 cm. Because she is in pain, she wouldn't, even she would not even mind you. But when we go inside there, we share the work. Let's say if all the beds is 8 and it's full, and the midwives are only three. We just share, write our names by the patient name. You know this is your patient and just focus on the patient and. So that one, you get the opportunity to communicate with the patients. But in case maybe just one person is inside. Sometimes, it happens. The communication will not be effective' (Hp1).

Another challenge was language barrier as stated below:

'It is not easy. Especially, one is the language barrier. It's the language barrier. We have people coming from Nigeria, we have people coming from Ivory Coast. And then even with our own local language, let's say somebody comes from the North. He or she doesn't understand anything. And you need to go down well with this client. You need to explain things to her. Even in the course of delivery, how to even say push becomes a problem. Or don't push, it's not yet time. It, it becomes a problem. And at times too, the client have their own perception about things that go on in the hospital. So you really need to allay their fears and then explain things further to them. At times to they have, let me say, they have their, their own idea' (Hp9).

The findings in this study are also similar to Collins (2009:11) who identified among other things, language barrier as a limiting factor to communication.

In a study in the United States on female genital cutting in Somali women, by Lazar, Johnson-Agbakwu, Davis and Shipp (2013:7), language barrier was also cited as a hindrance in communication in the study

The effects of poor communication and education on health care are well documented in the literature. In another study conducted in Ghana, Dzomeku (2011:32-34) reported that women indicated 'not receiving explanations for interventions and being ignored as key contributory factors for not using health facility services. A focus group study conducted in the northern part of Ghana noted poor communication and interpersonal relationship as some of the factors that negatively affected utilisation of childbirth services (Akum 2013:[3-4]). Another study done in two African countries reports that the participants felt that inability to communicate information to patients delayed medical intervention, misdiagnosis, poor judgment and inaccurate decision (Entea, Oyewumib & Mporac 2010:106-107).

The AWHONN (2012:151) recommends that each member of the woman's health care team should have the requisite knowledge and skills necessary to promote effective communication. Body language, non-verbal cues, courtesy and use of culturally appropriate gestures are important characteristics in the communication process. The importance of listening skills and recognition of the discomfort that the woman may be going through are also important in childbirth (Constand et al 2014:8). In addition, Frampton et al (2008:78) wrote that the single most important criterion by which patients judge health workers is by the way they interact with them. Clients want to receive information that is relevant to their needs, desires and life style (Creel et al 2002:5), just as health professionals are zealous to assist the achievement of this objective to their mutual benefit. Strategies for educating and engaging patients to take a more active role in the care process as demanded by the patient-centred care approach must be done with adequate knowledge of the socio-cultural context so that patients are not disadvantaged (Peters et al 2007:741-742).

7.3.4 Personal and interpersonal relationship with care provider (N=19)

The literature is replete with studies focusing on therapeutic relationships, partnerships, joint decision-making, negotiation, and collaboration that should exist between health care providers and their clients (Doherty 2009:41). Many childbirth service delivery and educational literature also acknowledge the need for positive, trusting, respectful, supportive, and educational therapeutic relationships between health care providers and clients (Andrissi et al 2015:2; Shumba et al 2013:78; Doherty 2009:41).

The discussion on involving clients and their families on open communication and education above all suggested the importance of having good interpersonal relationship in service delivery. The participants in the study perceived having a personal and good interpersonal relationship with women as an important attribute in client-centered care. The participants did not only describe client-centred care as care that is focused on the client but also indicated that it comprises having a personal relationship over the entire period of pregnancy, birth and beyond as demonstrated below:

'...I, will say that client centred care is a special care given to a client, a particular client at a time. That is depends on one midwife, a particular midwife giving a focused care to a particular client at a time. Like everything is done by a particular person, so that for, for the client to be able to voice out everything personally to the midwife or the nurse' (Hp9).

'...you are taking the client right from pregnancy till delivery. And now you are, they are extending it to six weeks of pregnancy. And it's there you discharge the mother to the child welfare clinic, the Public Health Nurse, to also continue. Or the community health nurse rather to continue' (Hp15).

The personal relationship described above appeared to be in line with the concept of focused ante-natal care programme being implemented in the country. The programme was introduced in 2002 in an attempt to address the comparatively high maternal mortality rate and to improve access, quality and continuity of ante-natal care (ANC) to pregnant women (Baffour-Awuah et al 2015:59). A key component of the programme is having a long-term relationship with the pregnant woman till delivery. Irrespective of the impact that this programme may have had on the responses of the participants, it was evident that some of the participants felt that the relationship they established with women made it possible for them to actually know the women and their families beyond just providing care. The quote below illustrates this point:

'...a pregnant woman as your client, that means you should focus on her from the day 1 up to time of delivery. That's the focus. Everything you have to do it beside the woman. You can follow up to delivery. To the delivery room, so that's the focus care is done...the focus, these clients they want it, it's now your client. So, everything. The, the conversation, everything you do with the client. So that's the focus... so, now my client knows I have been seeing her. So anytime she comes,

because of my initials in her book, when she comes and I'm not there, she will say so, so and so used to see me. When they open, they see they this thing. This focus, they are more confident, so when they come, today, it's Sister Irene who is seeing me, tomorrow you won't go to Auntie Josephine. You are the same person. So she is having the confidence. More happier than moving them this one will do this. This one will do this. This one will do urine testing. That's not the best way. As you are testing the urine, the result there, you tell Auntie, today, your urine is ok. Last week it was 3. But through the advice you give her and the education, she will be taking the more water for you. With her drugs when she comes it will be negative. Auntie, now your urine is fine, your Bp is ok, then they become happy. So, they like that. To be seeing one midwife. They don't like moving from midwife to midwife. That one is not good' (Hp10).

The participants referred to the women as 'my client', which is a sign of belongingness. They also cited some positive outcomes as: women building their confidence; improved adherence to advice and management plan; and becoming happy. They highlighted how the process made staff to know in detail the woman's history, medical records and even personal issues in order to help achieve safe delivery and good childbirth experience. This kind of relationships can be compared to what Doherty (2009:45) referred to as 'therapeutic alliance'. The therapeutic alliance is a process within a health care provider-client interaction that is initiated by an identified need for positive client-health care behaviour, whereby both parties work together toward a goal with consideration of the client's current health status and developmental stage within the life span. Doherty (2009:45) further explains that, the notion of client and provider "working together" conveys a particular form of collaboration and suggests a possible emotional bond. The fact that the participant in this study expressed the need for developing this kind of relationship, according to Dahlberg and Aune (2013:414), strengthens the possibility of mutuality and quality in the relationship and could allow the care providers to meet the woman in the context of holistic perspective and foster empowerment for the whole family.

However, mixed findings have been reported in the literature on the view related to client-provider relationships in practice. Dahlberg and Aune (2013:412) report that experiencing closeness to the midwife was important for the positive birth experience in their study. Likewise, Gill et al (2014:322) found good collaboration between parents and health staff in their study in Australia. Newick et al (2013:8) carried out a study on

student nurses in New Zealand about their perception of midwifery services and reported that many understood that the client-midwife relationships were based on shared power and familiarity. On the contrary, majority of the women in Mohammad et al's (2014:37) study reported low satisfaction with interpersonal care, information giving and involvement in decision-making.

However, it must be noted that there are other factors that influence the development of good relationships in maternity care. McCrea and Crute (1991) cited in Doherty (2009:41) explored midwives' understanding of the factors affecting the development of therapeutic relationships with clients and reported that four main issues are important: the nature and value of the midwives' role; recognition of authority and autonomy in the practicing role; emotional involvement with clients; and maintaining personal integrity. In the view of McCrea and Crute (1991) cited in Doherty (2009:41), when midwives are successful in managing the aforementioned issues, the relationship becomes therapeutic and special for clients. Conversely, mismanagement of these issues led to dilemmas that inhibit the development of positive, meaningful relationships. Additionally, the ability to focus on significant events, conditions or situations affecting the patient are other important skills which enable the health professional to deliver personalised care (Pelzang 2010:914).

7.3.5 Continuity (N=11)

As indicated in earlier sections, continuity of care is the degree to which a series of discrete health care events are experienced as coherent, connected and consistent with the patient's medical needs and personal context (Haggerty et al 2003:1221). Leep et al (2010:239-240) provided support for the association between good midwifery continuity of care by stating that it helps to build women's confidence around coping strategies for pain and reduces anxiety and use of pain interventions in labour.

Issues of carer or relational continuity were brought up by the participants in their discussion on personal and interpersonal relationship as presented above and will not be discussed in this section. The discussion on continuity in this section will thus focus on the practices during antenatal, delivery and postnatal care that foster continuity. The participants in this study described the practice of continuity during ante-natal in the following terms:

'...usually like I said, if a woman is pregnant and comes for booking, it's ante-natal. So if they have a problem and the ante-natal, every day we, we the doctors, we are there...what we do here is, from ante-natal, the client is being served by a midwife or a doctor. But mostly, when there is a complication, that's where another...that is why they see the obstetrician. And the midwife at antenatal, she doesn't take them through labour. They come here and meet someone else, who is at the maternity who receives them. Then they start providing care and when she is in active labour, she comes to labour ward...' (Hp18).

The above comments indicate that an assigned midwife(s) usually attends women during the ante-natal period. The midwife may refer the woman to see a doctor or an obstetrician when the woman's health status demands so. This is consistent with the guidelines in the Ministry of Health, Ghana (2008a:3-11) and the recommended strategies for providing ante-natal care services in the Focused Ante-natal Care guidelines (Ghana Health Service 2014:15). The Ministry of Health, Ghana (2009a:3-11) states that the pregnant woman is to have at least four visits during the antenatal period and may be referred to see a medical officer when required. Observations from the interviews showed that the midwife assigned to a particular woman may not necessarily conduct the delivery but is expected to introduce the women to the labour ward and the staff prior to delivery. However, deductions from the above statements and the one below indicate that this is often not the case.

'...one thing that we have started at ante-natal, when the people are getting closer to term, they ask them to come to the labour ward. Direct them up here. They come in and then even come and to see how the labour ward looks like. One of the reason why they ask them to come here is so that when you are in labour and you come, you know exactly where to go. So it's not now that you are going to go to the ante-natal, OPD and then they would want to direct you to the labour. And when they come here they come and meet us. And then at times too, we also go to the ante-natal after closing from work. You go in there, in a way to talk to our, maybe say hi to some of our colleagues there. They [women] also see us, then they say when you go to the labour ward, you would meet this woman. Or there are others who are nice. Everybody is fine. Then you also chat with them. So it keeps them at ease. The first time she comes her and she comes to meet you, you were the one I met at ante-natal. So that is what we are doing now. At times they just climb up here to see how the labour is. By so doing, they see you. With

this place, we are trying. There are times when they come, we don't really have time for them. If I have an emergency, I wouldn't leave the emergency and come and show you around, no. You know, there should be somebody to always welcome them when they come. Because when they come and we are all busy moving about, it would be like, I even went to the labour ward and nobody paid heed to me. It's, it's going to be difficult but we know when we start little by little, we will get there' (Hp5).

Medical officers are not expected to provide continuity of care. The literature review identified several models of midwifery practice designed to assure continuity of care and quality. These include: midwife-led continuity of care (that is, provide continuity of care to a defined group of women through a team of midwives sharing varying caseload); 'caseload midwifery' (that is, women receive their ante, intra- and postnatal care from one midwife or her/his practice partner); and a mix of other models led by obstetricians and family doctors (Sandall et al 2013:3). There is also the shared model of care, where responsibility for the organisation and delivery of care, throughout initial booking to the postnatal period, is shared between different health professionals (Sandall et al 2013:3). However, Pelzang (2010:916) cautions that in systems where care is not properly coordinated, health care providers develop a narrow, task-specific view of the patient's illness and are not able to view the patient as a whole person. This encourages the creation of role divisions, which causes the fragmentation of care which ultimately limits the opportunities for health professionals to see a patient's progress, and gives them only limited exposure to the complete course of a patient's illness.

In terms of delivery-postnatal continuity, the doctors and midwives stated that they often handover clients to the public health or community health nurses for further care. One interviewee's description of how continuity of care was practiced after delivery was:

'After delivery, we have explained to them that we have another unit where you will be sent to, because they stay with us just one hour after delivery. So we explain to her then there's another ward that you have to go there. And then they continue from there. And then do even postnatal for you, for the first 24 hours before you are allowed to go home. And then when you go home, third day, you have to come back, for continuity of the postnatal care. So you explain' (Hp11).

The responses below also demonstrate how informational and intrapartum continuity was carried out:

'Yes, documentation, most of the time saying the things verbally if any care you have given you document for another person to come and read to know how far you've gone' (Hp19).

'...documentation is very, very important. If I'm able to document everything accurately and then my next colleague is taken up, she will know I have ended here, so she would continue from there' (Hp5).

'Ok, you admit the patients and you provide service for the patient and you are, it's time that you go. So your colleague, you have to hand over everything. All the service that you've done for the client then she would continue from that point. The partograph is plotted then you do yours. If you've given any medicine. Medication everything. Everything about the baby. Then the mother, whatever concerns the mother too, you hand over. Then your colleague will also continue. Then it goes on' (Hp11).

The participant expressed the relevance of accurate and complete documentation. However, it appeared that not many women were actively involved in the handing over process. Support for documentation as a key component of continuity of quality care provision was asserted in Frampton et al (2008:112). Frampton et al (2008:112) argue that providing information on the discharge plan from the onset of treatment (and in some cases, even before) is important to foster continuity of care. The following literature also supports the findings in the study regarding difficulties that participants face that at times lead to fragmentation of care. Phillippi (2009:224) indicates that although both clients and health care professionals see continuity of care as a facilitator of client-centered care, continuity of care is difficult to provide. Gu et al (2011:245-248) report that midwives who provided one-on-one care for women from onset of labour to two hours postpartum reported feeling exhausted and fatigued, having a high sense of anticipation and uncertainty, facing a lot of inconveniences of covering on-call shifts, and not having enough sleep. Some other reasons given by health professionals for not providing continuity of care were inadequate staff, using of part-time staff and inappropriate physical structures (Maclachlan et al 2008:363). The importance of

instituting systems to assure all forms of continuity has been highlighted; it is imperative to the experience of not only the client but the health professional as well.

7.3.6 Dignity, respect and privacy (N=17)

The term 'respect' is widely used in the literature but its dimensions and operationalisation are unclear (Ali 2011:73; Dickert & Kass 2009:[1]). It is often equated to autonomy which is "acknowledgment of a person's right to hold views, make choices, and take action based on personal values and beliefs" (Beauchamp & Childress 2001 cited in Beach et al 2007:693). It is documented in NICE (2008:7) that women, their partners and their families should always be treated with kindness, respect and dignity and also that the views, beliefs and values of the woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times. Respect is a foundational element of professionalism that forms the core of the self-image of most health professions (Leape et al 2012:2). Respect is morally important and is expected in everyday interactions even with health professionals (Dickert & Kass 2009:[1]).

Dignity, respect, courtesy and privacy were used interchangeably in the study. Generally, the participants were consistent about the need to respect the dignity of the client and describe a number of measures that are employed to achieve this objective. The descriptions of how this is understood and practiced are expressed by the following:

'Can you imagine ante-natal, you as a client coming to me, and I will not identify you by your name, how will you feel? Excuse me to say, and I will call you Sister, or Her. If I address you, Auntie Adzoa, it you, you, you know, I draw myself closer to you. You understand? If you have a problem, you open up and tell me your problem. By opening up, telling me your problem, I also have complete access to that information, as to how best I will nurse you. But if I am not nice, I don't give you that kind of respect, as you expect from me, do you think you will open up for me? So respect of the individual, is key. You don't place your values, over the patients' values' (Hp11).

The importance of the statements above shows that respect is reciprocal irrespective of age or status in the community. It can be expressed in different forms including addressing people by their title, showing love and ensuring privacy. Others include non-discriminatory behaviour and assuring confidentiality. These views are in line with findings in the literature. Dignity, just like respect, consists of many overlapping domains such as respect, privacy, autonomy and self-worth and could also be seen as a state, quality or manner worthy of esteem or respect and self-respect (Cass et al 2006:6). 'Dignity in care means the kind of care which supports and promotes, and does not undermine, a person's self-respect regardless of any difference' (Cass et al 2006:6). Respecting the dignity of women is not the responsibility of the care provider alone but the woman herself also has great influence in preserving her own dignity (Morad et al 2013:68). In addition, in a phenomenological study in Taiwan, Kuo et al (2010:452-454) reported that women feel respected when their views and valued are considered and also when midwives tried to fulfil their expectations and got them involved in decision-making. In a study to assess patients' view on what constitutes respect, Dickert and Kass (2009:[3-7]) report attention to needs, empathy, care, autonomy, recognition of individuality, information provision and dignity as key elements.

Irrespective of the recognition of respect, dignity and privacy as key elements in client-centred care, a number of studies report gross disrespect in the provision of childbirth services in many developing countries (Leape et al 2012:5-7; Bower & Hill 2010:3). These disrespectful and abusive behaviour in childbirth include subtle or overt humiliation of women, discrimination against certain sub-groups, non-dignified care, non-consented care, non-confidential care, detention in facilities, abandonment and physical and verbal abuse during childbirth (Bowser & Hill (2010:3-8) and humiliating and demeaning treatment (Leape et al 2012:1). An assessment carried out in hospitals in Ghana reported that in several wards visited, there were either no dividing curtains in place, or at the windows, or one curtain between two beds (Ministry of Health, Ghana 2004:20). The staff reported that they used screens to ensure patient privacy or moved patients from the main ward to a private room to perform clinical procedures. However, on most wards, availability of screens ranged from one screen to twelve patients, to two screens to a total of 48 patients. They also noted that both medical and nursing staff members were observed attending to patients in the full view of other patients, visiting relatives and the rest of the professional team (Ministry of Health, Ghana 2004:20).

Regarding disrespectful behaviour, one participant illustrated one of such disrespectful attitude stating:

'They do, if I said they don't do I will tell lies, they do. Some people shout on them. Because of that shout, some people they are afraid even when they want to tell you something, about their condition or their, they are afraid to tell, that person. But rather if you are nice to them, they would rather call you. Then at times they will tell, why didn't you tell the one on duty or. I'm afraid maybe she would shout on me or something of the sort' (Hp6).

According to Leape et al (2012:5-7), contributory factors to these disrespectful attitudes include: (1) individual endogenous (for example, threat to self-esteem, insecurity, depression and anxiety), and (2) exogenous factors (for example, organisational culture) in the work environment. They argue that, though personality characteristics may predispose some individuals to disrespectful behaviour, for the most part, disrespect is learned behaviour that is supported and reinforced by the authoritarian, status-based culture found in most hospitals (Leape et al 2012:7). The stressful health care environment, particularly the presence of "production pressure," found in many health care organisations, is another major contributory factor (Leape et al 2012:1). Some of the above organisational challenges were described by a participant in this study as inappropriate infrastructure, high workload, inadequate staff and lack of cooperation from both staff and clients. An excerpt from one participant was:

'...let me make this statement first, that it has not been that easy to do that [assure respect, dignity and privacy], especially when you have to physically examine and I'd say that it's been, the assurance has not been good that I'd confess because when we look at even our wards situation, you have patient A here, patient B just next, sometimes you have to whisper, even whispering patients don't actually get it and then you have to probably raise your voice. Sometimes too, I'd say you would have to call the patient and the patient and then speak to him or her in secrecy. In our setting, you'd have to call the woman aside and speak to her in secrecy. Some of them you'd have to whisper and then, let me say...so I'd say that, in terms of assurance, our environment doesn't help at all for instance at the OPD where am giving now, we have probably two doctors or three doctors taking care of patients means there are three patients in the consulting room with just one examination couch. Sometimes you have to

expose a woman in the presence of another woman, the other thing is, but what we do is to avoid getting a male to enter the consulting room, that one we also always make sure we don't have to let husbands or partners follow their wives or spouses to the consulting room. But then, I'd say that every woman should still be protected from been seen from, by another woman because we are in a society where people will carry a lot information about one person to the other so that's the best we can do. We have a screen but I'd say it doesn't serve, it doesn't help, it doesn't help' (Hp17).

As comprehensively defined in Cass et al (2006:10), health care that respect and dignifies people: have a zero tolerance of all forms of abuse; supports people with the same respect they would want for themselves or members of your family; treats each person as an individual by offering a personalised service; enables people to maintain the maximum possible level of independence, choice and control; listens and supports people to express their needs and wants; respects people's right to privacy; ensures people feel able to complain without fear of retribution; engages with family members and carers as care partners; assists people to maintain confidence and a positive self-esteem; and acts to alleviate people's loneliness and isolation. Client-centred care do not only treat the person as a whole, but places importance on understanding the physical, psychological, emotional, and social status of the patients and incorporates this understanding into health intervention planning (Gras 2012:1).

7.4 QUALITIES AND CHARACTERISTICS OF HEALTH PROFESSIONALS

Health workers use a wide range of personal core values in daily practice. Most of these values often are specified in professional codes of practice and organisation's values. Kieft, De Brouwer, Francke and Delnoij (2014:4) report that the participants stated that social skills are an important competency to create a trustful care relationship with clients. The report indicated that correct behaviour and attitude, composure, making time for patients, and listening and having empathy were essential competencies that health care provider should have. Five (5) themes regarding the qualities or characteristics that health workers should have were identified from the data. These were as follows:

- Patience

- Tolerant
- Empathy
- Nice and friendly
- Confidentiality

7.4.1 Patience (N=13)

Patience in general parlance is seen as the state of endurance under difficult circumstances or forbearance when under strain, especially when faced with difficult situations. Health professionals are normally expected to be patient. Bradshaw (1998:438) stated that the attributes of nursing and for that matter the health profession have been outlined in many textbooks and guidance documents since the 20th century. Health care providers should be kind, compassionate and patient, to mention a few.

Majority of the participants in this study felt that it was important that the health professional had patience for their clients. The interviewee below commenting on the significance of patience in client-centred care said:

'Aside from becoming more calm with them clients, exercise more patience, so that they can communicate their feelings. Because one problem I identified was, clients or patients have difficulty in actually communicating what actually is happening to them. So with more patience, I realise that we exercise patience, we can really understand what story they are telling you, so that you can specifically know what is going on with them' (Hp18).

In the view of the participants, childbearing women go through many distressful situations, including dealing with pain, as such, not only must the care provider learn to be calm but being patient is imperative.

The researcher found no published literature to support the above statements.

7.4.2 Tolerance (N=6)

Tolerance and patience were at times used interchangeably by the participants. According to Vogt (1997:1) cited in Van Doorn (2014:3), tolerance is putting up with

something you do not like, often in order to get along better with others. The term is also seen as an attitude which corresponds with a willingness to put up with a person or behaviour that one finds objectionable (Mather & Tranby 2014:513). For one to express the qualities of tolerance, there must first be an aspect of dislike, disagreement or disapproval (Van Doorn 2014:2).

The context within which the term was used by the participants seems to suggest the existence of some unfavourable issues in the work environment with which they have to contend. A quote from one participant was:

'...one thing, one key characteristic, I think everyone must possess is tolerant. You have to be tolerant. You have to be tolerant, you see, no matter how you are. Whether you are quick-tempered, you have to change and be tolerant with your patient. Because if you are not tolerant, I don't think you can have that heart of kindness or the heart to accommodate and all the, anything. A client might not be doing the right thing that you expect him, her to be doing, ok. So if you are not tolerant, you might end up...' (Hp16).

The researcher found very limited literature on tolerance in the health sector. Tolerant or intolerant attitudes and actions at the interpersonal level should be of great importance as they may adversely affect care (Mather & Tranby 2014:513). In a qualitative study in rural Nigeria, Gazali, Muktar and Gana (2012) cited in Holmes and Goldstein (2012:31) found that midwives have little tolerance for traditional beliefs about childbirth such as delivering in a squatting position, women not crying out during delivery, and burying the placenta to ward off evil spirits. The intolerance for these practices often led to frequent conflicts in health facilities. Akum (2013:[5]) also reports that women mentioned patience and tolerance as vital staff attitudes they would expect in their care. It is noteworthy that for the theme 'tolerance' to come up from health professionals as an important quality for staff should engender health managers to critically find ways to support health workers to develop and exhibit tolerant qualities to improve the quality of care for mothers.

7.4.3 Empathy (N=10)

Empathy, sympathy and compassion are related words that are at times used interchangeably (American College of Obstetric and Gynecologist 2011:2). Empathy is defined as ‘a psychological process that encompasses a collection of affective, cognitive, and behavioral mechanisms and outcomes in reaction to the observed experiences of another’ (Larson & Yao 2005:1102). Empathy in a clinical context could be seen as the physician’s ability to understand patients’ emotions, which can facilitate more accurate diagnoses and more caring treatment (Killam 2014). In general terms, empathy may be seen as the ability to put one in another person’s shoes or the ability to understand and accept another person’s feelings and emotion. This quality is required in patient-centredness for one to be responsive to the needs, values, and expressed preferences of individual patients (IOM 2001:48).

The significance of empathy in childbirth service delivery was expressed in the following ways by some of the participants:

‘...you know being a woman myself, at times I put myself in their shoe. And I ask myself, if I were in their shoe, how would I do? Or how, what would I expect people to do for me? I ask that question myself. And then when I’m able to answer for myself, then I continue from there’ (Hp12).

‘...because they are also a human being. So whatever we do to them or say to them, we have to take it. Example, if somebody is doing this to me, will it be fair to me or, so we should, you have to see them as yourself. And no matter what is the situation may be, we have to accept what they would say and take everything by good heart, without bringing any conflict between staff and client’ (Hp19).

Empathetic knowledge is essential in order to get close to the client (Rogers 1979:2). However, the American College of Obstetric and Gynaecologist (2011:1) posits that generally most people do not have the innate capacity to show empathy towards others. To empathise with a client, the health care provider must endeavour to understand the feelings and personal meanings that are being experienced by the client and communicate this understanding to the client (Rogers 1979:2). In other words, it requires the health care provider to have the competence to understand the patient’s situation, perspective, and feelings; to communicate that understanding and check its

accuracy; and to act on that understanding in a helpful therapeutic way (Derksen, Bensing & Lagro-Janssen 2013:e76).

A number of benefits have been associated with health provider empathetic behaviour. The establishment of an empathetic relationship between the mother and health professional has been shown to decrease further quest of care in the postpartum period thereby reducing cost to the organisation (Andrissi et al 2015:10). In their systematic review, Derksen et al (2013:e80) concluded that there is a relationship between empathy in patient–physician communication and this includes: (1) patient satisfaction; (2) adherence to treatment; (3) patients' anxiety and distress; (4), better diagnostic and clinical outcomes; and (5) strengthening of patients' enablement. The majority of clients will recommend an empathetic health care provider to other patients (Vedsted & Heje 2008 cited in Derksen et al 2013:e77). Empathy enhances the health professionals' ability to understand individual patients' unique concerns , life experiences and decisions and allows for medical care that is more effective and acceptable to patients (American College of Obstetric and Gynecologist 2011:2). In stressing the significance of empathy in health services delivery, Guastello and Frampton (2014:2) pointed out that the interaction that happens between health care providers and patients happen at one of the most sensitive and vulnerable times during their life, and when these interactions transpire in a compassionate and caring attitude, it establishes the basis for a trusting relationship.

7.4.4 Nice and friendly (N=12)

The Collin's English Dictionary (2012:237) defines being friendly as showing or expressing liking or not being hostile. Having a friendly personality could be seen as being approachable and kind to people. Some patients perceive being friendly and kind as demonstration of a caring attitude (Emami, Ghofranipour, Ahmadi & Masoudi 2012:47). Friendliness, respect and feeling comfortable are also associated with higher level of satisfaction in health care (Netten et al 2004:28-29)

Most of the doctors and midwives felt that health care providers need to demonstrate a friendly attitude and to be polite to patients. They outlined that the way a client is received, the facial expression of the care provider and the manner of communication goes a long way to make the client feel at home. Some of their comments were:

'...I mean not to talk harshly to your client; you have to be friendly, throughout whatever she does. Even in labour, at times, it's very difficult. How you will receive the client and how you care for the client and how the client will appreciate what you've been doing to her. Like a client comes, your appearance, your facial appearance which would embrace the client for the client to know he or she is welcome at home. And everything that she would do for her, make her feel at home that she is in a safe hands...' (Hp1).

Holmes and Goldstein (2012:7) postulate that just as a friendly, informative and reassuring mannerism can help to reduce the existing fears of a patient, so an uncaring, judgmental or hostile attitude can exacerbate fears and inhibit people from seeking reproductive and maternal health care services, or from benefitting when they do.

7.4.5 Confidentiality (N=10)

Respect for patients' privacy, dignity and the maintenance of confidentiality are long-established principles of health practice since the time of Hippocrates. Privacy and confidentiality have overlapping meaning and are at times used synonymously (Moskop, Marco, Larkin, Geiderman & Derse 2005:53). The rules of confidentiality are grounded in the moral principles of human dignity, autonomy and beneficence (Moskop et al 2005:54). In health care practice, it is generally accepted that a duty of confidence arises when one person discloses information to another in circumstances where it is reasonable to expect that the information will be held in confidence (Health and Social Care Information Centre. 2013:8). Information provided by clients to a health care provider is done in confidence and must be treated as such so long as it remains capable of identifying the individual to which it relates (Health and Social Care Information Centre. 2013:8). The Ministry of Health, Ghana (2013) Health Professions Regulatory Bodies Act 2013 (Act 857), Ghana Health Services Code of Ethics (Ghana Health Service 2002a), the Ghana Health Service Patient's Charter (Ghana Health Service 2002b) and the Ghana Health Service Code of Conduct and Disciplinary Procedures (2003) all provide guidance on confidentiality and indicate the importance of respecting confidential information obtained in the course of duty and how this should be put into practice.

One other thing the participants highlighted was the need for health professionals to possess the quality of keeping issues clients discuss with them confidential. One of such narration was:

'...she was like she doesn't want the husband to know about her HIV status, and the way she said it, so I was like, well it is, though I, personally if I had my own way, the man should have been informed so that he could also come for the, but she said that no, and because of patients' rights or, we said that ok, that's all. So she should decide. And there was nothing I could do about it. I had to put my, my own feeling away and let her have what she, she wanted' (Hp16).

Literature supports the need for confidentiality and privacy in building trusting relationships, especially in a professional setting. Sankar, Moran, Merz and Jones (2003:659) mentioned that effectiveness of treatment requires accurate information and that patients are most likely to provide this information when they are not worried about public exposure. This presupposes that those who receive the information have a duty to protect it from disclosure to others who have no right to the information. Clients, particularly those who obtain services in secret, report higher satisfaction with providers who keep their needs and personal information confidential (Whittaker 1996:443). Another study in childbirth found that women are more likely to feel respected when they see that information is kept confidential (Morad et al 2013:69). Creel et al (2002:5) also noted that in some places, obtaining and using contraceptives can be a difficult and risky decision at times leading to abandonment, violence, ostracism or divorce, necessitating women to have the assurance of absolute confidentiality.

Assuring confidentiality facilitated the development of trusting relationships between health professionals and clients (Hall & Van Teijlingen 2006:9). Confidentiality consideration was associated with choice of place of birth in a study by Phiri et al (2014:[6]). Their findings noted that women and their husbands greatly valued the maintenance of privacy and confidentiality in health facilities and saw it as an advantage over home delivery. The report indicated that clients felt that there were many people around during delivery at home and such people go discussing their experiences. The women felt that it was shameful to have their birth experience discussed by others outside the delivery environment (Phiri et al 2014:[6]). Similar observations were made by Bhaskar, Koumousidis and Vause (2013:3), who indicated that mothers were

sensitive to other patients hearing discussions about them due to close living in hospital wards. Ford, English and Sigman (2004:1) underscored the need for providing confidential health care especially for the adolescent as the lack of it may hinder some of them from accessing health services.

The right of the individual in a health facility is not limited to only self-determination or autonomy, but also extend to information about themselves, their lifestyle and health, including the right to control who knows about things that they regard as integral to their sense of self and sense of identity (O'Brien & Chantler 2003:36). Despite confidentiality being a basic professional responsibility, there are instances where this can be bridged to protect the patient, protect others or obey the law (Moskop et al 2005:55). Nevertheless, the practice of confidentiality is not without challenges. The design of health facilities and the need to work in teams may greatly hinder the process. Health professionals should thus be mindful of these in their practice.

7.5 ORGANISATIONAL FACTORS THAT INFLUENCE IMPLEMENTATION OF CLIENT-CENTRED CARE

Epstein et al (2010:1492) suggest that effective implementation of patient-centred care does not depend on only having an informed and involved patient and family; equally important encapsulate receptive and responsive health professionals and putting in place a well-coordinated and well-integrated health care environment that supports the efforts of patients, families, and their clinicians. In addition, in their report on the patient-centred care in low-resourced countries, Silow-Carroll et al (2006:5) indicated that certain institutional structures and processes are essential for supporting implementation of patient-centred activities. These include: top management and department heads commitment to patient centredness and acting as role models; workforce development; and institutionalisation of systems to measure and provide feedback to staff, patients and families. This view is supported by Morgan and Yoder (2011:6) who note that within the health care environment, the antecedents that create a person-centred organisational climate include: vision and commitment of leaders; good organisational attitudes and behaviours; and shared governance.

The participants were requested to comment on the organisational factor that facilitated the implementation of client-centred care. The themes that emanated from the analysis of the data were:

- Leadership influence
- Training
- Guidelines
- Provision of resources
- Monitoring and feedback

7.5.1 Leadership influence (N=17)

Frampton et al (2008:41) argue that leaders determine, guide and communicate the vision of any organisation, and as such, leadership engagement in any organisational culture change initiative is crucial in setting the tone for the implementation of patient-centred care. Discussion on this theme tended to express what participants felt about the personal roles that leadership of health facilities played in promoting client-centred care. Two participants had this to say:

'...sometimes during our meetings with our DDNS she talks about client care, like everything that we do, it should be for the benefit of the client. But on specifically on client-centred care' (Hp6).

'Recently, the DDNS talked to us about it. Management discussed about staff relationship with clients and clients first at durbars' (Hp2).

Though the management occasionally discussed client-provider relationship issues, deductions from the comments of participants showed that no systematic approach was adopted towards institutionalising client-centred care. Client-centred care which is seen as a new way of providing service requires all the efforts necessary to facilitate its adoption. Greenhalgh et al (2004:607) posit that visionary leadership, clear strategic vision, and an organisational climate or culture conducive for experimentation and risk taking are required in institutionalising client-centred care. It may even require the use of influential persons or champions to precipitate interest and formation of positive attitudes for behaviour change (Dearing & Kreuter 2010:103-108). Manley, McCormack

and Wilson (2008:9) cited in McCormack, Dewing and McCance (2011:4) defined such as system as: 'a continuous process of developing person-centred cultures. It is enabled by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. The learning that occurs brings about transformations of individual and team practices. This is sustained by embedding both processes and outcomes in a corporate strategy. McCormack et al (2011:4) further explains that developing a health care system to offer client-centred care is a facilitated activity that focuses on helping individual clinicians and teams to understand the context in which they work and the characteristics of that context that may prevent them from practicing effectively.

It can be observed from the above that limiting the engagement of staff on client-centred care to discussions at staff durbars may not have the desired impact. The most consistent perspective that emerged among the participants interviewed was that, not much has been done by managers at the top to make client-centred care work in health facilities. One explanation of this finding could be the divergence between policy and practice that is often observed in many health systems as a result of weak governance and lack of organisational sustainability. Manley et al (2011:35) highlight the fact that many health care organisations and governments often articulate an intention to deliver person-centred care, but instituting measures to achieve the intention is often challenging. To succeed in this direction requires specific knowledge, skills and ways of working, a shared philosophy that is practiced by the health care team, an effective workplace culture and organisational support. This was affirmed in McClellan, McKethan, Lewis, Roski and Fisher (2010:989) who said that, achieving major lasting changes will not come easy, and that effective health reform requires real and significant changes in health care delivery as well as leadership from physicians and other providers at all the levels. In a study on implementation of client-centred care, Barnett et al (2011:[7]) concluded that the role of senior and top management is critical, since they hold financial support of the initiative, and thus its sustainability and success are often contingent upon their decisions. Bamm, Rosenbaum, Wilkins, Stratford and Mahlberg (2015:9), Martin et al (2012:197-198), and Morgan and Yoder (2011:6) all underscore the significant effect that transformational leadership and appropriate organisational culture has on implementation of client-centred care.

7.5.2 Training (N=19)

It is a well-known fact that quality health care is very dependent on the knowledge and skills of health workers (Negandhi, Negandhi, Sharma, Wild, & Zodpey 2015:[10]). In a report on the implementation of patient-centred care in low-resourced countries, Silow-Carroll et al (2006:5) indicated that workforce development was one of the essential institutional structures and processes for supporting implementation of patient-centred activities. The issue of training came up in all the interviews, especially during the discussion on how participants got to know about client-centred care and how prepared they were in delivering such a care. The results showed that majority of the participants had no formal training on client-centred care after graduating. Only a few mentioned that they attended a workshop on customer care or other workshops at which issues on how to handle clients were mentioned. These workshops took place within the past three years. Comments such as the following were made on how they got to know about client-centred care and the training sessions attended:

'...get to know about client centred care in school and at times workshop on customer care' (Hp4).

'...went for a workshop on focused ante-natal and that is how come I got to know about the...but have not had any specific training on client centred care or client focused care, no...' (Hp11).

'...got to know about it through training, workshops and then short, short presentations' (Hp15).

The customer care programme was introduced by the Ministry of Health, Ghana in 2009 (Ghana Health Service 2009a:14). The major component of the programme was to train all health workers so as to imbibe in them quality customer care attitudes that will ensure that customer care became an integral part of service delivery. Training manuals and posters were developed to train and create awareness nationwide. It cannot be said whether this was successfully done or not as the researcher did not come across any assessment of the impact of the programme in the literature search.

The findings of this study indicated that components of client-centred care were often incorporated in other health training programmes, but not addressed holistically as a package. As well, not all health workers benefited from such trainings. Gordon and Watts (2011:35) stress the fact that nurses and for that matter, health care workers have a pivotal role in ensuring that patients receive safe, effective client-centred care, based on the best available evidence. The ability to apply a combination of technical expertise, clinical reasoning and evidence appropriate to a range of health care settings do not happen overnight but develops over time through formal teaching, experiential learning, effective mentorship and reflective practice (Gordon & Watts 2011:37).

Observing that majority of the participants did not receive formal training indicated that more attention needed to be paid to building competencies in client-centred care. Although the concept was thought as part of the training programme of many health training institutions (Ferguson et al 2013:283), it is generally known that only few professionals received sufficient appropriate and effective training in client-centred care subjects during their pre-service training (Innes et al 2006:51). Furthermore, while managers and other care providers may possess some knowledge on how to provide care, few of them have skills that can systematically be applied to improve the patient care experience (Shaller 2007:18).

7.5.3 Guidelines on client-centred care (N=19)

Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances (Field & Lohr 1990:38). To effectively put client-centred care principles into practice and lead the change process, health workers need guidance that are specifically outlined in documents such as policies, guidelines, standard operating procedures and protocols. It is noteworthy that many international organisations, nations and institutions such as the Registered Nurses' Association of Ontario (2015), Bender (2013) and Frampton et al (2008) have developed evidence-based practice guidelines to support staff and users alike in service delivery. The WHO people-centred health care policy framework (2007:10) for the West Pacific Regions also recommends the incorporation of the values of people-centred care in professional codes of conduct, workforce development strategies and regulatory policies.

All the participants discussed issues on availability of guidelines but only a few stated that they have come across some documents that contained issues on how to make services client-centred. Some of the responses were:

'Guidelines? Aside something like the patient rights, aside that one there's I don't have that one. Unless you go online to browse for some information, before you get' (Hp15).

'I think it has to do with the protocols or procedures you adhere to during the care you give to a client and even some pictures of the ante-natal booklet give you a clear cue of how you go about things' (Hp12).

'...the Safe Motherhood protocol, I think these things are added to it .You know, it's very useful. And you know to be frank to you, it guides us mostly to take care of our clients, in the hospital and it's a protocol that gives you at least directive as to what to do when you see a particular condition' (Hp18).

Guidelines development and updates to address client-centred care are still sub-optimal with many of them focusing on clinical aspects of diseases instead of ensuring more integrated care for patients (Beejen, Hilbink, Nelen, Wiersma, Burgers, Kremer & Hermens 2014:1-2). The participants in this study obtained information on client-centred care from different guidelines documents on maternity care and service delivery, suggesting that components of client-centred care were included in those documents. The challenge though was that these documents seemed not to have comprehensively covered the needed knowledge and skills for client-centred care. This finding is supported in Belizan et al (2007:850) and Grol and Grimshaw (2003:1225) who report that practitioners obtain information from various formal and informal sources such as: clinical guidelines, journals, electronic sources like the internet and from peers.

As to the usefulness of the documents mentioned, one participant said:

'It helps also in auditing our near misses cases. If you have a case that had almost died and you were able to save that client, you can go through the guideline and see what you did. That is why you were able to save the client. So I think the Safe Motherhood protocol, has helped a lot and I think it is helping us in our client centred care...' (Hp18).

The participants that had access to the above-mentioned document found them useful. However, the findings on effectiveness of guidelines have been mixed in the literature. For example, while Miles (2010:117) noted that the development of guidelines was of significant use in fostering people-centred approaches to care, Farmer et al (2011:10) stated that the use of printed education materials such as guidelines in itself was often not very successful in improving practice. Some users even found these materials too long and at times complex or too impractical for use (Weiner et al 2007:S43). As it has been demonstrated in this study, people still have different ideas about what client-centred care is and what it takes to implement, especially for a developing country like Ghana. Providing specific recommendations to guide implementation may go a long way to help the system. Beejen et al (2014:9-10) recommend that a broad stakeholder consultation and involvement, including intensive patient engagement is required for developing these guidelines.

7.5.4 Provision of resources (N=8)

The quest for high quality care has put too much strain on the resources of many institutions. The DNV GL and Sustainia (2014:125) acknowledge that the initial steps in implementing client-centred care will require substantial investments. In the developed world, enough investment went into infrastructural development, information technology diffusion, payment reform, education and training of the workforce, and establishing collaboration networks (Nielsen, Langner, Zema, Hacker & Grundy 2012:5). It is common knowledge that many developing countries may not be able to meet such huge investments but could still institute measures to improve the patients' experience. Some of the views of participants on the provision of resources to enhance implementation of client-centred were:

'...the area that we are doing our deliveries; there are more equipped than former. Formerly, there was none, no items, I mean they items I may say the midwives are not enough to care, to manage the area. But this time, we rare enough that we have been managing, handle them' (Hp1).

'...some of the things that were not in place, management has been able to purchase them. So, it also makes the work...' (Hp8).

'You know in the past, we had so many deficiencies in terms of things we would use to, especially when it comes to maternal and child mortality and things to improve the care of mothers. Gradually, I think we've, we've passing through those stages' (Hp14).

Generally, the participants felt that the resource situation has improved but more still need to be done. Ensuring that staff have the resources they need to provide patient-centred care is of utmost importance if the programme is to succeed (Frampton et al 2008:41; Barnett et al 2011[9]). The general impression from the study was that though efforts are being made to provide resources, many of the equipment and supplies needed are not readily available. In addition, the participants mentioned a number of challenges or barriers which were discussed under the theme on organisational barriers. However, this resource constraint situation is not peculiar to Ghana. In their study, Willis-Shattuck, Bidwell, Thomas, Wyness, Blaauw and Ditlopo (2008:[5]) report that hospital infrastructure and resource availability were seen as very important by the participants in the study they conducted and the lack of these was an important demotivating factor in implementing health programmes. Another study to assess implementation of health sector reforms in two developing countries also noted that resource constraints were factors that hindered implementation (Ssengooba, Rahman, Hongoro, Rutebemberna, Mustafa, Kiehmann & McPake 2007:12).

7.5.5 Monitoring and feedback (N=16)

Jayadevappa and Chhatre (2011:22) and Epstein et al (2010:1493) argue that though there is a widespread interest to adopt patient-centred care to improve quality of care, till date there is no consensus on how best to measure and report patient-centred care performance. However, the OMA (2010:34-37) indicates that client-centred care can be measured from different perspectives (service users, direct health care providers and health care managers) and that measuring client-centred care from the different perspectives are important because different stakeholders tend to be selective in the emphasis that they put on the different dimensions of care. For example, while effective integration of care and access are important at the organisational level, at the health professional and patient levels, effective communication between provider and patient and issues related to shared decision-making process are key measurement aspects of

care (OMA 2010:34-37). The position of Hudon et al (2011:156) was that measures of the patients' perceptions are more successful at predicting client-centred care outcomes. In all of these, Shaller (2007:11) maintains that a major factor contributing to patient-centred care is the presence of a robust customer-listening capacity that enables an organisation to systematically measure and monitor its performance. In other words, there should be a system to continuously monitor the impact of specific interventions and change strategies in a patient-centred health care system. The value of such measurement and feedback lies in using them to design and implement specific interventions or processes to improve the patient experience.

Though the participants in the study mentioned some monitoring systems such as peer reviews, client complaint system, client satisfaction surveys and records review, on the whole, it was evident that they were not actively involved in such activities. Majority felt that there was very little documentation of any monitoring activity and dissemination of findings, if any, was poor. Client feedback mechanisms were mainly verbal and at the individual client-provider interaction level. One participant articulated that:

'...sometime ago, there was this form around that every client that comes in, most especially for those who go through Caesarean section. After the C-section or before they are going home, before they go home, those who can read we give to them, it's in a form of an interview question and then what, how care has been delivered to them and then so far, the comments they think should be like things has to be put in place. There was this going on and at appoint in time, they stopped because we couldn't get much information from that place. We don't know who was taking the papers and then how the papers would be evaluated and the rest...' (Hp12).

These findings are supported in Michalopoulos et al (2012:661) who after interviewing health workers on monitoring and feedback systems for a family-centred programme reported that overall, there was a general sense among child welfare workers that feedback was inconsistent. In their report on patient-centred care in low-resourced countries, Silow-Carroll et al (2006:5) indicated the lack of institutional structures and processes for monitoring and evaluation and also noted that the establishment of systems to measure and obtain feedback from both clients and staff was imperative.

Measurement is central to informing and supporting service quality improvement as well as improving resource allocation and making health care organisations accountable to the public. According to Ahmad, Ellins, Krelle and Lawrie (2014:7), monitoring data is required to sustain engagement with clients and policy makers; staff wants to know that the effort they are making to implement change is making a difference; and most importantly, measuring performance and effectively disseminating results in itself can trigger behaviour change through harnessing healthy competition. Health care organisations should put in place scientific evidence-based and standardised measurement and reporting systems that can enhance comparisons within and across organisations and practitioners (Shaller 2007:20). Client-centred childbirth data on inputs, processes and outcome should be tracked, benchmarked and used to improve quality of care.

7.6 CONTROL OVER DECISION-MAKING AND INFORMED CHOICE ON KEY ATTRIBUTES OF CLIENT-CENTRED CHILDBIRTH

Respecting the needs and preferences of women is a key attribute of client-centred childbirth (Jamás et al 2011:697; William et al 2010:619). Women should have control over the decision-making processes and should also exercise informed choice. Women having control over decision means: being given information about why particular actions are crucial; being involved in decision about all aspects of care with information on the whys, how and when; being given opportunity to choose among available options; and having the right to refuse specific treatments (Martin & Robb 2013:2). Choice can also be seen as an act which requires intimate connections between reason and rationality, a weighing up of risks and benefits and an ordering of preferences based on their utility (Allingham 2002 cited in Snowden et al 2011:[1]). Care providers (doctors and midwives) occupy a sensitive place especially in the exercise of control over decisions and informed choice. Therefore, it is important to understand care providers' views on these issues as the country moves forward to make services client-centred.

The participants in this study were requested to share their views and experiences regarding women having control over decision-making in childbirth as well as promoting informed choice in the following aspects of care:

- Place of birth
- Birth attendant
- Mode of birth
- Birth position
- Labour support person or companion
- Pain management
- Length of stay after delivery

Three themes were derived from the discussion regarding women having control over decision-making. These were:

- Shared decision-making
- Decision must be taken with husband or family
- Health professional dominance in certain situations

The discussion on the themes was undertaken in the context of the above childbirth areas examined for informed choice.

7.6.1 Shared decision-making (N=19)

Bernabeo and Holmboe (2013:251) maintain that existing models of patient involvement in health care decision-making can be arranged on a continuum with one extreme being the outmoded paternalistic model, in which the clinician makes decisions with little or no input from the patient and at the other end, patients taking decision fully. According to Bernabeo and Holmboe (2013:251), shared decision-making is somewhere in the middle of this continuum. Others like Coulter and Collins (2011:2) defined shared decision-making in the clinical area as a process in which clinicians and patients work together to clarify treatment, management or self-management support goals, sharing information about options and preferred outcomes with the aim of reaching mutual agreement on the best course of action. The process involves providing clients with reliable evidence-based information on the likely benefits and harms of interventions or actions, including any uncertainties and risks, eliciting their preferences and supporting implementation. The care providers in this context brings to the table expertise in areas such as prognosis and treatment while the patients come along with expert knowledge

on how the condition impacts on their daily life, their personal attitude to risk, values and preferences (Coulter & Collins 2011:3).

All the participants expressed the view that decisions in childbirth should not be the responsibility of the health provider alone but the client must be actively involved. The quote below represents views demonstrating shared decision-making from the perspective of the doctors and midwives:

'That is her health it's her reproductive right you can't take it away from her. Let's say her reproductive right that one cannot be taken away from her. So let's say for instance you want to do, perform Caesarean section on the woman and she says no, I won't. You, you just counsel. Do your best to counsel her to understand why you want to perform the Caesarean. If she still doesn't want to. The only thing you do is refer or maybe you get in more, opinion leaders or people more stronger in counselling than you to do the counselling. If not then you just explain to her the consequences of her actions. You, you don't have to force them to take your choices. It's their choice. That is the choice they are making. Yours is to just hammer on the consequences that are coming along with the decisions that they take' (Hp17).

Though these quotes implied that the participants were in favour of women taking the final decision, the tone and choice of words seemed to suggest that a client could be pressured to concur with the decisions of the care providers. Indeed, the content of one of the quotes did indicate that a client could be referred (even discharged) for not heeding to the advice of the professional. Colonge, Laube, Cox, Damus, Jevitt, King, Labbok, Leslie, Lothian, Myers and Osborne (2010:1) state that shared decision-making is a competency domain that requires specific knowledge, skills, and attitudes on the provider's part to engage a patient. Care providers apply these competencies through a series of behaviour and activities with patients, such as assessing patients' preferences and uncovering important psychosocial factors that either facilitate or impede effective decision-making. The context of shared decision-making process regards the partners as equals. Nevertheless, this appeared not to be the case in this study. The impression created seemed not to portray the understanding that women were regarded as equals with adequate knowledge base for making their childbirth decisions. There was frequent use of the phrase 'we tell them' and 'they don't listen' as if the women were being instructed. Colonge et al (2010:1) caution that though current approach to providing

childbirth services places the decision-making responsibility with the woman, the care givers approach will have a tremendous influence on how informed and educated the woman becomes in making decisions and what she actually receives.

According to the participants, the major challenges to shared decision-making were: poor literacy and low educational level; financial issues leading to overreliance on husbands to take decisions; inadequate time for discussion as a result of high workload and inadequate staff; and lack of cooperation from clients. See excerpt below:

'Sometimes when the clients come and then they are not willing to, ready to accept what we tell them to do, we find it difficult to come together and then give them the necessary care that we're supposed to give' (Hp18).

Irrespective of these observations, the findings of the study were consistent with the results in Kruske, Young, Jenkinson and Catchlove (2013:3); that the majority of the doctors and nurses agreed that the final decision must be taken by the woman. In a study on facilitators and barriers to provision of humanised care in Japan, Behruzi et al (2010:[11]) reported that health professionals seemed to agree that women should be offered choice, they should be allowed to participate in decision-making and should be provided with enough information, but in practice this was not the case. In addition, Behruzi et al (2010:[11]) indicated that the women in the study felt that decisions were greatly influenced by those of the care providers. After a systematic review of the literature on health professionals' perception on shared decision-making, Gravel, Legare and Graham (2006:4-5) reported that time constraints was the most often cited barrier for implementing shared decision-making. They also stated that some patient's characteristics and lack of resources as some other factors that hindered implementation.

7.6.2 Decision must be taken with husband or family (N=5)

Creel et al (2002:1) noted that in many parts of the world women do not have the decision-making power, physical mobility or access to maternal resources and may need their husbands' permission to seek health care. This observation appears to be prevalent in many low income countries and communities, where the impression is often created that most women cannot actively participate in collaborative or shared decision-

making process due to factors such as low literacy (Conway, Johnson, Edgman-Levitan, Schlucter, Ford, Sodomka & Simmons 2006:12). The interviewee below appeared to agree with this view:

'...I don't think they [women] have a singular decision, singular control over it. Because, women that come, others there is a man, there is a family. And delivery in our Ghanaian culture, family as a whole is part of the birthing process. So taking a decision, I think we should the husband or the man involved in the pregnancy and then the family should be involved in with, in making decisions. She can't come out with a singular decision to say do this, do that. Yeah, it is not left for the woman alone to make the decision other than the family members and the husband should...and when it is life threatening, you can stand in to take care of the decision. But at least I think you should; there should be a relative involved' (Hp6).

The participants in the study suggested that the husband or family should necessarily be involved in the decision-making process. According to them, this was especially imperative when the decision related to major clinical procedures such as Caesarean section or termination of pregnancy. The participants cited several instances where husbands were to be consulted in order for the women to accept clinical procedures. The participant also noted occasions when the need for consultation led to long delays. These views give credence to the findings observed in the earlier session on attributes of client-centred care that discussed involving client and family in care. The pros and cons of involving families were also discussed under that section. Client-centred care acknowledges the family as an integral part of every individual (Anjum 2014:611). The insistence on involving husband and family in major decisions could be because childbirth is a sensitive area and the choices made affect not only the woman (AWHONN 2012:152), but that of the family as well.

7.6.3 Health professional dominance in certain situations (N=11)

Noseworthy et al (2013:e44) point out that the traditional paternalistic method of decision-making still exists in health care settings. Some of the participants in this study expressed views that demonstrated health worker dominance in the decision-making process. The doctors and midwives often cited issues of safety, lack of logistics or lack

of skills, mother's lack of knowledge and non-availability of certain services for refusing requests. The sentiments of two participants were:

'...we can also decide something else which will be different maybe from what they've decided to do. If they decided something and it's not good, we need to let them understand. So whatever we know, we will also express it to them. So it not allowed that they should take control over everything' (Hp7).

'...woman having choice for birth position? It will help but very difficult for the health care providers. Because we don't have the equipment and the space for all those, it's not, we haven't made provision for all those, the positions. Only the lithotomy position that is made provision for. So if only they had made provision for, it would be easier. But now, it would not be easy actually for the service provider' (Hp13).

A number of research reports support this finding. For example, a study in South Africa reported that the approach during childbirth was characterised by limited participation of women, limited involvement in decision-making and information sharing, a proliferation of practices that fostered dependency and authoritative approach to care (Maputle & Hiss 2010:8). Another study observed that many women placed themselves in the hands of midwives and allowed midwives to make decisions for them, even when their own wishes were neglected (Bluff & Holloway 2008:308). Elwyn et al (2013:208) and Oduro-Mensah et al (2013:3-10) observed that health professionals often gave a number of reasons, including lack of logistics, to justify paternalistic approaches to decision-making.

7.6.3.1 Views on choice of place of birth

In principle, all the doctors and midwives in the discussion indicated that women should be allowed to choose where they want to give birth. Of course, the decision on where to go for ante-natal care was taken before the women met the health professionals. The results showed that issues of place of delivery were not routinely discussed at the antenatal stage. The assumption was that women would deliver at where they attended ante-natal care.

The most consistent perspective among the participants was that woman should be allowed to choose so long as the birth would take place in a facility where the delivery would be supervised by a trained health professional. The view below explains this fact:

'For me, I'd say, with the exception of home deliveries and the delivery, I find it acceptably for you, for any woman to make that decision. Home delivery, because it's poorly supervised and any complications could be, could endanger the woman's life. However if home delivery is supervised by a qualified midwife or health personnel who can, who is trained in the proficiency, to manage those complications or anything. Or recognise them early enough to say that lets to go the hospital; I personally, don't have any problems. Otherwise than that, I would have any problems saying that, for a patient to say that this where I want to have my delivery. Yes, so with the exception of home' (Hp17).

To the participants, home delivery is unsafe, it is associated with numerous complications and providers of such services may also not have ready access to medications, ambulance and other hospitals services when complications develop. Another reason for frowning on home birth was explained by one participant as *'...now because of maternal mortality, any maternal death in the locality is held against the hospital and even the political head of the district and portrayed as poor performance' (Hp18)*. For these reasons, health professionals often felt obligated to ensure that women delivered in places where they could be assured of safety, thereby limiting choice.

The following studies support these findings. Olsen and Clausen (2012:15) report that in spite of emerging evidence demonstrating positive outcomes for either planned hospital or planned home births for low-risk pregnant women, the choice of where to give birth is often limited by the assumption that birth outside the health facility is not safe. This sentiment was echoed in Sjoblom et al (2012:e13-15) who stated that the decision to deliver at home, even in some developed countries is often met with negative reactions relating to fear for life and death, irresponsibility and self-centredness even by some close relative and friends. This attitude is also prevalent among some health professionals who deem home birth as less safe (Vedam et al 2012:604). A study on informed choice in terms of place of birth by the Royal College of Midwives (2011b:11-20) among midwives highlighted the need to dispel this concern among health

professional and also reported that the midwives that participated in the study felt that women were not given enough information to make a choice. The midwives particularly described the lack of promotion of home birth amongst their colleagues as a major setback and felt that it was important to train staff specifically on how to promote home birth.

7.6.3.2 Views on choice of birth attendant

Closely linked to the place of birth is the choice of birth attendant. The discussion on birth attendant was limited to the choice of the health professional that conducts the delivery for the woman in the health facility. Unlike the general acceptance on choice of place of birth, varied views were expressed on promotion of choice of birth attendant. The participants were of the opinion that choice of birth attendant was not a normal practice in the country, though occasionally some women do request for specific midwives to conduct their deliveries. The following expressions of misgivings were noted: it is impractical due to the shift system and how work is organised, it could lead to conflicts in the work place; and may put pressure on some few staff that are hardworking and nice. To some participants, the promotion of choice of birth attendant in health facilities is contingent on having adequate number of staff. The following was one of the views expressed:

'Yeah, it's, it's, it's it happens at times but we allow them. Maybe she may come, she will be at the triage and the midwife will attend to her. It depends on the way you interact with her. She would gain confidence in you than somebody. Maybe you came on a shift and you are about closing and she was full, so you handed her over for somebody. She will say I will love this person going, so deliver me. Quickly I will call the person and say the client says you will stay, it's not bad. Just stay on, and she does that. That's what will make her happy...' (Hp4).

The right to choose who to conduct a birth as have been outlined is not an established procedure in health facilities. The researcher did not identify any local practice guidelines on the subject. However, promotion of choice of birth attendant could be incorporated as part of promotion of continuity of care and as part of the implementation of the focus ante-natal care. Health care providers could still determine the preferences

of women and discuss the options available to make childbirth services more client-centred.

No literature was identified to support this finding.

7.6.3.3 Views on choice of mode of birth

Women can give birth per Caesarean section, spontaneous vaginal or assisted vaginal delivery. The method chosen is dependent on the options available, preference and to some extent the condition of the woman. It is stated that many women in developed countries prefer Caesarean section (Karaku & Sahin 2011:61), while vaginal delivery appears to be the most preferred mode of delivery in many developing countries such as Ghana (Danso et al 2009:30).

The discussion on informed choice related to the mode of birth generated similar responses as was found on choice of birth attendant. On the whole, majority supported the fact that women should be given the choice. In practice, the options were neither routinely discussed during the pre-natal stage nor during labour. On few occasions, the discussion on mode of birth came up when the mothers' health status or history of previous deliveries leads the care provider to contemplate Caesarean section. There were instances also where pregnant women brought it as their preferred choice. Spontaneous vaginal delivery (SVD) was the predominant mode of birth. Most participants describe SVD as the 'normal' mode known to and preferred by most women. The findings showed that many more women were requesting for Caesarean section, but it is not uncommon for a request by a woman for Caesarean section to be denied. Some of the expressions on these views were:

'In the Ghana Health Service, what we normally know is the normal delivery, but nowadays, I have heard some of the clients saying as for me I like, as for me when I'm in labour, I will like them to operate me. So, I think Caesarean section is too, is becoming too much. So we shouldn't allow it. If the one can deliver normally, we should allow her to deliver' (Hp7).

'No. some people, sometimes when they opt for Caesarean section, we don't allow. Yesterday like this, there was a woman who opting for Caesarean

section and there's she had, she is gravida 3 para 2. The first one by CS, she delivered a second one by herself. Then the third one she said she wanted CS, ok. We should call doctor for her, but we told her she can deliver on her own. But she said no, she doesn't want to deliver. But we didn't grant that request that she said she wanted to see doctor, so early in the night. She got into labour in the night and she was still insisting that we should call doctor. Because, she doesn't want to deliver on her own. But the midwife said she didn't mind her when she was saying we should call doctor, because when we examined her, we realised she could make it. And finally when she delivered. So most at times, their requests, when we assess them and we realise they can make it, we don't give in' (Hp15).

A number of explanations and reasons were put forward for this state of affairs. These included: high workload; inadequate number of health professionals, especially medical officers; lack of logistics; the theatre is not ready; it is the doctor that will decide; the mothers can deliver on their own; and we are working according to the protocol. Since the choice of mode of birth was not normally discussed during the prenatal stage, women desiring other modes of birth aside SVD made their intention known during labour and these often generated conflicts between care providers and clients. The major indication for Caesarean section was concerns for the safety of women and baby. One participant noted that the position of the Ghana Society for Obstetricians and Gynaecologists on the primary indication for Caesarean section has not been approved. For that matter, medical officers often use their discretion on such issues.

The literature supports the finding that the choice of Caesarean section may not necessarily be a preference for the woman, but rather, a choice for safety and perceived higher quality of care (Gamble et al 2007:337). The finding that the decision of the health professional could override that of the woman for safety reason is also supported in Kruske et al (2013:4), where health professional's decisions prevailed over those of women. In terms of performance of caesarean section on maternal request, the American College of Obstetricians and Gynaecologists Committee on Obstetric Practice indicated that it is safe to carry out Caesarean section on maternal request but this should not be performed below the gestational age of 36 weeks and it is also not recommended for women who will want to have more children (American College of Obstetricians and Gynaecologist 2013:3). It is imperative to have local guidelines, but practitioners can also learn from the international perspectives.

7.6.3.4 Views on choice of birth position

There are different positions that a woman can assume during childbirth. The Royal College of Midwives (2011b:3-4) in a study on midwives practices on birth position enumerated as many as 10 different positions that the midwives used. These included lithotomy, lateral, supported standing, sitting on a ball, leaning forward on a chair, on all fours on the floor, squatting, leaning forward or kneeling on bean bag, on the bed (semi-recumbent) and in the pool of water (water birth). Literature indicates that women who assume upright position during the first and second stage of labour experience less interventions, report less severe pain and have increased satisfaction with their birth experience (Priddis et al 2012:104).

As it was observed in the previews sections, though the doctors and midwives felt that women should be allowed to make a choice, they also noted that under the current circumstances, it would not be possible to offer these choices. There appeared to be consensus among participants that in Ghana where the normal position for birth was the Lithotomy or dorsal position. Statements like: *that is the normal position; we do not have the convertible bed; we do not have enough space; the facility is not designed for that; that is what we were thought in school; that is what the mothers know; it is the safest; it is not only done in this hospital* and many others were given for not empowering women to choose the position they may prefer. Some participants stated that women who deliver in the squatting position often get perineal tears. It was evident that very few women request to use other positions such as the squatting, but that often was a difficulty for the participants. There were some interviewees who cited health challenges for not conducting delivery in the squatting position. One participant said;

'Well, the normal position we all use is the lithotomy position. Lying prone and delivering, but I, I, really, well I haven't tried the other modes, standing, squatting, so I don't know what goes into those ones, because it is the normal ones that I know. And that's the normal one we all know. So...since I started medical school, I started practicing, I have never. The squatting some, occasionally, you see a patient coming in the second stage and baby is already coming out. And then you see them, they squat or we even tell them to lie down, because sometimes, standing the baby can just drop like that' (Hp18).

There were some views that were not in line with current evidence on birth position. For example, one participant stated that the upright position was dangerous for delivery.

'No, we shouldn't, because some of the positions are not good for delivery. Especially if the woman is squatting, it is difficult for the care provider to deliver her. And even when she squats the baby can drop on the floor and get hurt. I, with I have not, we've not been trained after school. But in school, we were so once in a while when some of the clients decide that we do it for them' (Hp3).

Priddis et al (2012:104) state that many women in both developed and developing countries are still giving birth in the recumbent positions in health care facilities contrary to evidence that demonstrates positive outcomes of the upright position. However, the Royal College of Midwives in a study in 2010 reported that majority of the deliveries that were conducted by midwives in their study were in the upright position category, an indication that the midwives were basing their practices on the current evidence-based practice recommendations (Royal College of Midwives 2010:5-6). Other international organisations also recommend the upright positions (Coalition for improving maternal services (2007) cited in Priddis et al (2012:104). The findings on the birth position in this study calls for a more comprehensive study on the subject to better understand the philosophy of care providers and factors hindering care providers from adhering to recommendations on the upright position.

7.6.3.5 Views on choice of labour support person or companion

The relevance of having a labour support person with a woman throughout labour is well documented (Hodnett et al 2012:3). The support needed in childbirth include: emotional support; information about labour progress and advice regarding coping techniques; comfort measures; and advocacy to help the woman articulate her wishes to others (Hodnett et al 2012:3). Women who receive continuous one-to-one support are more likely to have a spontaneous vaginal birth; less likely to have intrapartum analgesia or to report dissatisfaction, have shorter labour and are less likely to have other birth interventions such as Caesarean section, instrumental vaginal birth or regional analgesia (Hodnett et al 2012:15). A study in Ghana supported this fact that

care and companionship during labour and delivery are highly cherished and valued (Akum 2013:[5]).

The quote below clearly portrays the findings on the aspect of informed choice regarding support in labour:

'I strongly, I strongly think it should be [women should be given the choice of a labour companion], because sometimes you just need someone to make you feel loved. To make you feel like you are not going through the pain alone. I think it helps a lot...but here you see patient screaming, and how many midwives do you have per patient. The ratio is very, very. I mean the gap is very, very wide. So, you can't have every one midwife per client. So if they have a companion, may be a mother, a brother or a sister or their spouses, I think it would be good. And it would help. At least psychologically, it makes them feel like they are not going through all that. So I think it should be promoted. In this hospital, I really can't tell why it's not being practised. And even the space, even the surrounding. Our labour wards are not so like you know conducive to even bring more people in, because infection and all that, so, the space, the space is very limited. If everybody should come in with a companion, it would be crowded...I mean I don't know how realistic it is, but ...maybe if it's only one per room or cubicle. So at least it's well covered and well shielded. But here is the case that everybody is seeing. This patient is seeing the next patient. That patient is seeing that patient. It's, it's, it's not possible, yeah. So if maybe our labour wards can be well constructed such that we have even...two or three patients per room, or if they are partitioned very well and a chair by every bed, for a companion to sit in, if practised or advocated would be a good idea' (Hp18).

The participants felt that it would help to promote labour support or companionship, but it was not routinely practiced in Ghana. The reasons comprised: concern for privacy; high workload; large number of clients; inadequate staff, inappropriate infrastructure; inadequate space and concern for privacy. Few of the participants were also of the view that when they allow female companion in the labour ward, they go gossiping or discussing things they see to the displeasure of patients. Occasionally, husbands or close relatives were permitted to stay with the woman during the first stage if the woman was the only client in labour. Normally, somebody (husband, mother, sister or a friend)

accompanied women to the hospital, but their role entailed hanging around outside the ward and performing errands to support the provision of care as and when necessary.

The published literature lends support to the findings in this study. Brown et al (2007:[5-8]) were unsuccessful in institutionalising childbirth companions in hospitals in South Africa even after a change in policy direction and the staff indicating their willingness to implement. They concluded that implementing childbirth support needs further development and testing especially in developing countries. Likewise, Aune et al (2013:[5-6]) stated that midwives were unable to offer effective childbirth support to women due to busy shifts. The above observations were also noted by Akum (2013:[5]) in a study in Ghana where contextual factors in the ward environment did not permit women to have care and companionship during labour. In the midst of the challenges limiting women having labour companions, it may be prudent to experiment with the use of doulas or if possible enable non-staff caregiver (friends, family members or spouses) to provide continuous labour support. As noted in Hodnett et al (2013:2), continuous support is most beneficial if provided by a person who is present solely to provide support, is not a member of the woman's social network, is experienced in providing labour support, and has at least a modest amount of training.

7.6.3.6 Views on choice of labour pain relief

Pain is seen as a subjective experience involving a complex interaction of physiologic, psychological, cultural and environmental influences (Leeman et al 2003:1109; Lowe 2002 cited in Madden et al 2013:1). It has been found that a major determinant of women's satisfaction with childbirth depends on how effective labour pain was managed (Leeman et al 2003:1110). However, the choice of pain management in any setting depends on what is available, the woman's preference and clinical practices therewith.

The participants characteristically had varied explanations why women would not routinely be allowed to exercise their preference for labour pain relief. The following were some of the views expressed:

'Labour is supposed to be painful. That's what we tell them, and we at times we don't try any drug for them. It's the doctor who will come and say maybe she may

need some drug to be given to subside the pain. But then when a dilatation is going on, well, there is nothing we can do than reassuring you that' (Hp6).

'...I must confess that our pain management in labor is not good, it's very poor. I've had, I've been very unhappy about the way we have offered such services from the time I was a student and I came into contact with pregnancy women even up to now, so they be offered the kind of pain management they want and especially if we have the resources to do it I strongly agree with that one' (Hp17).

As could be deduced from the statements, labour pain relief was generally at the discretion of the care provider. There were institutional protocols that gave guidance. However, this seemed not to include giving women the choice. Interestingly, the participants themselves felt that labour pain management was poor. Commonly used pain reliefs were Pethidine, Tramadol, Phenergan and Paracetamol. They indicated that some mothers used natural methods such as breathing exercises and massaging the sacral region. Epidural was rarely used due to lack of expertise and requisite staff. None of the participants mentioned inhalation techniques. The impression was also created by few of the participants that some of the women just abuse pain relief. This attitude may cause many women to be denied the needed services in childbirth.

In their recommendations for intrapartum care, the National Institute of Health and Care Excellence (2014:34) cautioned that health care professionals should be mindful about how their own values and beliefs inform their attitude to coping with pain in labour and ensure that their care supports the woman's choice or preferences. Individuals may differ in their preference for pain relief, for that matter health workers need to comprehensively determine the woman's need and address it appropriately. In a study to assess the attitudes of maternal health care providers regarding pain relief during labour in Nigeria, Ogboli-Nwasor Adaji, Bature and Shittu (2011:228-229) found that, though majority of the participants agreed that pain relief was needed during labour and were very knowledgeable about the different pain relief methods, in practice, most of them did not provide any form of pain relief to the women they attended to in labour.

A study by Mohammad et al (2014:37) reported that women who participated in their study felt that labour was more painful than expected; yet they received inadequate pain management. Client's poor pain control was found to be the leading cause of client

dissatisfaction (Melese et al 2014:3). In support of inadequate education of women by care providers on pain relief, a study in South Africa on labour pain management reported that most of the women gained knowledge of labour pain relief from previous birth experience, friends and relatives, the media and textbooks (Mugambe et al 2007:16).

7.6.3.7 Views on choice of length of stay after delivery

Length of stay after delivery in this study refers to the time lag between delivery and discharge. This period is very important to the mother, baby and family for various reasons. WHO (2010b:2) deems this period as a critical time that mother and infant will require appropriate care to prevent complications and even avert deaths. It is also a period within which the woman and the family begin to get to know the baby and either develop or renew confidence in their parenting skills. The need for support to go through this period successfully is imperative. Currently, the evidence available is insufficient to either support or reject the practice of early post-natal discharge (Bravo, Uribe & Contreras 2011:761-762). In recognition of this fact, WHO (2010b:13) noted that where a women and baby are without any problems, they could stay under the observation of a skilled attendant for 24 to 48 hours. In Ghana, data on national average length of stay after delivery was not readily available but the general practice ranged 24 to 48 hours or vaginal delivery and four to five days for Caesarean section.

The interviews with participants covered informed choice in relation to average length of stay. Contrary to the findings on the other aspects of informed choice studied where majority of the participants stated that women should be given the choice, in this regard almost all of them felt that it was impractical to offer such a choice. The time range for discharge for vaginal delivery was 6 to 48 hours depending on the health status of the mother and baby, and at time availability of bed. Women who had Caesarean section stayed between three to four days. The participants indicated that the mother and baby had to be observed for some period to ensure that their condition was stable before discharge. In the past, some women who were discharged early came back with complications. There was a general consensus among the participants that mothers could not be allowed to choose how long they want to stay due to: high number of deliveries, inadequate beds and inadequate space leading to congestion. There were

instances where two or three mothers had to share a bed. Others slept on the floor. In describing the factors contributing to lack of choice two of the participants said:

'Well, it's a very, very dicey one because they used to discharge the patients immediately after. Then some came, came back, they would have collapsed and all that. So I think it all depends on the... It should depend on the physician, to make a good judgement whether this patient can go home or not. Because, the patient. If, if we allow the patient to make their own decision, that they want to go home, maybe, maybe an hour or two after delivery, she goes home something happens, who is to be blamed? At least when the patient stays here at least like we said 8 to 12 hours or 24 hours, at least you know that everything has settled or close to settling down...' (Hp18).

'...the place is small, the number of beds too is. So they don't normally keep long here. Though we have to monitor them for about 6 hours, before taking them to the post- natal for discharge, sometimes two, three hours, because the place is full or we are sharing the same bed, with just a mattress and two three people are sharing. Because of that you just send them down, for them to be discharged, because the down too will get full. So if you allow them to make that decision, some, some of them will tell you, I feel dizzy, I want to sleep here. But you explain to her that if you sleep here, you can't sleep here. Because someone will be added to you in your bed, would you be able to cope? Then she will tell you, then I will leave. We don't allow them to...' (Hp1).

Though not much evidence exists in support of length of stay after delivery, it has been found that many women do not receive optimal care and are discharged within hours after childbirth without any indication of where they can obtain further care or support (WHO 2010b:3). Klingner et al (1999:256) also reported that even months after discharge, mothers who were discharged after 1-day hospital stay expressed dissatisfaction with the length of stay. They further noted that most mothers with 1-day stay believed that their stay was too short and would choose a longer stay with subsequent deliveries.

7.7 BARRIERS TO EFFECTIVE IMPLEMENTATION OF CLIENT-CENTRED CARE

Globally, many health care organisations and governments have accepted the positive transformation that implementing client-centred care approach would make to improve the quality of health services. Many of them have articulated their intention publicly and in policy documents. However, as noted in Manley et al (2011:35), achieving this objective is often challenging and difficult to sustain. Barriers to effective implementation in both developed and developing countries have been widely studied (Jonamlan, Jakson, Glasson & Nicholson 2014:S71; AHRQ 2011:2; Manley et al 2011:35; Pelzang 2010:915-6). Jonamlan et al (2014:S71) noted difficulties with transformation to a new system, change management issues, adoption of electronic health records (EHRs) and adapting payment models, inadequate resources, performance measurement and accreditation as some of the barriers. Pelzang (2010:915-6) argues that inadequate educational emphasis on patient-centred care and dominance of biomedical models were major barriers to patient-centred care. In this study, the participants mentioned a number of barriers that limited the implementation of client-centred care. These barriers have been classified into three categories: client; health care work; and organisational barriers.

7.7.1 Client factors that limit implementation of client-centred care

The following were themes regarding client related barriers that were mentioned:

- Client lack of knowledge
- Client cultural and spiritual issues
- Lack of cooperation from clients
- Client financial challenges

7.7.1.1 Client lack of knowledge (N=7)

Knowledge and education level influence health care seeking behaviour and ability to participate actively in health care decisions. For example, Ihaji et al (2014:314) found that people with high educational level score higher on health seeking behaviour assessments. As well, women with a lower educational background delayed seeking care significantly longer than women who had higher education (Ravi & Kulasekaran

2014:5). Likewise, Ford, Bayer, Gilman, Onifade, Acosta, Cabrera, Vidal and Evans (2009:[6]) reported that people with lower educational level such as only primary or incomplete secondary education delayed seeking health care. The participants in the study expressed similar sentiments noting difficulties with educating and encouraging women with low level education to understand clinical issues and also adhere to advice. According to them, women in this category are also more likely to delay seeking health care. One participant said:

'I am thinking, if they were to be educated well enough, even JSS is good. But the way they hold themselves, at times, excuse me to say, you wouldn't appreciate it that they have even gone to the stage of JSS, SSS. So this is the way they have to hold themselves. Somebody for example, would be sick, but would decide to stay at home for days. I believe, once you are not fine, why not come back to us...is it the educational background? You at this age, I do believe that if you are pregnant, you are losing liquor, you would stay at home for three, four days. You come, that is my only problem, the problem that I have for them' (Hp2).

Similar findings were reported in Bamm et al (2015:9) when they noted that poor health literacy affected clients' ability to participate actively in their care and prevented them from asking questions and making decisions. One study in South Africa also reported that women's lack of knowledge negatively influenced use of fertility services (Dyer, Abrahams, Hoffman & Van der Spuy 2002:1658).

7.7.1.2 Client cultural and spiritual issues (N=10)

Culture refers to the set of attitudes, values, beliefs, and behaviours shared by a group of people that is communicated from one generation to the next (Matsumoto 1996:16 cited in Spencer-Oatey 2012:2). Childbirth, though a biological event, is socio-culturally construed and shaped by the perceptions and practices of the society (Liamputtong 2011:16). In the health care encounter, patients and health care providers bring their cultural perspectives to bear; as such, health systems need to reflect an understanding of the diversities between and within these cultures (Beach et al 2006:6; NHMRC 2006:7 cited in Kruske 2011:7). Scheppers, Van Dongen, Dekker, Geertzen and Dekker (2006:343) also report that denying the aspect of spirituality and religion for some patients can act as a barrier. Thus, they encourage health care providers to understand

that belief in, or commitment to, traditional practices does not hinder the (acquired) perception that western health care can be very beneficial.

Drawing from the interviews with the participants, the major cultural barrier had to do with some women insisting on consultation with husbands before carrying out certain procedures even in emergencies. This issue also came up during the discussion on decision-making and informed choice. However, regarding spiritual practices, the doctor and midwives noted instances where the staff had to wait for a personal pastor to come and pray or smear anointing oil on a mother's abdomen before an emergency Caesarean section could be carried out. They also stated that such spiritual practice at times resulted in delays in seeking care as expressed by one participant:

'...because somebody can be in labour, may be even bleeding, not normal labour, and she is home, call her pastor, pray for me, and instead of her to come to the hospital. She would be home praying using anointing water and oil to see whether she could make it. While in actual fact, she cannot make it. And sometimes they get here when it's too late' (Hp14).

Similar cultural and spiritual issues were reported in the literature. Finlayson and Downe (2013:4-6) observed that women have cultural beliefs that influence decisions related to disclosure of pregnancy, ante-natal, labour and postnatal practices. Another study found that cultural factors accounted for the lower patient–physician interaction quality observed among Hispanics and Asians and stated that health care providers should seek to incorporate cultural competence into patient-centred care in order to provide health care that is both equitable and of high quality (Saha et al 2003:1716-1719). In recognition of these cultural and spiritual practices, Scheppers et al (2006:339) recommend that health care provider should be mindful of the influence of these beliefs and practices as they act as a barrier to accessing or benefiting from care. They further noted that these belief and practice can influence the way symptoms are presented and could result in a missed diagnosis. In stating an Ecuadorian government national survey, Dovey and Ransom (2009) indicate that women choose to deliver at home because they wanted to observe cultural traditions.

7.7.1.3 Lack of cooperation from clients (N=8)

Lack of cooperation from clients was also mentioned as a barrier to implementation of client-centred care. The major aspect of this challenge related to shared decision-making and has been outlined under that section. The participants felt that certain behaviour from some clients and families adversely affected care. One of such behaviour was not being truthful. A quote from one participant was:

'They don't tell the truth. They don't tell the truth. Seriously they don't, because even at the ante-natal, donate blood, donate blood. They come here [labour ward] and the only thing they would come and say is midwife, she just wrote it, she did not inform me. Then we pick a phone, we call the midwife, she comes to the labour ward, and here is the woman sitting down, she can't talk again. Some of them do lie a lot' (Hp17).

The staff often encountered this attitude in situations where relatives had to pay for a service or item. Probably, this is so because delivery is expected to be 'free'. A similar finding was reported in Bangladesh where health workers in a survey cited complaints from patients and bad behaviour from patients or their relatives as important among the problems they faced as health workers (Cockcroft et al 2011:[5]).

7.7.1.4 Client financial challenges (N=5)

Lack of financial resources or poverty is a barrier to health care (Scheppers et al 2006:339). In an analysis of the Ghana 2008 Demographic Health Survey, Moyer et al (2013:226-229) indicate that of all the access variable examined, financial issues or affordability (Insurance coverage) was the strongest access factor associated with facility-based delivery. Similarly, Adei et al (2012:17) support the issue of finance as one of the dominant factors that limit access. The participants stated that client's inability to or refusal to pay for delivery services was a barrier to provision of client-centred care. They felt that some of the women had no means of generating income and they relied on their spouses. A number of examples were cited where women could not provide basic logistics, including medicines for care.

'...and financially too, at times, when you prescribe drugs for the woman, I times, there is shortage. So you have to prescribe the drug. Because she is having the national health insurance, she will boldly tell you, I have the National Health Insurance. No, no, no, I will not go and buy it because I have the National Health Insurance. She won't go. No matter the explanation every things she will say she has the National Health Insurance. That thing is bringing about problems' (Hp14).

It must be noted that, Ghana began the implementation of a National Health Insurance Scheme (NHIS) following the passing of the National Health Insurance Act (Act 650) in 2003 to help ensuring equitable access to quality basic health care for all. This meant that user on the insurance scheme were to access care without having to make out-of-pocket payments at the point of service (Kusi et al 2015:2). Another policy exempting women from paying delivery fees and thereby reduce financial barriers in using maternity services was also introduced in 2005 (IMMPACT 2005). Therefore, women are not expected to pay for services including medicines and supplies for delivery; for the participants to state client's inability to pay for delivery services as a barrier implied challenges in the implementation of the policy.

7.7.2 Health care worker factors that limited implementation of client-centred care

Two themes were identified as health worker-related barriers to implementation. These were as follows:

- Inadequate knowledge and skills on some delivery options
- Poor staff attitude

7.7.2.1 Inadequate knowledge and skills on some delivery options (N=15)

The status of training and importance of health workers having the requisite knowledge and skill to provide client-centred care was extensively outlined under earlier discussion on organisational factors that promote implementation of client-centred care. A number of studies have come up with knowledge and skills that health workers must possess in order to provide effective client-centred care (Manley et al 2011:35; Pelzang 2010:916; Epstein et al 2000:101). Visser, Deliens and Houttekier (2014:[4]) outline that major

barriers related to care providers knowledge include lack of communication training and skills on how to communicate to patients and families. In this study, though most of the participants did not have formal training on client-centred care, their major concerns were inadequate knowledge and skills on the different birth positions and other methods of labour pain relief such as giving and monitoring epidural analgesia. One participant expressed the statement below:

You know because birth position, you know there are so many publications now about giving birth in the water, giving birth standing, giving birth. But you see in our training, we've only been trained in one way. Or we've had training specifically in the normal position we know a woman should lie down and give birth the lithotomy position, yeah, or the gynaecological position. Now, when they change I don't know how the outcome will be. I have not had that experience, in other positions. I know that the other day I heard on the news there's a facility in Accra that they give them the water bath delivery. I have not had experience with that. If I have, I have had a training on that I think that's the best way, fine. Then we can also opt for that...' (Hp18).

The benefits of especially the upright positions in birth over the lithotomy have been highlighted in literature (Priddis et al 2012:104; Thilagavathy 2012:71). Likewise, the importance of effective pain management to ensuring that women have good birth experience has been extensively documented (National Institute of Health and Care Excellence 2014:34; Leeman et al 2003:1110). Though participants mentioned these two aspects as barriers, it would be prudent to widen the scope of any training intervention to address knowledge and skills in areas such as leadership, communication and interpersonal relationship, performance management as well as mechanisms for monitoring and feedback as the findings on these areas were not very good.

7.7.2.2 Poor staff attitude (N=5)

Inappropriate staff attitude influences quality and utilisation of childbirth services. Mason, Dellicour, Kuile, Ouma, Phillips-Howard, Were, Laserson and Desai (2015:6) report that staff attitudes were a barrier to health facility delivery. Women in the study in Phiri et al (2014:[6]) complained of negative attitude from health workers such as being shouted on or ridiculed and the women perceived this as disrespectful and shameful

behaviour. Bamm et al (2015:9) note that positive attitudes from health workers are extremely important in creating pleasant experiences.

It was interesting to note that some doctors and midwives indicated that poor attitude from some of their colleagues' hindered effective implementation of care. They recounted instances where the staff shouted at patients or demonstrated disrespectful attitudes. It was surprising to note that some doctors and midwives felt that the shouting was justifiable because of patient's attitude. Some of the comments were:

'As a matter of fact, sometimes when they [women] annoy them [staff], they, they shout back at them. That's what I have experienced. It's true, especially at the labour ward...' (Hp1).

'...sometimes I see a midwife yelling at clients, I used to get offended why they shout, they sometimes shout at them, ok, sometimes they need, the reason why they do shout at them. Because sometimes they ask them, they tell them, especially when they are in labour, do this, do that, you tell them everything, but still they end up doing the opposite...and I just realised that when they try to shout at the clients, when they shout at them, they just become...senior midwives come, shout at them "Didn't you hear that" they just lie, so just got to know that they shouting, sometimes shouting at them, it's not because they want to. But the client sometimes, let them do so, ok' (Hp11).

As has been stated inappropriate staff attitude greatly affects women in childbirth. Similar attitude in childbirth in developing countries were reported in Leape et al (2012:5-7) and Bower and Hill (2010:3-8) where women were humiliated and discriminated against. Mwangome (2012:6) further reiterates that the fact that poor interaction between medical staff and pregnant mother can influence the women to remain at home and not utilise health facility services.

In explaining some of the contributory factors for staff poor attitude, Leape et al (2012:1) observed that probably the stressful health care environment, particularly the presence of "production pressure," in many health care organisations could be a major contributory factor. In addition, Silow-Carroll et al (2006:6) also state that some cultural and socio-economic issues, fatigue and competing priorities may be responsible for such attitudes. As much as the factors making health workers to demonstrate poor

attitude should be investigated and addressed, it is unacceptable for women to be disrespected or humiliated for choosing to come to deliver at the health facility.

7.7.3 Organisational barriers that limit implementation of client-centred care

Greene et al (2012:50) identified three major organisational attributes that impinge on client-centred care as: interpersonal, clinical, and structural. The interpersonal aspect deals with communication and interpersonal relationship. The clinical dimension related to decision support, coordination, care management, and continuity of care. The third component which is the structural attribute entailed the design of the built environment for it to meet the needs of both staff and clients. Greene et al (2012:50) further acknowledged that, leadership support, consistency in provision of patient-centred care at all encounters and trust in the health system to deliver safe and quality health care are equally imperative. Similar factors were identified in Willis-Shattuck et al 2008:[3], Epstein et al (2010:1492) and Silow-Carroll et al (2006:5). Drawing from these requirements, the lack of or ineffective functioning of any of these components will have adverse effect on implementation of client-centred care.

The participants were requested to identify the major organisational barrier to the implementation of client-centred care. The following themes were noted from the responses:

- Facility rules and routines
- Lack of equipment and logistics
- Infrastructure and space
- Inadequate staff
- Work organisation
- High workload

It is important to mention that other barriers came up during the course of discussion that has already been addressed. For example, non-availability of some services was identified as a barrier. This related to lack of some methods of labour pain relief and birth position and has been addressed under the discussion on views on informed choice. Language barrier has also been addressed under the presentation on

communication and education. Staff domineering attitude or controlling behaviour were associated with decision-making and informed choice. Examples of such attitudes have also been presented. The other barrier was inadequate monitoring and feedback mechanisms which were also discussed in that section.

7.7.3.1 Facility rules and routines (N=18)

Workplace guidelines, rules and routines are normally designed to assist health workers to offer appropriate and effective health care. As noted in Field and Lohr (1990:38), these standard operating procedures and protocols are expected to assist practitioners in making patient decisions. Normally, the recommendations in these documents should address the values, beliefs and core processes of not only the health institution but those of the patient. The perception of participants was that adherence to certain rules and routines hindered the provision of quality care and provision of choice to mothers. Some of these rules related to obtaining supplies like medicines, consumables and blood from other departments, especially in emergencies where clients or their families were not available to pay. One participant stated that:

'...if I go to the blood bank and I tell them that look, this patient need 2 units of blood, relatives are not around or those who came in were just good Samaritans, so they can't provide the or they can't foot the bills now. I need you get to get me the blood. I need you the pharmacist to provide me the medication without you telling me that this patient has to pay before these things should be rendered because at that time, if you lose the patient who is going to pay and what is the essence of keeping the medication when patients are dying and then when we are hard pressed with beds and we are to move patient A...' (Hp17).

Almost all the participants alluded to having to follow the protocols of the hospital for not offering labour support or companion, or offering women a choice of labour pain relief. Another barrier was adherence to rules and restrictions on visitation. Interestingly, it appeared that many of these rules were not written and the staff interpreted them anyhow. In support of these findings, a study in Kenya reported that one of the factors that hindered the implementation of interventions was challenges with structural and organisational arrangements for service delivery (English et al 2009:[4-7]). In another study that investigated barrier to implementation of client-centred care, Shafipour,

Mohammad and Ahmandi (2014:238) noted that a major problem was the presence of too many patients' relatives as visitors and how they interfered with the care and treatment of patients. In their view, the presence of the numerous visitors took the nursing staff time and disturbed the nurse-patient communication. It is the view of the research that rules and regulation should be developed with inputs from clients so that not only will they address the needs of the health facility and the staff but will also offer users good experience.

7.7.3.2 Lack of equipment and logistics (N=17)

Implementing client-centred care does not only require process and organisational redesign, it also requires effective investment in infrastructure to achieve the needed improvements in care (McClellan et al 2010:988). It is well-known that many public services often lack resources for implementing innovative projects (Djellal, Gallouj & Miles (2013:[1])). In a systematic review report, Jonamlan et al (2014:S71) stated that 18 studies reported barriers related to insufficient resources such as equipment, human resources and training materials in an effort to implement models of client-centred care.

The perception on lack of resources was echoed by almost all the interviewees. The quotes below clearly paint the picture:

We have barriers, the equipment are not enough. That's the most important one. The equipment. I will, if you are going to care for a client, and you need gloves, syringes, and those logistics are not available, how do you achieve your goal? So logistics is one...' (Hp3).

'Then also, equipment to work too, they want you to work with tools that are not good. That makes work done very difficult. Like if you come to our ward like this. Sometimes, we deliver babies that need oxygen, there will be no oxygen. Sometimes critical cases that we need to give of oxygen they would say that the oxygen concentrator is spoilt. Things are just getting spoilt just like that. And they are a lot. The instruments we use for delivery too, sometimes they are not plenty. When sometimes when we get cases like that, like about 4, we use them, then the set gets finished. And before you take that send to theatre for sterilisation, before they bring it. Sometimes, we have to just boil and reuse the same thing' (Hp5).

Concerns were expressed about acute shortage of beds, bedsheets, wheelchairs, sphygmomanometers, ceiling fans that do not work, broken down laboratory and diagnostic equipment, to mention a few. Similar findings were reported in 2004 in a study by the Ministry of Health, Ghana in which they found widespread lack of basic ward equipment like thermometers, sphygmomanometers and oxygen saturation machines (Ministry of Health, Ghana 2004:20). In addition, in a study to assess health workers' perception of the quality of and factors which impact provision of quality emergency obstetric care, Chodzaza and Bultemeier (2010:107-108) reported that health workers cited inadequate resources as the major causes of poor quality care in health facilities. Similar results were found in English et al (2009:[4-7]) who described the contextual factors that hindered the implementation of interventions in developing countries such as Kenya as: inadequate equipment and logistics; and provision of substandard supplies.

7.7.3.3 Infrastructure and space (N=19)

The physical environment of care has for a long time been recognised as having a significant impact on the care experiences and patient outcomes. The built and aesthetic environment is very important (McCormack et al 2011:3). As espoused in Ulrich et al (2008:63-111), the physical design of hospitals influences key outcomes such as patient safety (that is, infections, medical errors, and falls), patient outcomes (that is, pain, sleep, stress, depression, length of stay, spatial orientation, privacy, communication, social support, and overall patient satisfaction) and staff outcomes (that is, injuries, stress, work effectiveness, and satisfaction).

The findings on physical structure and space availability were not different from that of equipment and logistics. There was general consensus about the devastating effect of the current infrastructure on the quality of service delivery. Some comments were:

'Our first challenge is space and congestion everywhere even ante-natal. Labour ward and lying in, congestion is our main thing, thing and also because of the congestion, how they should be treated or some of them, don't get it like that. As am speaking now, in the lying in ward, some have delivered and they are lying on the floor. I said they should build more wards. So that we can get privacy' (Hp19).

'I think it has to do with space. It's, it's the place is too small for an emergency. It's, it's too small. It's all about the space. Cause, if we have space, then we can partition the place. Cause even, you saw the table we consult on? Two doctors on a table. So two patients being seen at a time. One, the patient that it's just their backs that are facing, are touching. So, whatever this patient tells the doctor, the next patient can hear. Patient- doctor confidentiality is breached. So it's all about spacing. Cause, we don't have enough space to say that ok, this doctor is consulting on this side. This other doctor is consulting. So it all has to do with space...' (Hp18).

There were concerns about elevators that were out of order as women in labour had to be carried by relatives to climb staircase from one floor to the other and general wards with no provision to offer privacy. The layout, design of equipment and fixtures all impact on the childbirth practice (Hammond et al 2013:3-4). The use of a common labour, delivery and postpartum room which was one of the concerns of the participants was also seen as a barrier to provision of client-centred care by women in Japan (Behruzi et al 2010:[11]). Another study found that some facilities do not have the physical space to accommodate newborns with their mothers in postpartum wards, or to allow companions in labour and delivery rooms (Choices and Challenges in Changing Childbirth Research Network, 2005:[6]). Similar observations were made in this study where mothers had to sleep on the floor with their infants due to lack of bed space.

7.7.3.4 Inadequate staff (N=19)

Understaffing is a major barrier to implementing client-centred care (Bamm et al 2015:9). The shortage of all categories of staff puts considerable pressure on staff and therefore impacts on the quality of care that they can deliver (Royal College of Nursing 2012:4). The participants in this study unanimously noted that the acute shortage of staff of all categories in the midst of high work load was a major hindrance. Every one of them described the difficulties they encountered. Some examples cited by the doctors and midwives were:

'I think it is human resource. The staffing situation, me, I look it from the angle that the staffing, because you come on duty, you are the only one, so you wouldn't be able to address the needs specifically to every client. You will not be able to do

that. When you have adequate trained midwives on duty, like take a shift, they can equally just share themselves unto the patients' (Hp16).

'...it's only the staff. Staffing is a worry and how to separate the wards. So if you get more staff, I think it will help. It will help because work here is stressful. Very, very stressful. And the clients they are coming in more. I don't t, I don't know how they see the hospital. They will be coming from far away, and so if we get more staff here, too it will help us. Because it's a hospital, they think it's a referral point. So they just be coming. So we need more staff to help us' (Hp4).

One participant described instances where doctors had to support relatives to carry patients down the staircases. Midwives had to do housekeeping activities due to lack of orderlies or labourers. The participants complained of stress and felt that the possibilities of making errors were high. These findings are supported by the following literature. The Ministry of Health, Ghana in 2004 noted similar results of inadequate number of staff in all the health facilities visited (Ministry of Health, Ghana 2004:19). The report stated that in some of the health facilities two (2) nurses were taking care of forty (40) patients and so questioned the kind of care that could be provided. Kieft et al (2014:6) report that the participants stated that the number of nurses available influenced how patients experienced the quality of care. In addition, Kieft et al (2014:6) further stated that the participants said that several tasks and assignments were transferred to nurses with lower qualification as a result of the shortage, which is a situation that they felt affected patient experiences and effectiveness of care. In their view, sufficient nurse staffing level determines whether patient wishes and needs are met or not.

Many countries still experience shortages in their health human requirements. Nyamtema, Urassa, Massawe, Massawe, Lindmark and Van Roosmalen (2008.120) report severe shortage of health care providers in almost all health institutions in Dar es Salaam region in Tanzania. They indicated that workload pressure at the municipal hospitals, which function as first referral facilities in the region, was very huge and exceeded the available human resources and noted that their findings suggest that the staff is under an extremely huge work pressure and questioned to the extent to which the desired professional standards could be met with the available staff. Nyamtema et al (2008.121) further stated that the shortage of staff led to high workload pressure which

in turn made staff to spend much less time on each activity than is set by the activity standards in the country.

7.7.3.5 Organisation of services (N=19)

The demands of client-centred care coupled with advances in treatments and therapies mean that all health care providing organisations need to regularly review the way they organise and deliver care (Hardiman & Dewing 2014:3). Many organisations that have embarked on the client-centred care journey have had to make changes in work organisation. For example, Jonamlan et al (2014:S70), in reviewing challenges with implementation of client-centred care in many developed countries observed that the implementation of client-centred care called for significant changes in the routine operations of practices in many aspects of services delivery.

Some of the organisational arrangement challenges that the participants mentioned in this study were: (1) operations at the ante-natal leading to long waiting time; (2) the sharing of patients among midwives in the labour ward during shifts for which women cannot choose who to conduct their delivery; (3) assignment of midwives to specific sections of the maternity unit and the difficulties with shifting them in times of shortages in other units; (4) frequent rescheduling of doctors to different units so they are not able to establish long relationships with clients; (5) lack of formal systems to orient women to the labour ward so they could be familiar with the labour ward environment and staff prior to labour; and (6) improper arrangement of wards such as putting the labour ward on the top floors in structures that have no elevators. One of the excerpts was:

'...in [name of hospital] here when we come, we share the client among the midwives. So if you have one particular midwife that you want the midwife and she already has other clients attending to, she can't leave her clients and come and take care of you. And then the one who is taking care of you wouldn't also understand why you want to. It will create a little confusion' (Hp2).

Clinical transformation for client-centred care is the cornerstone of success and it requires among others process and organisational redesign (McClellan et al 2010:988). Evidence shows that the way work is organised has influence on patients' experience (Maben, Peccei, Adams, Robert, Richardson, Murrells & Morrow 2012:23). A statement

by the Royal College of Midwives and other three bodies (2007:10-16) indicates that the arrangement of work, communication dynamics, leadership style, how individuals are managed such as scheduling of work, measures to address safety all are organisational issues that should be effectively handled. The challenges outlined by the participants may not be addressed within the short-term; however, design measures that can enhance the ability of staff to engage with patients in a meaningful personal level should be promoted.

7.7.3.6 High workload (N=18)

The human resource challenge and its accompanying high workload in many developing countries is common knowledge. Literature clearly links high workload to challenges of implementing client-centred care and for that matter the provision of quality health care (Kostick et al 2010:528; Mead & Brower 2000:1103-1104). For instance, Mead and Brower (2000:1103-1104) argue that time or workload pressures may limit possibilities for full negotiation and resolution of issue between doctors and patients compromising patient-centred care. Many participants also remarked that client-centredness can be undermined by the pressure put on health professions to “meet numbers” or other expectations for employment outcomes set by organisations (Kostick et al 2010:528).

Concerns by the participants on the inadequacy of human resources and high workload have been expressed in different sections of this study. The influence of high workload on quality of patient-provider interaction, provision of choice and pressure on resources were mentioned. The current situation is worrying and stressful for many of the participants as expressed below:

‘...the workload is much, the midwives are not sufficient. You come and there are a whole lot of patients. it’s only the staff. Staffing is a worry and how to separate the wards. So if you get more staff, I think it will help. It will help because work here is stressful. Very, very stressful. And the clients they are coming in more. I don’t, I don’t know how they see the hospital. They will be coming from far away, and so if we get more staff here, too it will help us. Because it’s a hospital, they think it’s a referral point. So they just be coming. So we need more staff to help us’ (Hp14).

These findings are supported in the published literature. A study in Ghana examined causes of stress among nurses and reported high workload as a major cause of stress and concluded that the need for additional nurses was necessary (Assibi et al 2013:768-810). Heavy workload was deemed to be the main cause of stress among nurses (McCormack, Dewing, Breslin, Coyne-Nevin, Kennedy Manning, Peelo-Kilroe, Tobin & Slater 2010:103). Similarly, workload and working under pressure, shortage of highly skilful nurses and high volume of paper work imposed long shifts and made staff to work under stress (Shafipour et al 2014:238). Concerns about staff shortages and workload were key factors for over 40% of staff who stated their intention to leave their current post and for nearly two-thirds of the remaining health workers who were interviewed in the study by Bradley, Kamwendo, Chipeta, Chimwaza, De Pinho and McAuliffe (2015:4). According to Bradley et al (2015:4), a common narrative among the participants who had seriously considered leaving their post was the challenge and stress of being responsible for a large number of patients, or of facing unmanageable workloads that exceeded their capacity to cope. The participants in this study cited examples where shortage of nurses left maternity staffing levels at a maximum of two nurses during the day, but only one at night to cover both labour ward and postnatal wards.

7.8 RECOMMENDATIONS BY DOCTORS AND NURSES

The recommendations stated by the doctors and midwives were as follows:

- Training of staff on client-centred care
- Recruitment of and provision of additional staff
- Re-organisation of services
- Improving measures for communication and education of mothers and the public
- Improving infrastructure

7.8.1 Training of staff on client-centred care (N=17)

Most of the participants in this study felt quite unprepared for client-centred care and indicated that they required training. Indeed, a few of them have not even heard of the

concept before. The expressions of the need for training by some participants were confirmed as:

'...I think if we are going to implement that [different birth positions] then a thorough teaching has to be done to, with the midwife so that they will be like they will be equipped to do that. Because I think most of the midwives it's just the bed thing, the lithotomy thing that you open your legs and its' just that one. With the other positions, most of us we don't have any idea about it. Like how to go about it' (Hp9).

'Okay, the term client-centred care and child birth, maybe I would say I haven't come in contact with that before but I have heard of focused care giving to client and like, all boils down to like, giving an individual care. And I got to know about this client-centred, when I heard about the interview that is going to come around, no, I have not received any training on client-centred care' (Hp12).

Health care workers, who constituted the major asset of any organisation, require training in the concepts and principles of client-centred care for them to develop and sustain the kind of communication and interpersonal skills, as well as the knowledge for determining, planning and prioritising the care needs of clients. The tenets of client-centred care must be thought not only during pre-service training but also through regular and sustained practice in the work area. Shaller (2007:19) particularly mentions this need for physicians since most do not receive such instruction in medical schools. Ahmad et al (2014:7), suggest that empowering health workers to be part of patient-centred teams and rewarding and recognising those that exhibit patient centredness principles are staff development practices that facilitate effective implementation. Pelzang (2010:916) specifies that apart from having knowledge on how to handle clinical diseases, the following skills are important:

- Data gathering or patient assessment skills (ability to determine, plan and prioritize the care)
- Procedural skills (ability to follow the principles of procedure, e.g. paying attention to patient comfort and dignity)
- Communication skills (ability to communicate with patient, family and professionals)

- Relationship skills (ability to develop and maintain the helping or professional relationship)
- Reporting and recording skills (ability to maintain and communicate the details of patient clearly, completely and concisely)

The IOM (2001:209) further recommends that preparing health staff to deliver quality patient-centred care among others must include training that will ensure that all those in the health care workforce have the skills they need, including how to use decision support systems, safety management principles and working collaboratively. This may require a change in health training curricula.

7.8.2 Recruitment of or provision of additional staff (N=19)

It is a known fact that staffing continues to be a significant concern for health care organisation, policy makers and consumers. In Ghana, maternal and perinatal mortalities and morbidities are problems of public health importance, and this is often linked to the shortage of staff, especially specialist and midwives in health facilities. There is enough evidence supporting how over worked staff could be a barrier to implementation of client-centred care. The IOM (2001:44) states that it would be futile to seek improvement by further burdening an overstressed health care workforce or by exhorting committed professionals to try harder. When clinicians are under stress themselves, it will be difficult for them to take care of patients who are ill and stressed (IOM 2001:208). The participants in this study recommended that the staffing levels in hospitals must be improved if the objectives of client-centred care are to be achieved. One of such comment was:

'...they should employ some more hands because the other day, I was complaining to the head of the environmental, and she said these days, they said there's a ban on employment. So, they can't employ or something, so we are still waiting' (Hp17).

The views of participants on shortage of staff as a barrier has to quality care have been noted. Ministry of Health, Ghana (2007:1) acknowledged that the health sector has over decades been confronted with inadequate numbers and unbalanced skills mix leading to gross understaffing in many facilities. The staffing levels may differ per country and

even per different areas in the same country. Some countries have clear guidelines on staff norms. For example, the position statement from RNAO (2010) maintains that the most appropriate number of care provider(s) be based on the patient's complexity and care needs. The statement recommends that each patient be assigned one nurse per shift who works to his/her full scope of practice and is responsible and accountable for delivering the total nursing care required by that patient. This may not be possible in many developing countries like Ghana. The process to develop staffing norm for the Ghana health sector started in 2011 but is yet to be completed.

7.8.3 Provision of equipment and logistics (N=16)

Following from the observation on lack of resources for care in the health facilities, the participants requested that additional resources were required not only to ease difficulties they have to go through, but to make clients more comfortable while in the health facility. Some of the requests were put this way:

'...hospital to purchase the needed equipment for us to work easy. Lack of delivery equipment or let me say, we are saying that we should practice ante-natal, focus ante-natal. Here is the case that every room should have Bp apparatus, weighing scale, registration books and the things. But we are not having, so I can say that we are practicing partial' (Hp13).

'I think they need more buildings and more infrastructures. Beds, screens and those things, they need to provide more. Whether it is the government or the hospital itself It's a big problem. Because the bed sheets, the rate at which the clients are coming and the number of bed sheets that are even, that are even available, is. So sometimes they have to be on the bed like that without bed sheets or you ask the mother if she herself is having a bed sheet, then we use it for them. And then postnatal like this maybe they would say that I'm exposing them or something...' (Hp9).

It can be deduced from the above statements that the situation was quite frustrating for some of the participants. The managers of the institutions may have to carry out an audit of the equipment and supplies situation for further action. Similar findings were reported in 2004 in a study which found the lack of necessary basic ward equipment (such as thermometers, sphygmomanometers, oxygen saturation machines and many

others (Ministry of Health, Ghana 2004:20). In a systematic review on causes of delays in providing maternity care in health facilities in developing countries, Knight, Self and Kennedy (2013:5) observed that inadequate supply and distribution of essential drugs, equipment and blood for transfusion were major prohibiting factors.

7.8.4 Improve infrastructure (N=19)

The call for improvement in infrastructure was collective. The need surfaced in all the discussions and was implicated in the factors that contributed to not providing choices for mother. These were some of the recommendations:

'...I would say that like I said, private public or public private partnership will help I'd say that hospital should be equipped enough to offer the services that they need to offer. In terms of bed space, maybe expansion works will help so that we'll have patients, as in we will be able to accommodate more patients...'(Hp17).

'I think the government should build, this is the building, we are talking about labour ward. The government should build a new maternity block for us. Because here, the labour ward is too small. And the deliveries we do even in a day, at times we do more than 15 deliveries a day. And our ward too, we have about 10 beds. So our labour ward is too small and I think the government, are able to build a new maternity block, this place would be fantastic' (Hp6).

This study has highlighted the infrastructural conditions under which women and relatives receive health care as well as the environment in which health staff work. The layout, design of equipment and fixtures has impact on the childbirth practice (Hammond et al 2013:3-4). It has been documented that some patients feel that having access to personal belongings and small items associated with one's own home in the health facility reliefs patients' suffering (Olansson et al 2013:241). In addition, access to water and electricity, and having intact mosquito nets are important to the women (Tuncalp et al 2012:3-6). While some participants were asking for individual cubicles, others felt the general wards were appropriate. In addressing infrastructural challenges, it would be necessary to further investigate the needs and preferences of both service users and staff.

7.8.5 Re-organisation of services (N=10)

There were some aspects of service delivery that participants indicated that if reviewed could facilitate the flow of services and improve the experiences of women and relatives.

'Like ante-natal, each client has a midwife. So I'm saying, if from ante-natal, they also can, they can choose their own midwife for delivery, it will help' (Hp10).

'...it would have been actually good like we have lying-in, gynae and CS, post CS case here [on the same floor]. If actually the theatre was in the same, floor labour ward was in the same floor, maybe the same floor. And maybe the ANC a stone-throw like not something that someone can come to ante-natal and she is labour and she has to struggle and come out...so actually the environmental setting, if they could all be within arms- reach, it will be good' (Hp13).

The participants noted that the sitting of health facilities and units or wards, processes to manage staff and clients, measure to procure and distribute logistics and leadership even at the unit level all impinge on the organisation of services. Areas identified by the participant for examination relate to how to ensure that women get to know their birth attendant prior to labour. A review of the sitting of wards and procedure areas to facilitate flow of work was mentioned. Others included the scheduling of both doctors and midwives so they can have continuous interaction with clients to build relationships as well as putting in measure to monitor staff during work hours so they can take responsibility and stay in the health facility to do their job. The participants also called for a review of the procedures for obtaining emergency medicines, blood and other supplies and formalisation of regular joint meeting of all staff to review progress of patient.

Work organisation, including flow of work has influence on patients' experience as such health care providing organisations need to design measures that can enhance staff ability to engage with patients in a meaningful personal level (Maben et al 2012:23). It will be beneficial if the mother organisation, Ghana Health Service, came out with comprehensive guidelines on these issues.

7.8.6 Improve communication and education of mothers and the public (N=15)

The participants in this study felt that clients should be given adequate education on the childbirth processes. This observation is supported in the literature. Richards 1998 cited in Coulter and Ellins (2006:27) reports that patients want more information than they currently receive. In the words of some interviewees:

'Our women need education. If, if, if you can use a lot of visual aids or some other things, just to educate them. Let's give them information. Especially at the ante-natal when they are more relaxed so that when they come into labour, and they are in pain, anything you say should be a reminder, but not something new to' (Hp16).

'...every pregnancy is a risk. You can never tell what will happen at the end. So if you are able to educate our citizenry well for them to understand, and know the issues around the family planning, I think it will help as a small community, then as a nation at large. A client who has gotten nine children and has moved to another man and wants to have a child by all means these are, these are issues, we should be addressing and empower the queen mothers. You can go round, but in communities. Everything starts from community level. They will understand the queen mothers than you and they will comply the more' (Hp15).

The participants in this study note that the strategies to improve communication and health education should not be limited to the health facility but should involve communities and schools. What information are women looking for? In which language, which form and within which context is most appropriate? A systematic review by Nolan (2009:28) suggests that: pregnant women like to receive emotionally demanding or intellectually complex information from a health care professional in person; they want to be able to ask questions, seek clarification, and relate information to their own circumstances; they like to learn about labour, birth, and motherhood in peer groups made up of a small number of pregnant women, with a facilitator who is able to identify how much information to give, has skills to present it in a way that is easy to remember, promotes discussion, gives plenty of opportunities for practicing skills, and encourages them to get to know and support each other. Health care providers and organisations will have to develop these skills and make time available if these requirements are to be met.

7.9 CONCLUSION

Overall, the results elicited themes commonly found in the literature on client-centred care. In terms of the meaning and attributes of client-centred care six elements: focus on the client and family; involving the client and family in care; open communication and education; continuity; and dignity, respect and privacy that emerged and how these were implemented were presented. Other components covered were qualities required of health professionals, organisational factors that impinge on implementation of client-centred and processes through which clinical decisions were made. The need for development of policy, guidelines and protocols to give direction was raised. These documents when developed should be widely disseminated for all to know and to put to use.

The results and discussion regarding barriers to effective client-centred care implementation brought a number of issues that require addressing if the country is to realise the objective of making women have good experience during childbirth. Client-related factors such as financial challenges, barriers related to health care workers like poor staff attitude and issues like high workload that hindered quality of care at the organisational level were noted. Some of these challenges have been well-known for years. However, being raised once more indicates that probably efforts to address them are not yielding the desired results. As the country forges ahead, there are many good lessons that could be learnt from this study to inform strategies and policies to make the experience of health workers and women better.

CHAPTER 8

GUIDELINES ON CLIENT-CENTRED CHILDBIRTH

8.1 INTRODUCTION

For several decades, instituting strategies to assure the physical wellbeing of women and children was the focus of many health care organisations and policy makers. In recent times however the mother's childbirth experience has also assumed great importance (Ahmar & Tarraf 2014:586). The ultimate aim of this thesis was to develop guidelines to assist improve the client-centeredness of childbirth services in Ghana. The objectives were to:

- Assess the factors that influence client-centredness of the care given to women from ante-natal to immediate postnatal period.
- Explore and describe women's views of and experiences with client-centred childbirth services.
- Explore and describe health professionals (doctors and midwives) views of and experiences with client-centred childbirth services.
- Based on the findings from the views and experiences of health professional and women, guidelines will be developed to improve client-centred childbirth services in hospitals in Ghana.

The findings on the factors that influence client-centredness of ante-natal, delivery and immediate postnatal care were presented and discussed with the relevant supporting literature in Chapter 5. Likewise, the findings of the in-depth interviews held with women were presented and discussed in Chapter 6. In Chapter 7, the results of the in-depth interviews with doctors and midwives were presented and discussed. Chapter 8 summarises the findings of the three studies, the process of developing the guidelines on client-centred childbirth and the final product are presented.

8.2 SUMMARY OF FINDINGS FROM THE THREE STUDIES

Literature indicates that the effectiveness of diffusion of an innovation is evidenced in its routine application (Greenhalgh et al 2004:582; Bergman & Beck 2011:361). The model of diffusion of innovation in Greenhalgh et al (2004:582) was used as a theoretical framework for examining how client-centred approach to childbirth service provision had permeated childbirth service delivery in hospitals. To achieve this objective, a number of factors that have been found to impinge on a woman having a positive client-centred birth experience or not were examined. Health professionals were also interviewed about their views and experiences with the implementation of client-centred care principles in childbirth.

On the whole, the findings showed that though measures were not put in place to systematically introduce and facilitate the implementation of client-centred care principles, some elements of client-centred care were practiced in the hospitals. Both the quantitative and qualitative study findings supported this fact. Most of the factors that were found to significantly influence client-centred care in the quantitative study findings were supported by the results obtained in the qualitative studies, giving credence to how prevalent practices were as well as how important the factors were to the experience of women. The findings further showed that there is still more room for improvement to routinise client-centred care.

In the first study, the researcher considered the factors that influence client-centred childbirth and their association with having excellent client-centred care. The descriptive data of the individual items vividly portrayed mixed performance on many of the variables examined. While some women had good experiences, a number of them expressed views of unacceptance experiences. Similarly, findings observed on the dimensional scores showed average performance as five (5) of the nine (9) dimensions scores fell in the 'need for improvement' category. These findings were not surprising as the quality of childbirth services in hospitals have over the years been of great concern to all stakeholders (Osei et al 2005:23-28).

Three demographic characteristics (that is, type of hospital, women's educational level and issues related payment of hospital fee) and a number of obstetrics specific

variables listed in the Table 8.1 below were significantly associated with having excellent client-centred care.

Table 8.1 Significant socio-demographic and obstetric characteristics associated with excellent client-centred care

<p>Demographic variables</p> <ul style="list-style-type: none">• Type of health facility• Educational level of women• Mode of payment of fees• Payment of fees without being given receipt
<p>Obstetric variables</p> <ul style="list-style-type: none">• Number of weeks pregnant before first seeing a health professional for ante-natal care• Number of weeks pregnant before delivery• First health professional seen during ante-natal check-up• Health professional who assisted with delivery (vaginal delivery)• Having confidence and trust in health professional during labour• Mode of delivery• Labour pain management• Length of stay after delivery

The summary of other findings are presented under the following subheading:

- Focused individualised care
- Dignity, respect, courtesy and privacy
- Involving and explaining issues to clients and family in health care
- Communication and education
- Interpersonal relationship
- Decision-making and control, and informed choice
- Support in childbirth
- Continuity of care
- Organisational factors that influence client-centred childbirth
- Factors the hindered client-centred implementation
- Recommendations from study participants

8.2.1 Focusing individualised care

Though the findings indicated that very little has systematically been done to make health care workers and clients aware of the concept of client-centred care and to institutionalise the practice in health facilities, the doctors and midwives that participated in the study felt that making childbirth services more client-centred can help improve quality of services. With the exception of a few, both the doctors and midwives expressed sentiments that demonstrated importance of individualising care and focusing on the client and family in health care delivery. The women that participated in the study also expressed views denoting that they would like health services to be designed to address their concerns. It must be noted that a key principle of client-centred care is respecting the needs and preferences of clients (Brookman et al 2011:19; IOM 2001:40; Mead & Bower 2000:1102).

8.2.2 Dignity, respect, courtesy and privacy

Dignity, respect, courtesy and privacy were important to both the women and the health professionals that participated in the study. The doctors and midwives identified these as key components of client-centred care and were generally consistent about the need to respect the dignity of the client. To the health professionals, respect is reciprocal irrespective of age or status and they expressed it through actions like addressing people by their title, showing love, assuring privacy and confidentiality and not discriminating against anybody. Not surprisingly, women also mentioned these variables as very important to them. Being polite and nice, talking well and friendliness were seen as signs of respect by women. The women felt respected even when basic activities such as bathing their baby, laying their bed, fetching water for them to drink were performed for them.

These notwithstanding, both the doctors and midwives and women indicated instances of disrespect and abuse of women in health facilities. These included being shouted at, being screamed at, abject display of impatience, verbal abuse, neglect, being left on benches for hours without any explanation, left to deliver unassisted and being ignored. The way a woman is treated by the professionals on whom she depends may largely determine how she feels about the experience for the rest of her life (Simkin 1991:210).

Therefore, health care workers should endeavour to make the childbirth experience of women more fulfilling.

Regarding privacy, it was evident that some health workers went to great length to offer privacy. The women noted instances where some health workers made efforts to talk to them privately or even lowered their tone when discussing issues. However, majority of the women were not happy with the mechanisms for assuring privacy. Women want to be able to confidentially discuss their issues without others hearing. There are instances where they do not even want other health care providers to hear what they discuss with their primary care providers. The need of the women for physical or visual privacy was strongly expressed. However, health professionals expressed their concerns and cited a number of challenges such as inappropriate infrastructure, lack of screens, high workload, inadequate staff and lack of cooperation from both staff and clients as contributing to their inability to provide effective privacy.

8.2.3 Involving and explaining issues to clients and family in health care

The participants in this study all underscored the importance of involving and explaining treatment and care issues to clients and families so as to gain their support. Mixed findings were observed in this aspect of care. While some women felt that their information need was addressed and that health care workers were open and discussed issues with them freely, others were not satisfied and felt left out in the discussion about their care and treatment. The women strongly felt that health professionals needed to be patient to listen to them.

The findings showed that some women required more information on their care and treatment than they were given. There are a few who were indifferent about their need for information and thought it should be left for the care providers since they know best. This demonstrates the need to continuously assess the information need of women. However, doctors and midwives had some challenges and noted that they were unable to effectively involve clients and families in care due to factors such as low level of education, lack of cooperation from clients, high workload and inadequate time.

8.2.4 Communication and education

The importance of communication and education in health care delivery cannot be overemphasised. Doctors and midwives noted that good communication and education makes clients to open up and discuss their problems. It also fosters a trusting relationship that enables clients to confide in them and helps women to identify complications so as to seek early treatment. The findings indicated that health workers were the major source of information for women. Some of the women indicated family and friends as additional sources of information. It was evident that women looked up to their care providers to let them know about their condition and care.

Regarding approaches to education, it was observed that most part of the education for women was done during the ante-natal period. Even doctors and midwives that participated in the study expected most of the education to be done during the ante-natal stage. Education of women was normally done in groups at the start of work. Thereafter, women had one-on-one discussion with their personal midwives. Not all women were happy with the group educational sessions. The lack of or limited availability of decision and learning aids constituted a major setback to effective education of clients. Language barrier was another hindrance as the language of communication varied greatly. Inadequate number of staff and high number of clients were also contributory factors to poor communication. In the end, both health professionals and women felt that the approach to education and communication of health formation was not very effective. Many participants called for identifying innovative ways to improve the current situation.

8.2.5 Interpersonal relationship

The participants perceived good personal and interpersonal relationship as an important attribute of client-centered care. According to doctors and midwives, the positive outcomes of such relationships include: building the confidence of women; improved adherence to advice and management plan; and women becoming happy. Doctors and midwives were of the view that health workers need to possess certain qualities or characteristics that would help achieve good interpersonal relationships in providing client-centred care. These were:

- Patience
- Tolerance
- Empathy
- Nice and friendly
- Confidentiality

Interestingly, the women who participated in the study also expressed similar sentiments regarding the need for the staff to foster good interpersonal relations overwhelmingly and called on the staff to be patient, nice and friendly. Women greatly valued the relationship that they had with their personal midwives during the ante-natal stage but a number of them were not satisfied with how they were treated during labour.

8.2.6 Decision-making and control, and informed choice

The finding on decision-making and control was mixed. Though international literature on childbirth care advocates control and choice for women (Jomeen 2012:60), the findings in this study did not fully support this view. Majority of the women would prefer the medical officer or midwife to be the key or final decision maker regarding procedures and treatments related to their pregnancy and birth. On the contrary, the doctors and midwives felt that the decision-making process was shared or at best collaborative and that women should have the final say in decisions. In practice, it was noted that the health professionals dominated the process and rarely provided adequate explanations on the issues. There were expressions that showed that women could suffer negative consequences for refusing to heed to instructions or advice from health professionals. Both the health professionals and women expressed views indicating that when dealing with major childbirth-related issues such as termination of pregnancy and surgery, the decision should not be left for the woman alone, but the husband and significant other must be involved. There were submissions that portrayed that women could suffer some negative consequences should they not heed to the advice of care providers.

Regarding informed choice, though doctors and midwives agreed that women should be given the choice on most of the care areas examined, in practice, women were not given the opportunity. On the whole, the practice of informed choice in terms of: place of birth; birth attendant; mode of birth; birth position and mobility; support in labour; labour

pain relief; and length of stay after delivery was poor. Almost all the women were not given information on the choices available. The major challenges to shared decision-making and informed choice were: poor literacy and low educational level of clients; clients financial issues leading to overreliance on their husbands to take decisions; inadequate time for discussion as a result of high work load and inadequate staff; and lack of cooperation from clients.

8.2.7 Support in childbirth

Issues of socio-cultural and spiritual; psychological and emotional; and physical support were observed in the study. Many women expected their spiritual needs to be fulfilled even when on admission and were highly appreciative of health professionals showing concern not only for them but for their families as well. In terms of psychological and emotional needs, the finding showed that the majority of the women were able to discuss their fears and worries with their care providers, especially during the ante-natal stage. The challenge was during labour where many women verbalised instances where their psychological and emotional needs were ignored. Major factors that generated fears and worries during labour for the women included having to go for surgery, low progress of labour, being left unattended and just wishing the labour would end. With the exception of few, most participants expressed positive emotions after birth.

Having somebody physically present at the woman's bedside throughout labour to provide emotional, psychological and other non-technical medical services such as comfort and encouragement was important to women. Majority would have liked to have their husbands around to support them. Though doctors and nurses recognised this need, they indicated a number of factors such as health facility regulations, inappropriate infrastructure, high workload and inadequate staff that did not allow them to offer the service or to allow the presence of family members in the delivery room.

8.2.8 Continuity of care

One of the major objectives of instituting continuity of carer is to facilitate the process of women knowing their care providers. Almost all the women were assigned to a personal midwife during the ante-natal period. Having a personal midwife was very important to

the women and they expressed positive views about the care they received and the relationship they had with their midwives. Per the tenets of the Focus Antenatal Care, women were to be given orientation (a tour) of the labour and introduced to the midwives there prior to labour so they could be familiar with the setting and staff. The results noted that none of the women benefited from this activity.

Regarding intrapartum continuity, while some of the women were involved in the handing over process, others had no idea except to see new staff attending to them. The women indicated the importance of knowing or at least being introduced to the midwives or other staff that cater for them during the different shifts. The doctors and midwives corroborated the views of the women. Doctors and midwives also stressed the importance of accurate and complete documentation in continuity of care.

In terms of intrapartum-postnatal continuity, while the women mentioned that they were not introduced to the postnatal care providers, in contrast doctors and midwives stated that they often handed over clients to the public health or community health nurses for further care.

8.2.9 Overall assessment by women

The majority of women indicated that they were satisfied with services, but a good number of them also made comments that showed unhappiness. Inconsistencies were observed in the overall ratings of satisfaction of women and the scores obtained on client-centred care. Some women who describe very disrespectful experiences at the end indicated high satisfaction with care. Williams (1994) cited in Beattie et al (2014:2) posit that for fear of reprisal or because of feeling empathy for those providing care, patients do not readily express dissatisfaction with the actual care received. This could explain why women generally indicated satisfaction with care.

8.2.10 Organisational factors that influence client-centred childbirth

Effective implementation of client-centred care depends on putting in place a well-coordinated and well-integrated health care environment that is supportive. The organisational factors identified as influential to client-centred care were: leadership, training of staff, provision of guidelines, provision of resource, and institution of

monitoring and feedback mechanisms. For leadership, the findings showed that though management of health institutions occasionally discussed client-provider relationship issues and expressed support for the initiative, very little was done to systematically demonstrate leadership or to create the organisational climate to facilitate the adopted of client-centred principles in the health facilities. Furthermore, only a few doctors and midwives stated that they have come across policy documents or guidelines that contained issues on how to make services client-centred. Relatedly, majority of doctors and midwives had no formal training on client-centred care. Only a few mentioned that they attended a workshop on customer care or other workshops at which issues on how to be client-friendly were mentioned. Learning materials were also in limited supply. Generally, it was evident that the women and health professionals would require training to make them better understand the approaches to making services more client-centred.

Regarding provision of resources, the general impression from the study was that though efforts are being made to provide resources, many of the equipment and supplies needed are still not readily available.

Monitoring systems such as peer reviews, client complaint system, and client satisfaction surveys and records review were some of the mechanisms that the participants mentioned as modes of monitoring and providing feedback. However, they noted that they have not been actively involved in such activities. As well, majority felt that very little documentation was carried out on monitoring or feedback to activities. Dissemination of findings at all levels was poor. Client feedback mechanisms were mainly verbal and at the individual client-provider interaction level.

8.2.11 Factors that hindered client-centred care

The success of client-centred childbirth will depend on a number of factors at the client, health care worker and organisational levels. Women and health professionals that participated in this study cited a number of user, health worker and organisational factors as barriers to the provision, utilisation and unacceptable experiences during childbirth.

8.2.11.1 Client factors that hindered client-centred care

The client level barriers that came up were: lack of cooperation from clients; clients' lack of knowledge; some cultural and spiritual practices, and financial challenges. Doctors and midwives felt that educating and encouraging women with low level education to understand clinical issues was difficult and also that women with low level of education were more likely to delay seeking health care. The major cultural barrier was insistence of some women on consulting their husband before agreeing to certain procedures even in emergencies. Similar concerns were raised about spirituality issues where staff at times had to wait for a personal pastor to come perform some rituals before surgery could be performed. The health professionals also felt that some clients were not truthful and often held back vital information that could facilitate care. Lack of cooperation from clients was generally seen as a barrier. Despite the implementation of the National Insurance Scheme and the free delivery policy by the Government of Ghana, this study observed that major financial barriers still existed in the hospitals.

8.2.11.2 Health care worker factors that hindered client-centred care

The findings on health workers factors that limited provision of client-centred care were: poor staff attitude; and inadequate knowledge and skills on some delivery options. Poor staff attitude was identified by both the health professionals and women who participated in the study. Staff impatience, verbal abuse, unhelpful behaviour and neglect are but a few of the issues mentioned. These attitude often greatly affected utilisation of services and the experience of women. Staff domineering attitude or controlling behaviour also negatively affected decision-making and informed choice.

In terms of knowledge and skills, it was noted that majority of doctors and midwives have not had formal training on client-centred care, necessitating the need to equip them not only on the knowledge and skills on client-centred care principles but also on some technical aspects such as birth positions and other methods of labour pain relief. Equally important, will be update on leadership, communication and interpersonal relationship, performance management as well as mechanisms for monitoring and feedback. The need for making women and the public as a whole awareness of the principles of client-centred care and their roles and responsibilities were noted.

8.2.11.3 Organisational barriers that limit implementation of client-centred care

According to the participants, the organisational factors that hindered effective implementation of client-centred care were: some facility rules and routines; lack of equipment and logistics; inappropriate infrastructure and inadequate space (built environment); inadequate staff; inappropriate work organisation; non-availability of some services; and high workload. Language barrier was also noted as a barrier. Summary of the findings on these factors are presented below:

8.2.11.4 Facility rules and routines

Doctors and midwives were of the view that strict adherence to certain rules and routines hindered the provision of quality care and provision of choice to mothers. These included procedures for obtaining supplies like medicines, consumables and blood from other departments in emergencies where clients or their families were not available to pay. Others were hospital protocols on labour support or companion, labour pain relief and rules and restrictions on visitation.

8.2.11.5 Lack of equipment and logistics

Views were expressed about acute shortage of beds, bedsheets, wheelchairs, sphygmomanometers, ceiling fans that do not work, broken down laboratory and diagnostic equipment and many others. Shortage of medicines such as Ergometrine and supplies like gloves came up.

8.2.11.6 Infrastructure and space (built environment)

Generally, both doctors and midwives, and women openly expressed their displeasure with the infrastructure and space for providing care. There were concerns about dysfunctional dilapidated elevators as women in labour had to be carried by relatives to climb staircase from one floor to the other. The physical structures did not allow for effective provision of privacy. Concerns were raised about the cleanliness of toilets and washrooms.

8.2.11.7 Inadequate staff

Another major barrier that was indicated by both women and health professionals was the inadequacy of the staff to offer services. The major categories mentioned were midwives, doctors and housekeeping (labourers and cleaners) staff. The participants noted that the low number of staff caused more delays in attending to clients. It also contributed to staff's inability to have time for the clients as was needed in client-centred care. Women were quite frustrated and hindered in even requesting for help from visibly tired midwives. The health professionals complained about stress, low job satisfaction and instances where doctors and midwives had to do housekeeping activities.

8.2.11.8 Inappropriate work organisation

The current practices that doctors and midwives felt were inappropriate were the following:

- The arrangements at the ante-natal clinics that resulted in long delays.
- The assignment of work at the labour ward that limited women's ability to choose.
- The assignment of midwives to specific sections of the maternity unit and the difficulties with shifting staff in times of shortages in other units.
- Frequent rescheduling of doctors to different units so they are not able to establish long relationships with clients.
- The lack of formal systems to orient women to the labour ward so they could be familiar with the labour ward environment and staff prior to labour.
- Improper location of wards such as putting the labour ward on the top floors in structures that have no elevators.

8.2.11.9 Non-availability of some services

Women do not want services that are fragmented but prefer a one-stop-shop. Non-availability of some diagnostic services such as sonography and other laboratory tests was seen a barrier.

8.2.11.10 High workload or patient numbers

High workload was mentioned by both women and health professionals as a barrier. Women felt that the inability of staff to deliver quality care was partly due to the high

number of patients as it contributed to long waiting time, inadequate staff time to attend to clients and even affected availability of beds and space.

8.2.11.11 Language barrier

Language barrier was seen by both women and the health professionals as a big barrier to effective communication. English is the main language used but the majority of women would prefer to be educated or communicated with in their local language or to have a health professional or an accredited interpreter to explain issues to them.

8.2.12 Recommendations from participants

Recommendations from both women and health professionals were in line with the barriers identified. The following were indicated:

- Improving staff attitude for them to be patient, attentive, friendly and also establish good relationship with client.
- Provision of relevant training for both health care workers and clients on client-centred care.
- Improving staffing levels in hospitals.
- Provision of the needed equipment and logistics to enhance service provision and also make clients more comfortable while in the health facility.
- Identifying avenues to improve health facility infrastructure to accommodate the workload and also facilitate easy flow of work.
- Institution of measures to review and re-organise the following services:
 - Put in place measures to ensure that women get to know their birth attendants prior to labour.
 - Sitting of wards and procedure areas to facilitate flow of work.
 - Scheduling of both doctors and midwives so that they can have continuous interaction with clients to build relationships.
 - Institution of a system where they could be assigned to a midwife in the labour ward as their primary delivery care provider.
 - Review of opening hours at the ante-natal and instituting systems to monitor staff during work hours so they can take responsibility and stay in the health facility do their job.

- A review of the procedures for obtaining emergency medicines, blood and other supplies.
- Formalisation of regular joint meeting of all staff to review progress of patient.

8.3 GUIDELINES TO IMPROVE CLIENT-CENTREDNESS OF CHILDBIRTH SERVICES IN HEALTH CARE SETTINGS IN GHANA

8.3.1 Introduction

Client-centred care has gained tremendous recognition globally as an important health care delivery strategy that helps to improve the safety and quality of care. This is because of the growing recognition that current childbirth services are not meeting the required standards that offer women good experiences. Many governments around the world are thus instituting measures to centre childbirth services on the needs and preferences of individual patients (Kitson, Marshall, Bassett & Zeitz 2012:1). As important as the outcome of childbirth may be for women and their families, the way in which a woman experiences pregnancy and delivery is also vitally important.

Like many developing countries, Ghana over the years has consistently been looking for ways to improve the quality of childbirth services. The Government of Ghana clearly expressed its commitment to this course and explicitly stated in the vision and values of the Ministry of Health, Ghana and Ghana Health Service are the objectives of providing individualised care and centring care on patients. The client-centred approach to health care provision has as its hallmark individualising care. It also encompasses qualities of compassion, empathy, and responsiveness to the needs, values and expressed preferences of clients (IOM 2001:48-51). To effectively put client-centred care principles into practice and lead the change process, health workers need guidance that are specifically outlined in documents such as policies, guidelines, standard operating procedures and protocols. Birken, Lee and Weiner (2012:1) note that the gap between evidence and practice can be closed only if health care organisations begin to adopt evidence-based practices. It is hoped that providing these recommendations to guide implementation will go a long way to help improve the experiences of women.

This document is tailored to the provision of client-centred childbirth services (that is, ante-natal, delivery and immediate post-natal) in health facilities. It is designed to be used in addition to other policies and standards operating procedure documents that are available in the country. The document is structured in three main sections. Section one outlines the process of developing the guidelines, definition of terms, scope of application, purpose, objectives, guiding principles of the document, definition of centred care childbirth and its attributes or principles. Section two deals with the technical guidelines on client-centred childbirth services, focusing on the major factors that influence client-centred childbirth. Section three presents issues on organisational factors required to support effective implementation of client-centred childbirth services.

8.4 SECTION 1: INTRODUCTION TO GUIDELINES

8.4.1 Process of guidelines development

The agenda for developing these guidelines emanated from the concerns about the quality of childbirth services in Ghana and the need to make services more client-centred. The findings from the studies in chapters 5 to 7 and extensive literature review were used to draft the guidelines. The draft document was subjected to reviews by a group of senior health professionals to build consensus on the content and to determine its feasibility in the Ghanaian context. The conceptual framework for developing guidelines is presented in Figure 8.1.

Considering the fact that client-centred care is still in its infancy in Ghana, the drafting and the review teams were mindful of the context of services delivery. Efforts were made to make the document portable and also use simple language while ensuring that the content meets the minimum acceptable standards that are practicable in the services delivery context of Ghana. It is also designed to meet the needs of patients and promote good professional practice.

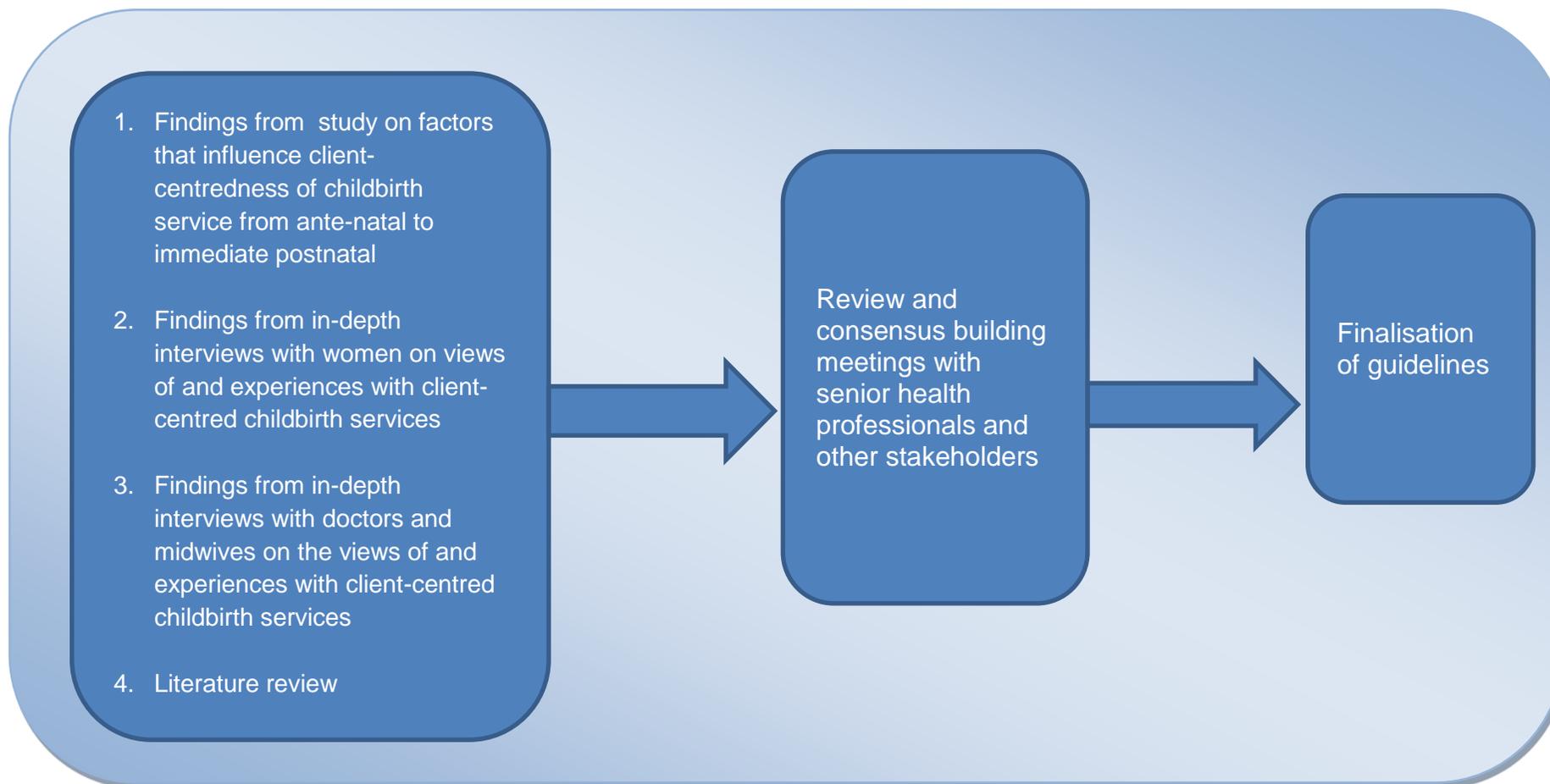


Figure 8.1: Framework for developing guidelines on client-centred childbirth

8.4.2 Scope of application of guidelines

The guidelines are to be applied in health care facilities and service delivery points that provide childbirth services in Ghana. It is designed to guide planning, implementation, monitoring and evaluation of childbirth services. The main target groups are health workers who are involved in providing direct patient care, health facility managers and health policy makers.

8.4.3 Purpose of the guidelines

The purpose of the document is to provide evidence-based guidelines on client-centred care to assist health facilities improve client-centredness of childbirth services in Ghana.

8.4.4 Objectives of the guidelines

The objectives are to:

- Explain the meaning of client-centred care with special focus on client-centred childbirth and its attributes.
- Describe recommended practices to make childbirth services more client-centred in health facilities.

8.4.5 Guiding principles of client-centred childbirth

The guiding principles are:

- Individuality of care
- Team work
- Mutual respect and trust

8.4.6 Definition and meaning of client-centred childbirth

Consensus on the most acceptable international conceptualisation of patient or client-centred care is lacking. Several definitions, and models and allied concepts such as person-centred care, relationship-centred care, and patient-focused care have been

proposed. In this document, patient-centred and client-centred care will be used interchangeably. Client-centred care has been defined as ‘focusing on patient and individual's particular health care needs, incorporating patient's view points and perspectives into management of his/her illness’ (Anjum 2014:611). The concept was also defined in McCormack et al (2011:1) as ‘an approach to practice that is established through the formation and fostering of therapeutic relationships between all care providers, patients, and others significant to them’. The term has also been seen as an approach to care that includes ‘informing and involving patients, eliciting and respecting their preferences; responding quickly, effectively and safely to patient’s needs and rights; ensuring that patients are treated in a dignified and supportive manner; delivering well-coordinated; and integrated care (Coulter 2004 cited in IAPO 2007:9). There appears to be many similarities in the definitions but a cross-cutting view is the importance placed on the needs and preferences of clients.

An adaptation of the definition in Coulter (2004) cited in IAPO (2007:9) is proposed as the definition of client-centred childbirth in the guidelines document. Therefore, client-centred childbirth refers to *‘an approach to providing health care which entails informing and involving clients and their families, eliciting and respecting their preferences; responding quickly, effectively and safely to clients’ and their families’ needs and rights; ensuring that clients and their families are treated in a dignified and supportive manner; and delivering well-coordinated and integrated care’.*

The definition implies that the design and implementation of all health care activities such as procedures and treatments during pregnancy, birth and immediate post-natal stages should meet the clients’ goals for care while fully informing and involving the patient and family in the decision-making process. Additionally, the importance of involving the family or social network in childbirth is imperative as childbirth experience does not include the patient alone but a host of other family members and health care team (AWHONN 2012:151). This definition is broad and applicable to the delivery of childbirth services.

8.4.7 Components or attributes of client-centred childbirth

The attributes of client-centred childbirth and their explanations are presented in Table 8.2.

Table 8.2 Components or attributes of client-centred childbirth and their explanations

Component/attribute	Explanation/definition
Individualised care	This implies care that is planned to meet the needs and preferences of a patient. It includes making a holistic assessment to 'know' the patient and avoiding the one-size-fits all approach to care. In this regard it also includes involving the family. Client-centred means that the client comes first in the service delivery relationship.
Respect, dignity, courtesy and privacy	<p>Respect, dignity, courtesy and privacy are often used interchangeably.</p> <p><u>Respect</u> refers to the “acknowledgment of a person’s right to hold views, make choices, and take action based on personal values and beliefs” (Beauchamp and Childress 2001 cited in Beach et al 2007:693).</p> <p><u>Courtesy</u> could be seen as good manners or showing politeness in one's attitude towards others.</p> <p><u>Dignity</u> in care, means the kind of care which supports and promotes, and does not undermine, a person’s self-respect regardless of any difference (Cass et al 2006:6).</p> <p><u>Privacy</u> refers to visual, auditory and informational privacy. Assuring these help to maintain individual dignity and promote confidentiality.</p>
Effective communication and education	Implementing mechanisms to ensuring that every pregnant woman bases her childbirth care decisions and actions on accurate, up-to-date and comprehensible information.
Interpersonal relationship	Refers to the existence of close association or interaction between the client and the care provider that makes it possible for them to work together toward achievement of set goal(s). The notion of client and provider “working together” conveys a form of collaboration and suggests a possible emotional bond (Doherty 2009:45).
Decision-making	The evidence-based practice from the literature recommends that a patient be given control over decision (Martin & Robb 2013:2). Women having control over decision means: being given information about why particular actions are crucial; being involved in decisions about all aspects of care with information on the whys, how and when; being given opportunity to choose among available options; and having the right to refuse specific treatments (Martin & Robb 2013:2).

Component/attribute	Explanation/definition
	While some clients in Ghana would want to have control over decision, others would give the responsibility to health providers or family member. However, clients want to be given information or explanation actions by care providers. It is recommended to seek clients' views on which approach to use.
Informed choice	Choice can also be seen as an act which requires intimate connections between reason and rationality, a weighing up of risks and benefits and an ordering of preferences based on their utility (Allingham 2002 cited in Snowden et al 2011:[1]). This implies providing accurate and complete information on all available options on issues related to pregnancy and birth and allowing the women to make a choice.
Involving clients and families in health care	Client and family involvement in health care is the process and state of being engaged, informed, collaborative, committed to one's health care or the mutual exchange of information and ideas between the care-giver and patient resulting in an emphatic, trusted relationship which benefits the experience of the user (Patel & Rajasingam 2013:597; Johnson et al 2012:1).
Support in childbirth	<p>Women tend to require more physical, psychological and emotional as well as socio-cultural and spiritual support during pregnancy and childbirth.</p> <p>Physical support refers to having somebody physically present at the woman's bedside throughout labour to provide emotional, psychological and other non-technical medical services such as comfort and encouragement.</p> <p>Socio-cultural support comprises family support, respect for religion, traditional beliefs, values and norm.</p> <p>Likewise women do have strong moods and emotions, and worries – these psychological and emotional issues require the needed support from the care providers.</p>
Continuity	<p>Continuity of care is defined as the degree to which a series of discrete health care events are experienced as coherent, connected and consistent with the patient's medical needs and personal context (Haggerty et al 2003:1220-1221). The three types of continuity are: informational; management, and relational continuity.</p> <p><u>Informational continuity</u> is the aspect that links care from one provider to another and from one health care event to another, and comprises accurate documentation and provision of information on diseases, procedures, patient's preferences, values and context of service delivery. Information can be transmitted through several media.</p> <p><u>Management continuity</u> refers to the sharing of management plans or care protocols to facilitate continuity in care.</p>

Component/attribute	Explanation/definition
	<i>Relational continuity</i> relates to establishing ongoing relationships with individual or multiple care givers thereby assuring patients of a sense of predictability and coherence.
Safety of care	Safety of care means that patients should not be harmed by the care that is intended to help them, nor should harm come to those who work in health care (IOM 2001:44).
Integration and Coordination of care	Integrated health care refers to the management and delivery of health services in such a way that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system (Waddington & Egger 2008:4). Coordination refers to the deliberate organisation of patient care activities between two or more people (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services (McDonald et al 2010:4). It includes working as a team to minimise duplication.
Accessibility and receptiveness of the health system	Accessibility is defined as the possibility to identify health care needs, to seek health care services, to reach the health care services, to obtain or use health care services and to actually be offered services appropriate to the needs for care (Levesque et al 2013:4). In this context, much emphasis should be placed on the quality of reception the patient obtains on arrival at the health facility.
Welcoming built environment	This aspect entails the health facility designs and features such as space availability, ambiance, source of power and water.

8.5 SECTION 2: TECHNICAL GUIDELINES ON CLIENT-CENTRED CHILDBIRTH

This section provides the technical guidelines related to provision of client-centred childbirth services in health facilities. It must be noted that though recommendations are presented under discrete sub-headings, most of them are interrelated.

8.5.1 Providing individualised care

Individualised care refers to care that is designed to meet the needs and preferences of a patient. It also includes involving the family and significant others. To provide individualised care, the following should be applied:

- Care providers should focus on each woman's needs and requirement looking at her capacities and strengths.
- At the ante-natal level, the personal midwife in conjunction with the woman should develop a personalised plan of care (i.e. nursing care plan) for her care.

This could be done on a separate sheet and attached to the maternal health records. This plan will help to coordinate the care for the woman throughout the continuum of care. The care plan could also be used as a quality assurance tool to monitor the woman's progress.

- The care plan should take in consideration the woman's changing needs, situation and circumstances. The care plan should be updated at the different stages, for example, labour and postnatal.
- Be empathetic in your approach to care, put yourself in the woman's shoes.
- Make effort to understand the reaction of women to issues.
- As much as possible:
 - promote use of personal attire while in the health facility
 - be flexible about time for health facility procedures such as food service and sleeping time
- Just asking what a woman prefers may go a long way to personalise care.

8.5.2 Dignity, respect, courtesy and privacy

Women, their partners and their families should always be treated with kindness, respect and dignity. In the same vein, the views, beliefs and values of the woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times (NICE, 2008:7). The guidelines for assuring these are as follows:

- Address or call women by their titles and names they prefer to be called.
- Do not refer to clients as diagnoses, problems or labels.
- Introduce myself and share some information about yourself, for example, your profession and reason for the contact with the woman.
- Women feel respected when addressed politely and nicely, and when 'talked to well'.
- Demonstrate respect and value for clients by listening with openness. Some women feel respected when their views and values are considered and when they are involved in decisions.
- Be attentive to the needs of women, be empathetic, demonstrate caring behaviour, promote autonomy where required and recognise individuality of women.

Note:
Respect is reciprocal irrespective of age of social status.
Women also have the responsibility to preserve their own dignity.

- Demonstrate or show love.
- Assure privacy – at least visual and auditory privacy.
- Assure confidentiality. In health care practice, it is accepted that a duty of confidence arises when one person discloses information to another in circumstances where it is reasonable to expect that the information will be held in confidence (Health and Social Care Information Centre 2013:8).
- Be non-discriminatory in your dealings with women.
- Do not describe clients as compliant or non-compliant.
- Women also feel respected when assisted to carry out basic activities such as touching and bathing their baby.

8.5.3 Ensuring effective communication and education

Communicating effectively with patients and families is a cornerstone of providing quality health care. The manner in which a health care provider communicates with a patient is as equally important as the information being conveyed. Women who understand their providers are more likely to accept their health problems, understand their treatment options, modify their behaviour and adhere to follow-up instructions (Frampton et al 2008:78). Note also that education and information needs vary among women. The following are provided as guides to improve communication and education:

- Sit near the woman, rather than stand.
- Make eye contact with the woman.
- Beware of your body language and its subconscious meaning.
- Whenever possible, reassure the woman through touch. Be aware of communication barriers and enquire from the woman the language she is comfortable with. Women prefer a health worker that speaks their language to translate for them if required rather than using another client.

- Explain what you want to say to the woman slowly and in small doses, giving them adequate time to process the information. Let the woman give feedback or paraphrase.
- Encourage women to share their knowledge and skills.
- Pay attention to the woman, listen. Listening requires hearing and understanding “what the person actually says and means or intends” – the woman is listened to and respected; encouraging and supporting her to ‘open-up’ (RNAO 2002:23).
- Gently ask the woman to tell you what she understood from the information and repeat what the woman said or asked to ensure you understand her question.
- Build clients’ capacity. Based on your assessment of the capabilities of the woman, provide or suggest articles, websites and books that might be helpful for further understanding. The maternal health records booklet contains very useful information that may be used as a teaching tool. You may develop a personalised information package for women.

Note:

The marital status, culture, religion, parity, trimester, and educational level should all be taken into consideration in planning what information to provide when designing and deciding on what and how to give information to women.

- Use appropriate technology to highlight your point. Videos in different languages could be used or even given out to mothers to watch at home. Text messaging may be used for those who are capable of using such devices.
- Ask if the manner and style in which you communicate is effective for the woman.
- Find out how the woman is progressing at every visit. The mother could be encouraged to keep a small book in which they could document issues they would like to know about and those discussed so that they can monitor themselves.

The group education or talk is good but clients want to be given further education one-on-one when they meet their personal care providers. As well, it would be preferred if the women were grouped according to trimesters or preferred language for the group educational sessions.

8.5.4 Personal and interpersonal relationship

The importance of quality relationship and interaction between women and health workers in the implementation of client-centred care cannot be overemphasised. To promote good relationships, the following are recommended:

- Demonstrate friendly attitude and be nice to women. The way you receive a woman, your facial expression and the manner of communication go a long way to make the client feel at home.
- Make all efforts to understand the woman and her background. Women want a personal trusting relationship. They want their care providers to know them. Support them to open-up. Health care workers need to get to know the person beyond the diagnosis and build relationships with woman and their family.
- Respect, courtesy, dignity and privacy are highly valued everyday interactions; show these qualities in your interaction with women.
- Try to understand a person in her own terms and avoiding making assumptions.
- Help women to pursue their objective through acting to promote their good and assist them to satisfy their needs and wants.
- Show empathy. To be able to empathise requires the health care provider having the competence to understand the patient's situation, perspective, and feelings, to communicate that understanding and check its accuracy; and to act on that understanding in a helpful therapeutic way.
- Assuring confidentiality, this helps to build better relationships.

8.5.5 Decision-making and informed choice

Effective decision-making in health care requires the care provider not just giving the information but also ensuring that the information is understood and that the woman is capable of making the decision or choice (Noseworthy et al 2013:e43). Factors that influence the practice of control, decision-making and choice in childbirth include personality, educational level, age, past experience, the risk implications of the decision and other contextual issues. Every woman knows or has ideas about what she wants regarding her pregnancy and childbirth. The following are provided as guidelines:

- Women require the help of their care providers to make decisions. Majority preferred shared decision with the care provider leading. There are a few women who want to have the final say, and a few are indifferent when asked of their opinion.

Shared decision-making process involves providing clients with reliable evidence-based information on the likely benefits and harms of interventions or actions, including any uncertainties and risks, eliciting the preferences of the decision maker and supporting implementation. The care providers in this context brings to the table expertise in areas such as prognosis and treatment while the client comes along with expert knowledge on how the condition impacts on their daily life, their personal attitude to risk, values and preference.

- There are yet some women who would necessarily want their spouses to be present especially when a major decision such as surgery and termination of pregnancy is to be made.
- Ensure that your communication styles and approaches are appropriate, discuss the possible positives and negatives in simple language and in the medium that client is comfortable with.
- Follow the client's leads and desires for participation.
- What is most important to them is their pregnancy and birth, but this may differ at different stages.
- Give them time to think about it. Decisions could be deferred to another visit if it is not an emergency.
- If you think the woman does not have enough knowledge to make the decision or if she is finding it difficult to decide, you can request that she brings in other people of her choice into the conversation and then leave the woman to make the decision in the presence of them that came in to support.
- Women have the right to say no and to refuse advice from their care providers.

In some exceptional situations where decisions have to be made per court order, follow the institutional rules and regulations. For example, if a decision need to be made about the unborn baby.

8.5.5.1 Informed choice

Informed choice and promotion of shared-decision-making mandates that the woman be given accurate, complete and objective information in the context of a non-authoritarian relationship with the active involvement of the woman, but often women believe that they do not have enough knowledge to choose interventions even when offered the opportunity. Health workers often give a number of reasons to justify why women could not be given choice. However, it must be noted that even in the midst of scarcity, the principle of informed choice can be practiced. Considerations to promote informed choice are:

- Women want to know the options and the choices available to them regarding their pregnancy and birth. At a minimum women require information and support to choice:
 - Place of birth
 - Birth attendant
 - Mode of birth
 - Birth position
 - Labour support
 - Labour pain relief
 - Length of stay after delivery
 - Mode of payment

The individualised care plan for the woman should clearly indicate their choices regarding these aspects of care.

- Health care providers need to know the options available in their health facility and identify with the woman regarding the one that they prefer. Clarify and provide information or education.
- Act as an advocate for the woman with other care providers and at times even with the family and community if necessary.
- Respect the woman's choices and decisions.

8.5.6 Involving women and family in care

Patient collaboration, patient involvement, partnership, patient empowerment, patient engagement are terms used interchangeably in literature in relation to how clients should be involved in their health care delivery (Longtin et al 2010:53). It is an accepted practice that when important decisions are to be made, the patient must receive detailed information on the illness, treatment options and prognosis. Health workers are of the view that involving and explaining issues help women to have idea of what is happening and that helps to get their cooperation. The following guidelines are designed to facilitate effective involvement of women and families in health care:

- Majority of women want to be involved in their care and they want issues to be explained to them but make it clear to the woman that being involved in care is voluntary.
- Create conducive environment for the engagement, taking cognisance of privacy and confidentiality needs.
- Involve them throughout the process of care. In labour especially, they want to be in the know of all that is happening or may feel abandoned, especially during labour.
- Facilitate and support client to reflect on their experience.
- Document the client's perspective with regards to what they want to achieved, noting their strengths and weaknesses.
- Ask questions to clarify aspirations, wishes, needs, preferences and concerns from women.
- Discuss what she is willing to do to improve her health.
- Find out from women those that they will like to be involved in their care. This refers to family and significant others as per the woman's wishes. Most women want at least one family member to be with while on admission.
- Engage family members present, recognising their important role in the care of the patient.

8.5.6.1 Role of the woman and family

To make the involvement process, effective women should:

- Decide their goal
- Be truthful about the information they provide to support their care
- Provide full and accurate information
- Be open to learn and actively participate in decision-making and provide feedback
- Be willing to follow through with decisions agreed on

8.5.7 Support in pregnancy and birth

Client-centred childbirth recognises the need to support the mind, body and spirit of women and their families during the trying periods of pregnancy and birth. The kind of support required at a particular time will depend on the status of the woman. The following are proposed to assist women in this regard.

8.5.7.1 Socio-cultural and spirituality support

Several women perceive pregnancy and delivery as a condition characterised with spiritual and social threats and for that matter require protection (Dako-Gyeke et al 2013:4). Guidelines in this direction are:

- Encourage women to discuss social issues that affect their well-being while under your care. Having a good interpersonal relationship with them will enable them open-up to you.
- Seek their permission if you have to involve other care providers such as the social health worker.
- Support women to realise their spiritual needs even when on admission. For example, pastors, imams and other spiritual heads could be allowed to offer prayers women required. The health facility could make arrangement for such services as well.
- Allow women to use religious artifacts such as beads and anointing oil that do not hinder the provision of care.
- Encourage women to perform other rituals that are not amenable to be carried out in the health facility prior to admission or after discharge.

8.5.7.2 *Psychological and emotional support*

According to Jomeen and Martin (2008:393-4), women usually have strong moods and emotions, and worry about issues during pregnancy and birth and will require the health worker to recognise these and offer the needed support. Some of the strategies to help women include the following:

- Women want to be able to discuss their worries and concerns with their care providers. An enabling environment should be created for women to feel free to approach and discuss their fears and worries.
- Ask clients regularly about their experiences with the care and service that they are receiving.
- When required, encourage women to make changes in their personal life and circumstances to support their health.
- Seek permission from the woman to engage the services of a clinical psychologist or a counsellor when necessary.

8.5.7.3 *Physical support*

This refers to the presence of a labour companion at the woman's bedside during labour to offer emotional, psychological and physical support. The evidence indicated that when continuous labour support is provided, women have more spontaneous vaginal birth, shorter duration of labour, less use of labour analgesia, fewer Caesarean sections and instrumental deliveries and fewer babies with low Apgar scores and most importantly, they express more satisfaction with birth experience (Amorim & Katz 2012). Currently, these services are not routinely offered in health facilities. The following are proposed to encourage this practice:

- The benefits of continuous intrapartum support seems to be the greatest when labour support is provided by a doula or any continuous non-staff caregiver (friends, family members or the baby's father) can provide labour support (Amorim & Katz 2012).
- Most women would prefer their husbands or other female family member to be by their bedside during labour.

8.5.8 Continuity of care

Continuity of care is the degree to which a series of discrete health care events are experienced as coherent, connected and consistent with the patient's medical needs and personal context (Haggerty et al 2003:1221). Client-centred childbirth requires that the staff get the opportunity to know their clients. Continuity of carer is important for this to occur. As indicated earlier, women value the personal relationship that they have with their care providers, especially the midwives. The guidelines for promoting continuity of care are presented below.

8.5.8.1 Ante-natal continuity of care

Women are happy with the concept of continuity of carer that is being practiced as part of the implementation of the focus antennal care.

- Personal midwives should endeavour to foster good relationship with the women under their care (*refer to guidelines under personal and interpersonal relationship*).
- The personal midwife should give prior knowledge to women if she will not be available during their visit. Use their contact numbers – call or text. Women would like to meet their personal midwives at every visit to the hospitals during the ante-natal period.
- Should it become necessary to reassign a woman to another midwife, the woman should be offered explanation for the change and officially introduced to the new midwife.
- If possible, provide information to enable the woman anticipate what to expect during the visit to the health facility so they can plan. For example, whether they will be doing any laboratory or imaging tests.
- Personal midwives should accompany women and introduce them to any health worker that they will refer them to for specialist care such as the medical officer and nutritionist.
- All women should be introduced or be given orientation of the labour ward prior to delivery so that they the can familiarise themselves with the setting and the staff.

8.5.8.2 *Intrapartum continuity of care*

In patient-centred childbirth care, traditional off-shift reporting is expanded beyond a peer-to-peer exchange of information to also involve the woman (Frampton et al 2008:112). This process provides the opportunity for the woman to actively participate in the dialogue about the plan of care, concerns that have arisen, and progress made.

- All staff should endeavour to introduce themselves prior to caring for the woman. This could be facilitated by the wearing of name tags.
- Shift handing over should involve the woman and must be done at the woman's bedside. However, if your assessment of the environment in terms of privacy and confidentiality make this impractical, ensure to introduce the new staff to the women during the chart rounds.
- Progress report should be provided to the woman at regular intervals.
- The woman should be involved in all discussions about her care and treatment.

8.5.8.3 *Intrapartum – postnatal continuity of care*

- Providing information on the discharge plan, especially an estimation of the length of stay after delivery from ante-natal stage helps the woman and her family to plan ahead.
- On admission, a discharge plan should be developed with the woman and her family. This plan also equips the woman and her family with the knowledge, skills and confidence to better manage their health when discharged. The discharge plan also serves as a quality assurance and monitoring tool.
- Educate women based on their need prior to discharge; special attention should be paid to first time mothers.
- The discharging midwife should officially introduce the woman to the staff responsible for postnatal care in the health facility or link them to the Community Health Nurses in the community for subsequent care.

8.5.9 Organisational factors that promote implementation of client-centred childbirth

Effective implementation of client-centred care does not depend on only providing technical guidelines and having an informed and involved patient and family; equally important, are having receptive and responsive health professionals and putting in place a well-coordinated and well-integrated health care environment that supports the efforts of patients, families, and their care providers (Epstein et al 2010:1492). Leadership and commitment from top management and department heads, workforce development and institutionalisation of systems to measure and provide feedback to the staff, patients and families are but a few of the contextual factors required supporting client-centred approach to care. The following are some suggested ways to address these issues.

8.5.9.1 Leadership

Leadership from top management, departmental and unit heads, supervisors, physicians and other senior health care providers at all the levels, is paramount for the approach to care to succeed. As noted in Frampton et al (2008:41) leaders in their own behaviours and values, set the tone for implementation of client-centred care. Walking the talk means communicating openly, soliciting and responding to input from the staff, patients, families and others, and ensuring that the staff members have the resources and flexibility they need to provide patient-centred care. The following are proposed:

- There is the need for clear strategic vision and promotion of a climate conducive for experimentation and risk taking in health facilities.
- Facility managers will have to examine organisational policies and rules to encourage the implementation of the principles of client-centred care practice. This could be facilitated by conducting health facility readiness assessment to identify the aspects on which to focus.
- It may not be necessary to establish another structure for implementation if the health facility already has a functioning quality assurance team or committee. However, institutional champions or focal persons will be required to help precipitate interest and formation of positive attitudes for behavioural change. New initiatives require leaders who will transform an idea into a lived reality (RNAO 2002:28). The champions can serve as a vital linkage to senior

management, sharing information, influencing others and fostering synergy with broader organisational goals.

- It is imperative for leadership to help inspire action among the multiple players needed to advance patient-centred care through demonstration of open commitment and serving as role models.

8.5.9.2 Staffing

An important ingredient for client-centred childbirth is adequate staffing and appropriate levels of full-time staff, especially midwives. It is common knowledge however that the health sector has over the years been grappling with inadequate numbers, and unbalanced skill mix and mal-distribution of staff. As the Ministry of Health puts in measures to develop a national staffing norm and also redistribute staff (Ministry of Health 2015b), managers of health facilities would have to identify other innovative ways to improve the efficiency and effectiveness of available staff. The use of retired staff to work flexible hours could be explored. It is also common knowledge that there are a number of qualified health professionals that the government is unable to offer employment. Health facility managers in collaboration with some Non-governmental Organisations could explore the possibility of engaging them as volunteers.

8.5.9.3 Education, training and staff development

Competent health practitioners are required to deliver health care that is responsive to the needs, preferences and expectations of women. Gordon and Watts (2011:35) stress the fact that nurses and for that matter health care workers have a pivotal role in ensuring that patients receive safe, effective client-centred care, based on the best available evidence. Components of client-centred care are often incorporated in other health training programmes, but it appears that key aspects of client-centred childbirth are usually not addressed holistically. The education and training of health workers is thus imperative.

- All health workers, including managers should have regular training on client-centred care tailored to the specific job. Regular in-services training at the workplace cannot be overemphasised. On-the-job training through supportive supervision must be encouraged.

- Principles of client-centred care should be incorporated in all health training programmes, including pre-service training programmes. This may call for a review of curriculum.
- Regulatory bodies could make training in client-centred care one of the requirements for renewal of registration.
- Educational programmes must teach and assess knowledge and skills more frequently and rigorously.
- Aside having knowledge on how to handle clinical diseases, introduction to client-centred care (that is, what it is, its importance in health care, attributes) and clarification of personal values, and values and beliefs that underlie client-centred childbirth. Pelzang (2010:916) indicates that the following skills are important for health professionals:
 - Data gathering or patient assessment skills (ability to determine, plan and prioritise patient care. This may include development of the patient care plan).
 - Procedural skills (ability to follow the principles of procedures, for example, paying attention to patient comfort and dignity).
 - Communication skills (ability to communicate with patient, family and professionals).
 - Relationship skills (ability to develop and maintain the helping or professional relationship).
 - Reporting and recording skills (ability to maintain and communicate the details of patient clearly, completely and concisely).
- Use all adult teaching and learning strategies that promote learning.
- Empower health workers to be part of teams responsible for promoting client-centred care.
- Recognise and reward staff that exhibit patient-centred principles.

8.5.9.4 *Equipment and supplies*

The guidelines can only be effectively implemented when the necessary resources are made available. Resources were required not only to ease difficulties that staff goes through in offering services but also to make clients more comfortable while in the health facility. For example, availability of bed is a major limitation to client-centred

childbirth care. Managers of institutions may have to carry out an audit of the equipment and supplies situation for further action. For example, the findings from the audit could provide evidence-based data to better engage Developmental Partners and other Non-Governmental Organisations for support.

8.5.9.5 *Infrastructure and environment*

The built and aesthetic environment of health facilities is very important to the well-being of both clients and care providers (McCormack et al 2011:3). Patients often enter the doors of a hospital with heightened feelings of stress, anxiety and vulnerability and that the environment that meets them has the potential to profoundly exacerbate, or conversely, to profoundly lessen these states of mind (Frampton et al 2008:170). Health facility beds and gowns, nametags and treatment schedules, are examples of routines that objectify clients and detach them from their personal world (RNAO 2002:29). Creating a more humane and home-like environment with personal items and pictures can assist clients to maintain a sense of identity and signals that caregivers honour the clients' world. The following are provide as guides:

- Environmental cleanliness is important. Cleaning should comply with the infection prevention and control guidelines of the Ministry of Health. A patient-centred environment of care is one that is safe and clean.
- Infrastructural design should endeavour to provide adequate space for the workload and facilitate patient privacy, comfort and dignity.
- Waiting areas should be comfortable and have inadequate seat for clients and visitors.

8.5.9.6 *Re-organisation of services*

To make services more client-centred managers of health facilities may consider reviewing and re-organising the following services or aspects of services:

- Engaging the staff on siting wards and procedure areas to facilitate flow of work.
- Scheduling of both doctors and midwives so they can have continuous interaction with clients to build relationships.

- Instituting systems to monitor staff during work hours so that they can take responsibility and stay in the health facility do their job.
- A review of the procedures for obtaining emergency medicines, blood and other supplies so that can have easy access to such items for care.
- Formalisation of regular joint meeting of all staff to review progress of patient.
- Offering women the opportunity to get to know their birth attendants prior to labour.
- Institute open visiting hours for women.
- Re-look at the opening hours at the pre-natal clinics to help reduce the long delays at the ante-natal clinics.
- Institute a system where women could be assigned to a midwife in the labour ward as their primary delivery care provider.

Utilising quality improvement approaches of further analysing the suggestions for reorganisation, hypothesing the best ways or ideas and testing to see if it works or not will be beneficial.

8.5.9.7 *Integration and coordination of care*

Different care providers offer services to women during pregnancy and birth. To enhance the experience of women, care needs to be delivered in a coordinated manner among the caregivers. The following are proposed to help offer a more integrated and coordinated childbirth service:

- All women seeking pregnancy and delivery care in health facilities should have individualised care plan that reflect activities or actions aimed at achieving their identified goals (*see section on individualised care*).
- Promote teamwork. This helps effective communication and reduces fragmentation while ensuring that all service providers involved in the care of the woman obtain the requisite information to guide her care.
- Regularly solicit women's perceptions about the coordination of care or services and make this information available to relevant care providers involved in the care process.

- As practicable as possible, health facility managers should put measures in place for women to be able to source all needed services, including laboratory, diagnostic and pharmaceutical services from their primary health facility.

8.5.9.8 *Staff health and welfare*

Promoting client-centred care is not limited to only issues seeking to enhance the experience of the external client (women and family); equally imperative, is the welfare and experience of the internal client (staff). Considerable attention must also be paid to the experience of care providers. As outlined in Frampton et al (2008:195), providing client-centred care requires the staff to give tremendous amounts of themselves (both physically and emotionally) and that acknowledging and being responsive to their experience, and the multi-faceted demands placed on them every day, is fundamental to the achievement effective client-centred care. Facility managers, heads of department and units as well as supervisors should endeavour to determine and address the needs of staff. Ensuring the availability of staff health or assistance programmes will offer support and demonstrate caring. It is imperative to institute performance management and recognition programmes that benefit all care providers.

8.5.9.9 *Monitoring and feedback*

The implementation of client-centred care in health facilities is a systematic process that requires baseline and interval evaluations of the changes experienced by clients and health care providers (RNAO 2002:29). In other words, there should be a system to continuously monitor the impact of specific interventions and change strategies in a patient-centred health care system. The value of such measurement and feedback lies in using them to design and implement specific interventions or processes to improve the patient experience. It is proposed that:

- Systems for regular monitoring and feedback on client-centredness of childbirth services are put in place in all health facilities. This could be extended to the community. A sample tool has been provided in Annexure 1 that could also be used to assess client's experience with childbirth services.

- The Ghana Health Service also recommends at least twice a year both staff and patient satisfaction surveys are carried out in all health facilities. This practice is very effective and should be promoted.
- Data on inputs, processes and outcome should be tracked, benchmarked and used to improve quality of care.
- At the individual level, the staff should engage clients in evaluation of care and outcomes. Find out what they think about their care, progress and achievement of goals. This should be continuous and be done in every visit to the health facility.

8.6 CONCLUSION

Client-centred care has gained tremendous recognition globally as an important health care delivery strategy that helps to improve the safety and quality of care. WHO (2007:3) states that improving health care quality and safety, and enhancing people's experience of care require attention not only to health system design but also to the process of patient care. This guidelines document was developed with inputs from a series of local research and extensive literature review. It was also subjected to reviews by senior health professionals. Not only does the document offer technical guidelines but also provides ways to address local organisational factors necessary for effective implementation. This guideline though specific to client-centred childbirth could be adopted to suit other aspects of service delivery.

CHAPTER 9

CONCLUSION AND RECOMMENDATIONS OF THE STUDY

9.1 INTRODUCTION

The purpose of this thesis was to examine issues related to the provision of client-centred childbirth services and to develop guidelines that would help improve client-centred childbirth services in health facilities in Ghana. The study encompassed care providers as well as the users of the service so as to have a comprehensive view of experiences. Both quantitative and qualitative methods were used to obtain information. Chapters 5 to 7 presented the findings and discussion of the three studies conducted while Chapter 8 entailed the summary of the findings and the guidelines on client-centred childbirth. This chapter presents the conclusions of the study, the limitations and recommendations.

9.2 CONCLUSIONS

This study sought to examine the extent of implementation and or routinisation of client-centred practices in childbirth care so as to develop guidelines to improve services. Though the findings showed that there is still more room for improvement, the research produced some valuable results that could be used to improve the client-centredness of childbirth services and quality of services in hospitals generally. On the whole, the quantitative study findings showed average performance, depicting that while some women had good experiences, a number of them had major concerns with their care. The scores of as many as five (5) of the nine (9) dimensional scores indicated need for improvement. Seven (7) items were retained as significant on the binary regression analysis. This indicates the relevance of these variables in promoting client-centred care. The importance of the variables that were significant portrays that improvement efforts should pay more attention to: the quality of care in all categories of health facilities that provide childbirth care; pain management practices; mechanisms of conducting the different modes of delivery; the category of health professional that assists in delivery; the length of stay after delivery; and the educational level of women.

A number of the findings in the quantitative study were corroborated in the qualitative studies. The women valued good relationship, especially, the one they had with their personal midwives but also expressed shortcomings in many aspects of care including preservation of their dignity and privacy. General lack of informed choice and a number of instances of gross disrespect and abuse were cited. Disrespect and abuse are counterproductive in the client-centred care environment and should not be tolerated. Therefore, it was not surprising that most of recommendations made by the women were in the relational and communication components of care. It was also evident from the interviews that mechanisms needed to be instituted to enhance practices geared towards emotional, psychological, socio-cultural, spiritual and physical support that women receive during childbirth. It must be indicated that though women expressed high ratings on overall satisfaction with care, major part of their actual experiences did not support their ratings. This finding supports the views of many researchers that posit that assessment of women's experiences should not be limited to just their overall judgement of satisfaction but should also determine how specific aspects of care were experienced.

The conclusions from the interviews with the doctors and midwives indicated that though majority of them have not had any specific training on client-centred care, they appreciated the need to individualise care and pay attention to the needs and preferences of women. However, the intent was not fully practiced. The themes that emanated from the interviews pointed to the fact that health care workers recognised the shortfalls in their own practice. They realised the need to create more opportunities for clients and families to be involved in care; they felt the need to better promote open communication and education of women, and most importantly, they voiced the relevance of health staff having qualities such as patience, tolerance and empathy that can translate into improve behaviour and attitudes. Inadequate leadership, unsupportive organisational structures and measures required to implement client-centred care as well as inadequate commitment on the part of both direct care providers and managers continue to be a major barrier to the effective institutionalisation of client-centred care. Having policies, guidelines and protocols to give direction was raised. Poor infrastructure, limited equipment and logistics, inadequate staff, high workload and some disobliging facility rules and regulations were issues that needed to be addressed. The organisational challenges hindering effective implementation of client-centred care that the health professionals tabled cannot be overlooked.

However, the conclusions of this research must be considered with its limitations kept in mind.

9.3 RECOMMENDATIONS

The following are recommended:

9.3.1 Leadership and organisation for client-centred care

Successful implementation of client-centred care in health facilities requires concerted leadership effort and workable organisational arrangements. A national strategic plan guided by clear policy direction emphasising the importance that all stakeholders in health should attach to routinising the principles of client-centred care is imperative. Leadership engagement needs to make this vision amply known to all staff and should also demonstrate open commitment to achieving client-centred care objectives.

Equally important is making available guidelines and protocols which do not only outline the standards required for practice but also serve as reference and learning documents. The starting point could be the implementation of guidelines on client-centred childbirth that was developed as part of this project. Ministry of Health, Ghana could focus on this aspect of service delivery, adopt the guidelines, build more consensus on it through wider consultations and facilitate its implementation.

It is imperative to have structures in hospitals that can continuously oversee the day-to-day issues of implementation. Quality assurance teams or committees, if in existence, could be assigned this responsibility. Champions could also be nominated to precipitate interest and formation of positive attitudes for the behavioural change required.

The need for substantial investment in infrastructure, process and organisational redesign was noted in this study. At the initial stages an assessment of the organisational climate or culture could provide valuable information on organisational indices to strengthen to support the experimentation and risk taking that are often required in institutionalising client-centred care. It may be necessary to carry out a pilot study in a limited number of health facilities before embarking on a nationwide roll-out. Some health facilities could also be developed into centres of excellence to offer

opportunities to exchange experiences with best practices. Both bottom-up and top-down approaches could be examined.

9.3.2 Health care worker education and training

On-going learning to update knowledge and skills for client-centred care cannot be understated. Education and training should not be limited to only the health staff that provide direct patient care but must be comprehensive enough to build the competencies of leaders and manager to offer effective leadership. This may require a systematic examination of management capabilities and training needs assessment. It is also recommended that trainings be informed by periodic assessments in the gaps in practices. It should be mandatory for all health care workers to have regular in-service training on the subject. These trainings should imbibe staff qualities that will improve their attitudes. Officials of pre-service training health institutions should be engaged to evaluate the adequacy of curricula content on client-centred care and possible updating.

9.3.3 Reorganisation of services

Reconfiguration of childbirth service organisation and delivery may be necessary. Enough time and investment are required to coordinate care effectively for better outcomes. Calls for review of ante-natal clinic opening hours to address delays, instituting measures to offer a better coordinated care where all services could be sourced in the primary hospital and formalising the orientation of women to the labour ward so that they could familiarise themselves with what goes on at the ward prior to labour were made in this study. These are important process issues to address continuity of care. An evaluation of the Focus Ante-natal Care concept could help address gaps. Likewise, investigating the feasibility of linking women to a 'named midwife' at the labour ward could be examined to further foster continuity and development of personal relationship during labour. Re-examination of the flow of services so as to cut down irrelevant steps and activities that lead to unnecessary delays is important.

9.3.4 Staffing

The detrimental effect of understaffing on implementation of client-centred care was noted in the study. Addressing the acute shortage of staff should be given the urgency that it requires. Staffing norms should be made available to managers to guide their action.

9.3.5 Infrastructure and resources

Many concerns were raised about the state of infrastructure. Inadequate space for the workload negatively affected quality of care. Attention must be paid to obtaining additional bed space, improving the comfortability of waiting areas and most importantly, cleaning and maintaining the cleanliness of toilets and bathrooms. Not only do cleanliness and good hygienic practices in hospitals ensure an aesthetic environment but they are also vital components of client-centred care. Health care managers need to make sure that standards on cleanliness and hygiene are monitored.

9.3.6 Provision of resources

Implementing client-centred care requires significant support in terms of resources. It is imperative to improve current logistical supply system. This is fundamental for successful implementation of client-centred care recommendations. An assessment of current status of equipment and logistics management system could provide information on gaps. It may be necessary to also review procedures for obtaining emergency medicines, blood and other supplies to assure easy access.

9.3.7 Communication and patient engagement

Good client-provider interaction and relationship as well as the client involvement in care are fundamental. This study demonstrated a gap in approaches to client education, engagement and communication in general. It may be prudent for managers to procure the services of professional interpreters or at least ensure that the staff members that are proficient in the local languages are assigned to interpret educational, treatment and care issues to clients.

Women's information need and preferences vary among various groups and one-on-one educational sessions. At the ante-natal period where most education is done, health staff should endeavour to find out the preference of women on how much information and in what ways or forms information should be provided to guide their approaches and content of education. Promotion of choice in childbirth is imperative. Women need to know the childbirth options available to them. The limiting factors such as strict adherence to facility rules and regulations, inadequate knowledge and skills and lack of certain equipment and logistics need further investigation for redress. Furthermore, sensitisation campaign for patients and community member could be launched to bring to the fore the issues of client-centredness, patient rights and responsibilities. Strategies may include use of community meetings, open days, community durbars, circulars, conferences, seminars and electronic and print media.

9.3.8 Monitoring and evaluation

Measurement is central to informing and supporting service quality improvement. The shortfalls in the various aspects of care highlight the need for continuous monitoring and supervision of practices. Gathering baseline data against which future performance will be compared is recommended in all hospitals. Clients' perceptions are very useful in predicting client-centred care outcomes but the findings of this study noted that mechanisms by which clients' views could be incorporated into services delivery leaves more to be desired. Managers should institutionalise systems to regularly obtain feedback not only from client but also from their staff. Other ways of monitoring could be:

- formalisation of regular joint meeting of all staff to review progress of patient
- incorporation of indicators on client-centred care in other integrated monitoring systems such as the Health Information Management System (HMIS) and the annual peer review
- introducing client-centred care performance related incentives
- institution of review conferences and seminars for health workers to share experiences and learn from each other

9.4 FURTHER RESEARCH

The results from this study provide several opportunities for future research. Further research could explore client-centredness of childbirth services in other regions to provide more understanding of childbirth issues and provide data for comparison. Data obtained for this study were largely subjective. Therefore, other studies could explore collecting additional objective measurements of prenatal health data for example through chart reviews. Additionally, client-provider interactions could be assessed through direct observations or audio-recording to compared subjective accounts from women with actual experiences. These methods could assist to identify clear mechanisms or behaviours that better explain the differences.

Studies have shown that factor personality characteristic as such as psychological and emotional state of women (Jomeen & Martin 2008:392) influence women's experiences. As findings in these aspects of care were not very encouraging in this study, the health system could benefit from future studies that focus on these subjects.

An evaluation of the Focus Ante-natal Care concept, specifically the role of personal or 'name' midwives and how their activities could be further facilitated to enhance ante-natal experience would be beneficial. Likewise, investigating the feasibility of linking women to a 'named midwife' at the labour ward could be examined to foster continuity and development of personal relationship during labour.

It is also important that the implementation of the client-centred care guidelines be supported with targeted implementation research.

9.5 CONTRIBUTION OF THE STUDY

It must be indicated that although these results are not novel findings, their value must not be underestimated. There is limited research exploring doctors' and midwives' experiences and perceptions of childbirth practices in Ghana, culminating in the lack of local research evidence supporting many of the common practices carried out during pregnancy and birth. This study is the first in Ghana that has combined both qualitative and quantitative methods to comprehensively examine views from both users and care providers on client-centredness of childbirth services. The guidelines document that

emanated from the study is also the first that has defined a framework for making childbirth services more client-centred in Ghana.

9.6 LIMITATIONS

The following are limitations of the study:

- Criticism levelled at qualitative research in general often pertains to issues of small sample, interpretation and bias. The researcher is of the view that the rich description of the sample, data collection methods and the process of analysis demonstrates the transparent nature of the research in phases 2 and 3.
- One limitation is also that data were collected through questionnaire and in-depth interviews; a direct observation of the professionals at work would have added another dimension to enrich the findings. However, the participants were very open and clearly articulated details of their experiences.
- The health professionals and mothers voluntarily participated in the study, the views and experiences of those who did not volunteer may be different.
- Although findings may not be generalisable because the study was done in only three hospitals in one of the 10 regions, they may be transferable to other settings of similar characteristics. It must be noted also that majority of the themes identified were supported by the local and international literature. As such, the findings could be very useful to health organisations that desire to improve the client-centredness of childbirth services. The findings may also guide future research.

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ANNEXES

Annex 1: Questionnaire- women experiences with childbirth services

Instruction

This survey is about your recent experience with childbirth. Your views are very important in helping to find out how good services are and how they can be improved. Please answer the questions by ticking (✓) inside one box using a pen. Where applicable you may be requested to tick more than one box.

SECTION A - Arrival and reception during labour

A1. Did you have to wait on arrival before you were seen by a nurse/midwife/doctor?

- 1 Yes
2 No **Go to B1**

A2. How long did you have to wait before you were attended to by a nurse/midwife or doctor?

- 1 Less than 15 minutes 2 16 to 30 minutes
3 31minutes to 1 hour 4 More than 1 hour
5 Cannot remember

A3. Were you able to find a comfortable place to sit during the waiting period?

- 1 Yes, I found a comfortable place to sit 2 Yes, but it was not comfortable
3 No, I could not find a place to sit 4 Cannot remember

A4. While you were waiting, did the staff keep you informed about the reason for the delay?

- 1 Yes 2 No
3 Cannot remember

A5. Were the front desk staff friendly?

- 1 Yes, certainly 2 Yes, some how
3 No

A6. While waiting did the health care providers treat you with courtesy and respect?

- 1 Never 2 Sometimes
3 Usually 4 Always

SECTION B - Information on baby

B1. What time was your baby born? (If you had twins or more than two babies this time, please fill in this question about the baby who was born first)

- 1 Early morning (12:01am-6:00am) 2 Morning (6:01am-12:00 noon)
3 Afternoon (12:01pm-6:00pm) 4 Evening / Night (6:01pm-12:00 midnight)

B2. Roughly how many weeks pregnant were you when your baby was born?

- 1 Before I was 37 full weeks pregnant 2 When I was 37 weeks pregnant or more

B3. How much did your baby weigh at birth? (If you had twins or more than two babies this time, please fill in this question about the baby who was born first)

- 1 Less than 2500g / 2.5kg (Less than 5 pounds 8 ounces)
2 2500g / 2.5kg or more (5 pounds 8 ounces or more)
3 Cannot remember

SECTION C – Ante-natal care experience

C1. Who was the first health professional that cared for you when you first visited the health facility with this pregnancy? (Tick only one response)

- 1 Doctor
 2 Midwife/ Nurse
 3 Others (specify).....

C2. Roughly how many weeks pregnant were you when you first saw this health professional about your pregnancy care?

- 1 Before I was 7 full weeks pregnant
 2 When I was 7 to 12 weeks pregnant
 3 When I was more than 12 weeks pregnant
 4 Cannot remember

C3. At the start of your pregnancy did you have a choice about where you could have your baby?

- 1 Yes (**Go to C4**)
 2 No (**Go to C5**)
 3 Cannot remember (**Go to C5**)

C4. Did you get information from a midwife/nurse or doctor to help you decide where to have your baby?

- 1 Yes, definitely
 2 Yes, to some extent
 3 No
 4 No, but I did not need this information
 5 Cannot remember

C5. Given the choice where would you have had your baby?

- 1 At public hospital
 2 Private hospital
 3 Maternity home
 4 At home by a trained midwife
 5 At home by a TBA
 6 At home by a relative
 7 Do not know
 8 Others (specify).....

C6. Were you given any information during the ante-natal period by the health care providers on the choices available to you regarding the following?

No	Question	Response		
		Yes	No	Cannot remember
C6.1	Labour pain relief			
C6.2	Birth attendant			
C6.3	Birth position			
C6.4	Labour companion			
C6.5	Mode of delivery			

Ante-natal check-ups

A 'check-up' is any contact with a doctor or midwife to check the progress of your pregnancy. It usually includes having your blood pressure and urine checked. *Please ignore other appointments that **did not** include these things, such as a visit to the hospital for a scan or a blood test only.*

C7. Roughly how many ante-natal check-ups did you have in total? (**Not** including appointments for only blood tests or visits to the hospital for a scan)

- 1 None (**Go to D1**)
 2 1 to 6 (**Go to C8**)
 3 7 to 9 (**Go to C8**)
 4 10 to 14 (**Go to C8**)
 5 15 or more (**Go to C8**)
 6 Cannot remember (**Go to C8**)

C8. During your pregnancy were you given a choice about where your ante-natal check-ups would take place?

- 1 Yes
2 No
3 Cannot remember

C9. Which of the following health professionals did you see for your **ante-natal check-ups**? (Tick ALL that apply)

- 1 Midwife/nurse
2 Doctor (all categories)
3 Different categories of staff (doctors/nurses/midwives)
4 Others (specify).....

C10. If you saw a midwife for your ante-natal check-ups, did you see the same one every time?

- 1 Yes, every time
2 Yes, most of the time
3 No
4 I only saw a midwife once
5 I did not see a midwife
6 Cannot remember

C11. During your pregnancy did you have the name and/or telephone number of a midwife you could contact if you had concerns?

- 1 Yes
2 No
3 Cannot remember

C12. Did you contact a midwife when you had concerns about your pregnancy?

- 1 Yes
2 No (**Go to C14**)
3 Cannot remember (**Go to C14**)

C13. If you contacted a midwife, were you given the help you needed?

- 1 Yes, always
2 Yes, sometimes
3 No

C14. Thinking about your ante-natal care, were you spoken to in a way (language and choice of words) you could understand?

- 1 Yes, always
2 Yes, sometimes
3 No
4 Cannot remember

C15. Thinking about your ante-natal care, were you involved enough in decisions about your care?

- 1 Yes, always
2 Yes, sometimes
3 No
4 I did not want / need to be involved
5 Cannot remember

C16. During your pregnancy, did you attend any ante-natal classes provided by the hospital or care provider?

- 1 Yes
2 No, I was not offered any classes
3 Cannot remember

C17. Did you attend any other ante-natal classes that were not provided by that hospital or care provider?

- 1 Yes
2 No, I was not offered any classes
3 Cannot remember

Tests and scans

C18. Did you have a scan at the start of your pregnancy?

- 1 Yes
2 No
3 Cannot remember

D6. Which pain relief method did you use during delivery?

- 1 Natural methods (e.g. breathing, massage) 2 Injection of pethidine or a similar painkiller
3 Epidural or similar (injection in your back) 4 I was not told
5 Cannot remember 6 Others
(specify).....

D7. Were you satisfied with the pain relief method you used?

- 1 Yes, definitely 2 Yes, to some extent
3 No 4 Cannot remember

The birth of your baby

D8. Thinking about the birth of your baby, what **kind of delivery** did you have?

- 1 Normal vaginal delivery (**Go to D9**) 2 Assisted vaginal delivery (**Go to D9**)
3 Planned Caesarean delivery (**Go to D16**) 4 Emergency Caesarean delivery (**Go to D16**)

D9. Who assisted you with the delivery of your baby?

- 1 A doctor 2 A midwife/nurse
3 I do not know 4 Other (specify).....

D10. If you could choose, who would you prefer to assist in delivering your baby in the health facility?

- 1 Doctor 2 Midwife/nurse
3 Do not mind who 4 Others (specify).....

D11. Where did you give birth? (Tick ONE only)

- 1 On a bed in the ward 2 Delivery bed
3 On the floor 4 In a water or birthing pool
5 Others (specify).....

D12. What position were you in **when your baby was delivered**? (Tick ONE only)

- 1 Sitting / sitting supported by pillows 2 Lying on my side
3 Standing, squatting or kneeling 4 Dorsal position
5 Others (specify).....

D13. What position would you have preferred to deliver? (Tick ONE only)

- 1 Sitting / sitting supported by pillows 2 Lying on my side
3 Standing, squatting or kneeling 4 Dorsal position
5 Others (specify).....

D14. If you had an episiotomy (cut) or tear requiring stitches, how long after your baby was delivered were the stitches done?

- 1 I did not have an episiotomy (cut) or a tear 2 I did not have stitches
3 Within 30 minutes 4 31 minutes to 1 hour
5 More than 1 hour 6 Cannot remember

D15. Did you have skin-to-skin contact (*baby naked, placed directly on your chest or tummy*) with your baby shortly after the birth?

- 1 Yes
2 No
3 No, because this was not possible for medical reasons
4 I did not want skin-to-skin contact with my baby

The staff caring for you

D16. Had you met any of the staff who cared for you during your labour and birth **before** you went into labour?

- 1 Yes
2 No
3 Cannot remember

D17. Did the staff caring for you introduce themselves?

- 1 Yes, all the staff introduced themselves
2 Yes, some of them introduced themselves
3 Few, introduced themselves
4 none introduced him/herself
5 Cannot remember

D18. Did you have confidence and trust in the staff caring for you during your labour and birth?

- 1 Yes, definitely
2 Yes, to some extent
3 No
4 Cannot remember

D19. Given the choice which of the following would you prefer to stay with you during labour and birth? **(Tick only one)**

- 1 Spouse/partner
2 Family member/friend
3 Others (specify).....

D20. If you had a partner or a companion with you during your labour and birth, were they made welcome by the staff?

- 1 Yes, definitely
2 Yes, to some extent
3 No
4 I did not have a partner or a companion with me
5 Cannot say

D21. If you had a partner or a companion with you during your labour and birth were you (and/or your partner or a companion) left alone by midwives or doctors at a time when you were worried?

- 1 Yes, during labour
2 Yes, shortly after the birth
3 Yes, during labour and shortly after the birth
4 No, not at all

D22. Thinking about your **care during labour and birth**, were you spoken to in a way (language and choice of words) you could understand?

- 1 Yes, always
2 Yes, sometimes
3 No
4 Cannot remember

D23. Thinking about your **care during labour and birth**, were you involved enough in decisions about your care?

- 1 Yes, always
2 Yes, sometimes
3 No
4 I did not want / need to be involved
5 Cannot remember

D24. If you raised some concerns during labour, did you feel that it was taken seriously?

- 1 Yes, always
2 No
3 I did not raise any concerns

D25. When you called did you receive assistance within a reasonable time?

- 1 Yes, always
2 Yes, sometimes
3 No
4 I did not call
5 Cannot remember

D26. Overall, how would you rate the care received during your **labour and birth**?

- 1 Excellent
2 Very good
3 Good
4 Fair
5 Poor

SECTION E. CARE IN HOSPITAL AFTER THE BIRTH (POSTNATAL CARE)

E1. How long did you stay in hospital after your baby was delivered?

- 1 Up to 12 hours 2 More than 12 hours but less than 24 hours
3 1 to 2 days 4 3 to 4 days
5 5 or more days

E2. Retrospectively, do you feel that the length of your stay in hospital after the birth was...

- 1 Too long 2 Too short
3 About right 4 Not sure

E3. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

- 1 Yes, always 2 Yes, sometimes
3 No 4 Cannot remember

E4. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

- 1 Yes, always 2 Yes, sometimes
3 No 4 Cannot remember

SECTION F. FEEDING YOUR BABY

F1. During your pregnancy did any care provider discuss infant feeding with you?

- 1 Yes, definitely 2 Yes, to some extent
3 No 4 Cannot remember

F2. During your stay in the hospital after the delivery, how was your baby fed? (Tick ONE only)

- 1 Breast milk (or expressed breast milk) only 2 Both breast and formula (bottle) milk
3 Formula (bottle) milk only 4 Not sure

Thinking about feeding your baby (breast or bottle) in the first few days after the birth...

F3. Did you feel that midwives and other carers gave you **consistent advice**?

- 1 Yes, always 2 Yes, generally
3 No 4 Do not know
5 I did not want or need this

F4. Did you feel that midwives and other carers gave you active **support**?

- 1 Yes, always 2 Yes, generally
3 No 4 Do not know
5 I did not want or need this

SECTION G. CARE AT HOME AFTER THE BIRTH

G1. Were you given enough information about your own recovery after the birth?

- 1 Yes, definitely 2 Yes, to some extent
3 No 4 No, because I did not need this information
5 Cannot remember

G2. Were you given enough information about any emotional changes you might experience after delivery?

- 1 Yes, definitely 2 Yes, to some extent
3 No 4 No, because I did not need this information
5 Cannot remember

G3. Were you given information or offered advice from a health professional about contraception?

- 1 Yes 2 No
3 Cannot remember

G4. Overall, how would you rate the care received **after the delivery**?

- 1 Excellent 2 Very good
3 Good 4 Fair
5 Poor

SECTION H. HOSPITAL ENVIRONMENT

H1. In which type of accommodation were you admitted during the first stage?

- 1 General maternity ward 2 Single room
3 Others (specify)

H2. In which type of accommodation were you admitted after delivery?

- 1 General maternity ward 2 Single room
3 Others (specify)

H3. Which type of accommodation would you have preferred?

- 1 General maternity ward 2 Single room
3 Do not mind 4 Others (specify)
.....

H4. How clean was the ward in which you stayed?

- 1 Very clean 2 Fairly clean
3 Not clean 4 Did not stay on the ward

H5. How clean were the toilets/bathrooms in the ward?

- 1 Very clean 2 Fairly clean
3 Not clean 4 Did not use
5 Was not available

H6. How clean were the bed sheets in the ward?

- 1 Very clean 2 Fairly clean
3 Not clean 4 Did not use
5 Was not available

SECTION I. DEMOGRAPHIC DATA

Please complete as many of these questions as you can. Your answers will help us to describe the women taking part in the survey and to find out whether the care offered to women is the same regardless of their background or circumstances.

I1. Have you had any previous pregnancies?

- 1 Yes 2 No (**Go to I3**)

I2. How many babies have you given birth to before this pregnancy? (Dead or alive)

- 1 None
2 1-2
3 3 or more

I3. May I know your age?

I4. Who do you live with currently?

- 1 I live alone (with or without my baby / children)
2 With a partner/husband/boyfriend
3 With family members other than a partner/husband/boyfriend (e.g. parents)
4 With friends
5 Others (specify).....

I5. What is your highest level of education?

- 1 Never been to school
2 Primary/Junior secondary
3 Senior secondary/Vocational
4 University degree/diploma and higher

I6. Did you come for ante-natal care at this hospital during this pregnancy?

- 1 Yes
2 No

I7. How did you settle your hospital fee?

- 1 Health Insurance
2 Fee for services (out of pocket)
3 Both Health Insurance and out of pocket
4 Free service
5 Others (specify).....

I8. Did you give or pay money to any of the health professional(s) that attended to you for which you were not given an official receipt?

- 1 Yes
2 No

I9. Where do you live?

- 1 Urban
2 Semi-urban
3 Rural

J. ANY OTHER COMMENTS

J1. Is there anything else you would like to tell us about your maternity care?

THANK YOU VERY MUCH FOR YOUR HELP
Please check that you answered all the questions that apply to you.

Annex 2: Sample participant informed consent (qualitative study)

Principal researchers Name: Gertrude Sika Avortri
Address of principal researcher: Ghana Health Services, ICD, PMB, Ministries, Accra, Ghana. Tel: 00233-202011514

Dear participant,

Introduction

In line with efforts to improve the quality of care and safety practices in health facilities, a study is being conducted on client-centered care in childbirth. The findings are to guide policy and practice. You are invited to participate in this very important research project. Though you have been selected to participate in this study, your participation is voluntary. You should not agree to participate unless you are completely happy about what is expected of you. Participation in the study involves an interview on your views and how client-centered care is being or should be promoted. The interview will take about 1hour and will take place at a private office in the hospital (.....) at (.....). Apart from taking part in the interview, we do not anticipate any other risks associated with participating in the study. You will not benefit directly or personally from participating in the interview. The discussions will be audio-tapped and transcribed.

You may decline to answer any question that you are not comfortable with. You can withdraw from the study at any stage if you so wish. Even after completing the interview you can still recall your responses (refuse that your interview be transcribed) within a week. Your withdrawal will involve no penalty or loss of benefit. Once the transcription of the tapes is completed the tapes will be kept in a locked cabinet in the principal researcher’s office for a maximum of two year and thereafter they will be destroyed.

Your responses will be treated as confidential and will remain anonymous but will, however, be combined with those of other participants. Data that may be published in academic journals will not include any information that will identify you as a person. The combined results will be used to improve the quality and safety of health care. All information obtained during the course of this study will be strictly confidential. If you have any questions during this study, please do not hesitate to ask.

We sincerely appreciate your help.

Do you want to participate in the study? Yes No

Annex 3: Schedule of work for field work and report writing

Date	Activity
Jan –February 2014	<ul style="list-style-type: none"> • Letter for access and consent from hospitals • Further meetings with hospitals managers • Posting notices on notice boards
February 2014	<ul style="list-style-type: none"> • Recruitment of 3 research assistants
10 th - 20 th March 2014	<ul style="list-style-type: none"> • Two-day training of research assistants • Pre-test of questionnaire • Arrangements for data collection (Procurement of logistics, printing of questionnaire) • Recruitment of statistician to support data analysis
24 th March to 23 April 2014	<ul style="list-style-type: none"> • Data collection quantitative research with daily data entry
30 th April 2014	<ul style="list-style-type: none"> • Data analysis completed
3 rd April	<ul style="list-style-type: none"> • Pre-testing of interview guides
3 rd to 6 th April 2014	<ul style="list-style-type: none"> • Arrangements for phase 2 field work (visits to the hospitals • Meeting with maternity in-charges)
10 th May to 5 th June 2014	<ul style="list-style-type: none"> • Phase 2 field work, including daily transcribing of interview recordings • Further meetings with hospitals managers • Arrangement for phase 3 field work (Phone calls to health professionals, face-to-face meetings to recruit participants)
19 th June to 6 th July 2014	<ul style="list-style-type: none"> • Phase 3 field work, including daily transcription of interview recordings
August –sept	<ul style="list-style-type: none"> • Reading and familiarisation with transcription of interview
November 2014 to February 2015	<ul style="list-style-type: none"> • Meetings with participants to review content of transcripts • Expert review of transcripts • Analysis of qualitative data, including expert review of codes and themes
April 9 th to 7 th July 2015	<ul style="list-style-type: none"> • Visit to South Africa • Qualitative data analysis finalisation with supervisor • Report writing
July to September 2015	<ul style="list-style-type: none"> • Development of guidelines on client-centered care • Report writing

Annex 4: Sample letter to the Regional Director of Health Services

In case of the reply the number and the date of this letter should be quoted.

My Ref. No.
Your Ref. No.



GHANA HEALTH SERVICE
INSTITUTIONAL CARE DIV.
PRIVATE MAIL BAG
ACCRA. GHANA.

Date 13-03-14

THE RDHS
HO
VOLTA REGION

Dear Dr. Nuetey

STUDY TO EVALUATE CLIENT-CENTEREDNESS OF CHILDBIRTH SERVICES IN HOSPITALS IN GHANA

Patient/client-centered care has gained tremendous recognition globally as an important health care delivery strategy that helps to improve the safety and quality of care. In Ghana, huge investments and introduction of new programmes and approaches to providing care in the last two decades have helped to improve maternal and child health indicators but there is still great concern about the quality of maternal and child health services. New approaches to implementing evidence-based quality improvement strategies in childbirth services need to be explored to help address the situation. Institutionalising client-centered health care is seen as one of the acceptable approaches to improving quality maternity care.

The purpose of the study is to investigate the state of client-centered childbirth services in Ghana and the impact it has had on quality of childbirth services so as to develop guidelines to improve client centered childbirth services in Ghana. The objectives are to:

- explore and describe the perception and experiences of health professionals (doctors, midwives and nurses) about client-centered childbirth services in Ghana;
- explore and describe the perception and experiences of clients (women who used client-centered childbirth services in Ghana); and
- develop guidelines to improve client-centered childbirth services in hospitals in Ghana.

Three (3) hospitals (list attached) have been selected in your region for the study. This letter is to inform you and also seek your support. Letters will be sent to each hospital to also request their participation. The research team will visit the hospitals to brief the hospital management on the work plan and to gather data between 7th to 30th April 2014.

The study subjects will comprise doctors, midwives and nurses involved in providing direct childbirth services. Women who utilise services in the hospital will also be part of the study. The participation of the staff will involve semi-structured interviews to explore the prevailing systems for providing client-centered childbirth services, the readiness of hospitals to adopt improvement

strategies and views on mechanisms that should be put in place to improve services. A questionnaire and interview sessions will be used to obtain data from women.

Ms Gertrude Sika Avortri from Ghana Health Service (HQ) is the Principal Investigator. The researchers wish to assure you that no information that will identify the hospital as an entity or the staff that participate in the study personally will be disclosed in any report or presentation which may arise from the study. Please contact the principal researcher Gertrude Sika Avortri on phone number 0202011514, the address is Ghana Health Service, ICD, PMB, Ministries, Accra, Ghana, E-mail:gertrudeavortri@gmail.com for further information. The study is supported by Ghana Health Service. Attached is a copy of the ethical clearance letter.

Yours sincerely,



Dr Samuel Kaba Akoriyea
Director, ICD
Ghana Health Service (HQ)

Annex 5: Items and scoring scheme for client-centered care dimensions

Arrival and reception

No	Outcome or dimension or domain	Question	Recoding for scoring	Type of question	Maximum score obtainable
A1	Access and reception	Did you have to wait on arrival before you were seen by a nurse/midwife/doctor? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Go to B1	2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes	Negative	2
A2	Access and reception	How long did you have to wait before you were attended to by a nurse/midwife or doctor? 1 <input type="checkbox"/> Less than 15 minutes 2 <input type="checkbox"/> 16 to 30 minutes 3 <input type="checkbox"/> 31minutes to 1 hour 4 <input type="checkbox"/> More than 1 hour 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Less than 15 minutes 4 <input type="checkbox"/> 16 to 30 minutes 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> 31minutes to 1 hour 1 <input type="checkbox"/> More than 1 hour	Negative	5
A3	Access and reception	Were you able to find a comfortable place to sit during the waiting period? 1 <input type="checkbox"/> Yes, I found a comfortable place 2 <input type="checkbox"/> Yes, but it was not comfortable 3 <input type="checkbox"/> No, I could not find a place to sit 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, I found a comfortable place 3 <input type="checkbox"/> Yes, but it was not comfortable 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No, I could not find a place to sit	Negative	4
A4	Access and reception	While you were waiting, did the staff keep you informed about the reason for the delay? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Do not know/cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
A5	Access and reception	Were the front desk staff friendly? 1 <input type="checkbox"/> Yes, certainly 2 <input type="checkbox"/> Yes, some how 3 <input type="checkbox"/> No	3 <input type="checkbox"/> Yes, certainly 2 <input type="checkbox"/> Yes, some how 1 <input type="checkbox"/> No	Negative	3
A6	Access and reception	While waiting did the health care providers treat you with courtesy and respect? 1 <input type="checkbox"/> Never 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Usually 4 <input type="checkbox"/> Always	4 <input type="checkbox"/> Always 3 <input type="checkbox"/> Usually 2 <input type="checkbox"/> Sometimes 1 <input type="checkbox"/> Never	Negative	4
Total score obtainable on access and reception					21

DIGNITY, RESPECT, COURTESY AND PRIVACY

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
D17	Dignity, respect and courtesy	Did the staff caring for you introduce themselves? 1 <input type="checkbox"/> Yes, all the staff introduced themselves 2 <input type="checkbox"/> Yes, some of them introduced themselves 3 <input type="checkbox"/> Few, introduced themselves 4 <input type="checkbox"/> none introduced him/herself 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, all the staff introduced themselves 4 <input type="checkbox"/> Yes, some of them introduced themselves 3 <input type="checkbox"/> Few, introduced themselves 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> none introduced him/herself	Negative	5
D24	Dignity and respect	If you raised some concerns during labour, did you feel that it was taken seriously? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> No 3 <input type="checkbox"/> I did not raise any concerns	3 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> I did not raise any concerns 1 <input type="checkbox"/> No	Negative	3
D25	Dignity, respect and courtesy	When you called did you receive assistance within a reasonable time? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> I did not call 5 <input type="checkbox"/> Do not know / cannot remember	5 <input type="checkbox"/> Yes, always 4 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> I did not call 1 <input type="checkbox"/> No	Negative	5
E4	Dignity, respect and courtesy	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, always 3 <input type="checkbox"/> Yes, sometimes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
Total score obtainable					17

INFORMED CHOICE, CONTROL, DECISION-MAKING

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
C4	Control, decision-making and informed choice	Did you get information from a midwife/nurse or doctor to help you decide where to have your baby? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> No, but I did not need this information 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, definitely 4 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> No, but I did not need this information 1 <input type="checkbox"/> No	Negative	5
C6.1	Control, decision-making and informed choice	Were you given any information on choices of labour pain relief available to you during the ante-natal period by the health care providers? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C6.2	Control, decision-making and informed choice	Were you given any information on choices of birth attendants available to you during the ante-natal period by the health care providers? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C6.3	Control, decision-making and informed choice	Were you given any information on choices available to you regarding birth positions during the ante-natal period by the health care providers? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C6.4	Control, decision-making and informed choice	Were you given any information on choices available to you regarding labour companion during the ante-natal period by the health care providers? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C6.5	Control, decision-making and informed choice	Were you given any information on choices available to you regarding mode of delivery during the ante-natal period by the health care providers? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C8	Control, decision-making and informed choice	During your pregnancy were you given a choice about where your ante-natal check-ups would take place? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3

INFORMED CHOICE, CONTROL, DECISION-MAKING...

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
C15	Control, decision-making and informed choice	Thinking about your ante-natal care, were you involved enough in decisions about your care? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> I did not want / need to be involved 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, always 4 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> I did not want / need to be involved 1 <input type="checkbox"/> No	Negative	5
D23	Control, decision-making and informed choice	Thinking about your care during labour and birth, were you involved enough in decisions about your care? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> I did not want / need to be involved 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, always 4 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> I did not want / need to be involved 1 <input type="checkbox"/> No	Negative	5
Total score obtainable					33

POSITION OF BIRTH

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
D2	Birth position	During your labour, were you able to move around? 1 <input type="checkbox"/> Yes, most of the time 2 <input type="checkbox"/> Yes, some of the time 3 <input type="checkbox"/> No, not at all 4 <input type="checkbox"/> No, because it was not possible to move around	4 <input type="checkbox"/> Yes, most of the time 3 <input type="checkbox"/> Yes, some of the time 2 <input type="checkbox"/> No, because it was not possible to move around 1 <input type="checkbox"/> No, not at all	Negative	4
D3	Birth position	During your labour, were you able to choose the position that made you most comfortable? 1 <input type="checkbox"/> Yes, most of the time 2 <input type="checkbox"/> Yes, some of the time 3 <input type="checkbox"/> No, not at all 4 <input type="checkbox"/> No, because it was not possible to move around	4 <input type="checkbox"/> Yes, most of the time 3 <input type="checkbox"/> Yes, some of the time 2 <input type="checkbox"/> No, because it was not possible to move around 1 <input type="checkbox"/> No, not at all	Negative	4
Total score obtainable					8

SUPPORT IN LABOUR

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
D20	Labour support	If you had a partner or a companion with you during your labour and birth, were they made welcome by the staff? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> I did not have a partner or a companion with me 5 <input type="checkbox"/> Cannot say	5 <input type="checkbox"/> Yes, definitely 4 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> Cannot say 2 <input type="checkbox"/> I did not have a partner or a companion with me 1 <input type="checkbox"/> No	Negative	5
F4	Labour support	Did you feel that midwives and other carers gave you active support? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, generally 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Do not know 5 <input type="checkbox"/> I did not want or need this	5 <input type="checkbox"/> Yes, always 4 <input type="checkbox"/> Yes, generally 3 <input type="checkbox"/> Do not know 2 <input type="checkbox"/> I did not want or need this 1 <input type="checkbox"/> No	Negative	5
Total score obtainable					10

LENGTH OF STAY

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
E2	Length of stay	Retrospectively, do you feel that the length of your stay in hospital after the birth was: 1 <input type="checkbox"/> Too long 2 <input type="checkbox"/> Too short 3 <input type="checkbox"/> About right 4 <input type="checkbox"/> Not sure	4 <input type="checkbox"/> About right 3 <input type="checkbox"/> Not sure 2 <input type="checkbox"/> Too short 1 <input type="checkbox"/> Too long	Negative	4
Total score obtainable					4

COMMUNICATION AND EDUCATION

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
C16	Communication and information giving	During your pregnancy, did you attend any ante-natal classes provided by the hospital or care provider? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No, I was not offered any classes 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No, I was not offered any classes	Negative	3
C14	Communication and information giving	Thinking about your ante-natal care, were you spoken to in a way (language and choice of words) you could understand? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, always 3 <input type="checkbox"/> Yes, sometimes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
C19	Communication and information giving	Was the reason for this scan clearly explained to you? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, definitely 3 <input type="checkbox"/> Yes, to some extent 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
C21	Communication and information giving	Were the reasons for having a screening test clearly explained to you? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, definitely 3 <input type="checkbox"/> Yes, to some extent 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
D22	Communication and information giving	Thinking about your care during labour and birth, were you spoken to in a way (language and choice of words) you could understand? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, always 3 <input type="checkbox"/> Yes, sometimes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
E3	Communication and information giving	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, always 3 <input type="checkbox"/> Yes, sometimes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4

COMMUNICATION AND EDUCATION

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
F1	Communication and information giving	During your pregnancy did any care provider discuss infant feeding with you? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes, definitely 3 <input type="checkbox"/> Yes, to some extent 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
F3	Communication and information giving	Did you feel that midwives and other carers gave you consistent advice? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, generally 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Do not know 5 <input type="checkbox"/> I did not want or need this	5 <input type="checkbox"/> Yes, always 4 <input type="checkbox"/> Yes, generally 3 <input type="checkbox"/> Do not know 2 <input type="checkbox"/> I did not want or need this 1 <input type="checkbox"/> No	Negative	5
G1	Communication and information giving	Were you given enough information about your own recovery after the birth? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> No, because I did not need this information 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, definitely 4 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> No, because I did not need this information 1 <input type="checkbox"/> No	Negative	5
G2	Communication and information giving	Were you given enough information about any emotional changes you might experience after delivery? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> No, because I did not need this information 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, definitely 4 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> No, because I did not need this information 1 <input type="checkbox"/> No	Negative	5
G3	Communication and information giving	Were you given information or offered advice from a health professional about contraception? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
Total score obtainable					45

CONTINUITY OF CARE

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
C10	Continuity of care	If you saw a midwife/nurse for your ante-natal check-ups, did you see the same one every time? 1 <input type="checkbox"/> Yes, every time 2 <input type="checkbox"/> Yes, most of the time 3 <input type="checkbox"/> No 4 <input type="checkbox"/> I only saw a midwife once 5 <input type="checkbox"/> I did not see a midwife 6 <input type="checkbox"/> Cannot remember	6 <input type="checkbox"/> Yes, every time 5 <input type="checkbox"/> Yes, most of the time 4 <input type="checkbox"/> I only saw a midwife once 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> I did not see a midwife 1 <input type="checkbox"/> No	Negative	6
C11	Continuity of care	During your pregnancy did you have the name and/or telephone number of a midwife you could contact if you had concerns? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
D16	Continuity of care	Had you met any of the staff who cared for you during your labour and birth before you went into labour? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
Total score obtainable					12

BUILT ENVIRONMENT

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
H4	Built environment	How clean was the ward in which you stayed? 1 <input type="checkbox"/> Very clean 2 <input type="checkbox"/> Fairly clean 3 <input type="checkbox"/> Not clean 4 <input type="checkbox"/> Did not stay on the ward	4 <input type="checkbox"/> Very clean 3 <input type="checkbox"/> Fairly clean 2 <input type="checkbox"/> Did not stay on the ward 1 <input type="checkbox"/> Not clean	Negative	4
H5	Built environment	How clean were the toilets/bathrooms in the ward? 1 <input type="checkbox"/> Very clean 2 <input type="checkbox"/> Fairly clean 3 <input type="checkbox"/> Not clean 4 <input type="checkbox"/> Did not use 5 <input type="checkbox"/> Was not available	5 <input type="checkbox"/> Very clean 4 <input type="checkbox"/> Fairly clean 3 <input type="checkbox"/> Did not use 2 <input type="checkbox"/> Not clean 1 <input type="checkbox"/> Was not available	Negative	5

BUILT ENVIRONMENT...

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
H6	Built environment	How clean were the bed sheets in the ward? 1 <input type="checkbox"/> Very clean 2 <input type="checkbox"/> Fairly clean 3 <input type="checkbox"/> Not clean 4 <input type="checkbox"/> Did not use 5 <input type="checkbox"/> Was not available	5 <input type="checkbox"/> Very clean 4 <input type="checkbox"/> Fairly clean 3 <input type="checkbox"/> Did not use 2 <input type="checkbox"/> Not clean 1 <input type="checkbox"/> Was not available	Negative	5
Total score obtainable					14

OVERALL SATISFACTION OF CARE ASSESSMENT

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
C23	Ante-natal overall score	Overall, how would you rate the care received during your ante-natal period? 1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 4 <input type="checkbox"/> Fair 5 <input type="checkbox"/> Poor	5 <input type="checkbox"/> Excellent 4 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 2 <input type="checkbox"/> Fair 1 <input type="checkbox"/> Poor	Negative	5
D26	Labour overall score	Overall, how would you rate the care received during your labour and birth? 1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 4 <input type="checkbox"/> Fair 5 <input type="checkbox"/> Poor	5 <input type="checkbox"/> Excellent 4 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 2 <input type="checkbox"/> Fair 1 <input type="checkbox"/> Poor	Negative	5
G4	Postnatal overall score	Overall, how would you rate the care received after the delivery? 1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 4 <input type="checkbox"/> Fair 5 <input type="checkbox"/> Poor	5 <input type="checkbox"/> Excellent 4 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 2 <input type="checkbox"/> Fair 1 <input type="checkbox"/> Poor	Negative	5
Total score obtainable					15

Annex 6: Items and scoring scheme for antenatal, labour and post-natal experience

ANTE-NATAL EXPERIENCE

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
C4	Ante-natal	Did you get information from a midwife/nurse or doctor to help you decide where to have your baby? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> No, but I did not need this information 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, definitely 4 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> No, but I did not need this information 1 <input type="checkbox"/> No	Negative	5
C6.1	Ante-natal	Were you given any information on choices of labour pain relief available to you during the ante-natal period by the health care providers? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C6.2	Ante-natal	Were you given any information on choices of birth attendants available to you during the ante-natal period by the health care providers? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C6.3	Ante-natal	Were you given any information on choices available to you regarding birth positions during the ante-natal period by the health care providers? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C6.4	Ante-natal	Were you given any information on choices available to you regarding labour companion during the ante-natal period by the health care providers? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C6.5	Ante-natal	Were you given any information on choices available to you regarding mode of delivery during the ante-natal period by the health care providers? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3

ANTE-NATAL EXPERIENCE

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
C8	Ante-natal	During your pregnancy were you given a choice about where your ante-natal check-ups would take place? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C10	Ante-natal	If you saw a midwife/nurse for your ante-natal check-ups, did you see the same one every time? 1 <input type="checkbox"/> Yes, every time 2 <input type="checkbox"/> Yes, most of the time 3 <input type="checkbox"/> No 4 <input type="checkbox"/> I only saw a midwife once 5 <input type="checkbox"/> I did not see a midwife 6 <input type="checkbox"/> Cannot remember	6 <input type="checkbox"/> Yes, every time 5 <input type="checkbox"/> Yes, most of the time 4 <input type="checkbox"/> I only saw a midwife once 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> I did not see a midwife 1 <input type="checkbox"/> No	Negative	6
C11	Ante-natal	During your pregnancy did you have the name and/or telephone number of a midwife you could contact if you had concerns? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C14	Ante-natal	Thinking about your ante-natal care, were you spoken to in a way (language and choice of words) you could understand? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, always 3 <input type="checkbox"/> Yes, sometimes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
C15	Ante-natal	Thinking about your ante-natal care, were you involved enough in decisions about your care? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> I did not want / need to be involved 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, always 4 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> I did not want / need to be involved 1 <input type="checkbox"/> No	Negative	5
C16	Ante-natal	During your pregnancy, did you attend any ante-natal classes provided by the hospital or care provider? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No, I was not offered any classes 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No, I was not offered any classes	Negative	3

ANTE-NATAL EXPERIENCE (UPDATED FOR ANALYSIS)

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
C17	Ante-natal	Did you attend any other ante-natal classes that were not provided by that hospital or care provider? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No, I was not offered any classes 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No, I was not offered any classes	Negative	3
C18	Ante-natal	Did you have a scan at the start of your pregnancy? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C19	Ante-natal	Was the reason for this scan clearly explained to you? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, definitely 3 <input type="checkbox"/> Yes, to some extent 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
C20	Ante-natal	Did you have any screening tests (e.g. a blood test)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
C21	Ante-natal	Were the reasons for having a screening test clearly explained to you? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, definitely 3 <input type="checkbox"/> Yes, to some extent 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
F1	Ante-natal	During your pregnancy did any care provider discuss infant feeding with you? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, definitely 3 <input type="checkbox"/> Yes, to some extent 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
Total score obtainable on ante-natal experience					72

LABOUR EXPERIENCE

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
D2	Labour position	During your labour, were you able to move around? 1 <input type="checkbox"/> Yes, most of the time 2 <input type="checkbox"/> Yes, some of the time 3 <input type="checkbox"/> No, not at all 4 <input type="checkbox"/> No, because it was not possible to move around	4 <input type="checkbox"/> Yes, most of the time 3 <input type="checkbox"/> Yes, some of the time 2 <input type="checkbox"/> No, because it was not possible to move around 1 <input type="checkbox"/> No, not at all	Negative	4
D3	Labour position	During your labour, were you able to choose the position that made you most comfortable? 1 <input type="checkbox"/> Yes, most of the time 2 <input type="checkbox"/> Yes, some of the time 3 <input type="checkbox"/> No, not at all 4 <input type="checkbox"/> No, because it was not possible to move around	4 <input type="checkbox"/> Yes, most of the time 3 <input type="checkbox"/> Yes, some of the time 2 <input type="checkbox"/> No, because it was not possible to move around 1 <input type="checkbox"/> No, not at all	Negative	4
D7	Labour pain relief	Were you satisfied with the pain relief method you used? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, definitely 3 <input type="checkbox"/> Yes, to some extent 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
D15	Normal labour	Did you have skin-to-skin contact (<i>baby naked, placed directly on your chest or tummy</i>) with your baby shortly after the birth? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> No, because this was not possible for medical reasons 4 <input type="checkbox"/> I did not want skin-to-skin contact with my baby	4 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No, because this was not possible for medical reasons 2 <input type="checkbox"/> I did not want skin-to-skin contact with my baby 1 <input type="checkbox"/> No	Negative	4
D16	Labour continuity	Had you met any of the staff who cared for you during your labour and birth before you went into labour? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
D17	Labour courtesy	Did the staff caring for you introduce themselves? 1 <input type="checkbox"/> Yes, all the staff introduced themselves 2 <input type="checkbox"/> Yes, some of them introduced themselves 3 <input type="checkbox"/> Few, introduced themselves 4 <input type="checkbox"/> none introduced him/herself 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, all the staff introduced themselves 4 <input type="checkbox"/> Yes, some of them introduced themselves 3 <input type="checkbox"/> Few, introduced themselves 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> none introduced him/herself	Negative	5

LABOUR EXPERIENCE

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
D18	Labour confidence and trust	Did you have confidence and trust in the staff caring for you during your labour and birth? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, definitely 3 <input type="checkbox"/> Yes, to some extent 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
D20	Labour support	If you had a partner or a companion with you during your labour and birth, were they made welcome by the staff? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> I did not have a partner or a companion with me 5 <input type="checkbox"/> Cannot say	5 <input type="checkbox"/> Yes, definitely 4 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> Cannot say 2 <input type="checkbox"/> I did not have a partner or a companion with me 1 <input type="checkbox"/> No	Negative	5
D22	Labour courtesy	Thinking about your care during labour and birth , were you spoken to in a way (language and choice of words) you could understand? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, always 3 <input type="checkbox"/> Yes, sometimes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
D23	Labour decision-making	Thinking about your care during labour and birth , were you involved enough in decisions about your care? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> I did not want / need to be involved 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, always 4 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> I did not want / need to be involved 1 <input type="checkbox"/> No	Negative	5
D24	Labour courtesy	If you raised some concerns during labour, did you feel that it was taken seriously? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> No 3 <input type="checkbox"/> I did not raise any concerns	3 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> I did not raise any concerns 1 <input type="checkbox"/> No	Negative	3
D25	Labour courtesy	When you called did you receive assistance within a reasonable time? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> I did not call 5 <input type="checkbox"/> Do not know / cannot remember	5 <input type="checkbox"/> Yes, always 4 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> I did not call 1 <input type="checkbox"/> No	Negative	5
Total score obtainable on labour experience					59

POSTNATAL EXPERIENCE

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
E2	Postnatal	Retrospectively, do you feel that the length of your stay in hospital after the birth was: 1 <input type="checkbox"/> Too long 2 <input type="checkbox"/> Too short 3 <input type="checkbox"/> About right 4 <input type="checkbox"/> Not sure	4 <input type="checkbox"/> About right 3 <input type="checkbox"/> Not sure 2 <input type="checkbox"/> Too short 1 <input type="checkbox"/> Too long	Negative	4
E3	Postnatal	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, always 3 <input type="checkbox"/> Yes, sometimes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
E4	Postnatal	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Cannot remember	4 <input type="checkbox"/> Yes, always 3 <input type="checkbox"/> Yes, sometimes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	4
F3	Information	Did you feel that midwives and other carers gave you consistent advice ? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, generally 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Do not know 5 <input type="checkbox"/> I did not want or need this	5 <input type="checkbox"/> Yes, always 4 <input type="checkbox"/> Yes, generally 3 <input type="checkbox"/> Do not know 2 <input type="checkbox"/> I did not want or need this 1 <input type="checkbox"/> No	Negative	5
F4	Support	Did you feel that midwives and other carers gave you active support ? 1 <input type="checkbox"/> Yes, always 2 <input type="checkbox"/> Yes, generally 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Do not know 5 <input type="checkbox"/> I did not want or need this	5 <input type="checkbox"/> Yes, always 4 <input type="checkbox"/> Yes, generally 3 <input type="checkbox"/> Do not know 2 <input type="checkbox"/> I did not want or need this 1 <input type="checkbox"/> No	Negative	5
G1	Information	Were you given enough information about your own recovery after the birth? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> No, because I did not need this information 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, definitely 4 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> No, because I did not need this information 1 <input type="checkbox"/> No	Negative	5

POSTNATAL EXPERIENCE

No	Outcome or dimension or domain	Original question and coding	Recoding for scoring	Type of question	Maximum score obtainable
G2	Information	Were you given enough information about any emotional changes you might experience after delivery? 1 <input type="checkbox"/> Yes, definitely 2 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> No 4 <input type="checkbox"/> No, because I did not need this information 5 <input type="checkbox"/> Cannot remember	5 <input type="checkbox"/> Yes, definitely 4 <input type="checkbox"/> Yes, to some extent 3 <input type="checkbox"/> Cannot remember 2 <input type="checkbox"/> No, because I did not need this information 1 <input type="checkbox"/> No	Negative	5
G3	Information	Were you given information or offered advice from a health professional about contraception? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Cannot remember	3 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Cannot remember 1 <input type="checkbox"/> No	Negative	3
H4	Cleanliness of room	How clean was the ward in which you stayed? 1 <input type="checkbox"/> Very clean 2 <input type="checkbox"/> Fairly clean 3 <input type="checkbox"/> Not clean 4 <input type="checkbox"/> Did not stay on the ward	4 <input type="checkbox"/> Very clean 3 <input type="checkbox"/> Fairly clean 2 <input type="checkbox"/> Did not stay on the ward 1 <input type="checkbox"/> Not clean	Negative	4
H5	Cleanliness of toilets	How clean were the toilets/bathrooms in the ward? 1 <input type="checkbox"/> Very clean 2 <input type="checkbox"/> Fairly clean 3 <input type="checkbox"/> Not clean 4 <input type="checkbox"/> Did not use 5 <input type="checkbox"/> Was not available	5 <input type="checkbox"/> Very clean 4 <input type="checkbox"/> Fairly clean 3 <input type="checkbox"/> Did not use 2 <input type="checkbox"/> Not clean 1 <input type="checkbox"/> Was not available	Negative	5
H6	Cleanliness of bed sheets	How clean were the bed sheets in the ward? 1 <input type="checkbox"/> Very clean 2 <input type="checkbox"/> Fairly clean 3 <input type="checkbox"/> Not clean 4 <input type="checkbox"/> Did not use 5 <input type="checkbox"/> Was not available	5 <input type="checkbox"/> Very clean 4 <input type="checkbox"/> Fairly clean 3 <input type="checkbox"/> Did not use 2 <input type="checkbox"/> Not clean 1 <input type="checkbox"/> Was not available	Negative	5
Total score obtainable on postnatal experience					49

Annex 7: Interview guide for women

1. Tell me your experience with this childbirth from the time you arrived during labour till your discharge home. Probes: Reason for using services in hospital. How were you received? Did you have to wait before being seen?
2. How do you feel about the way the doctors, nurses and hospital staff communicated with you during the period? Probe language used and ability to understand issues.
3. Tell me about how the health workers related with you?
4. Describe your experiences on how decisions related your pregnancy and birth were taken during pregnancy and birth? Probes: how did you decide on the following?
 - place of birth, birth attendant, mode of birth, birth position, pain management , companion during labour, length of stay after delivery, mode of information giving, support you had during labour and immediate the post-natal period
5. I will like you to describe how you felt about issues of respect, dignity and privacy during your pregnancy and birth?
6. Going forward, what would be the things you would want changed to make services excellent?
7. Do you have any additional comments about your experience with pregnancy and childbirth?
8. How happy are you with the overall service that you received during ante-natal, labour and immediate postpartum?

DEMOGRAPHICS:

9. Is this your first time delivering in this hospital?
10. How many children do you have? Probe parity –death/alive
11. How are you going to pay your fees? (Health insurance, others)
12. Did you make any payment for which receipt was not given?
13. Where do you live? (Rural, Urban, Sub-urban)
14. What is your age?
15. What is your highest level of education?
16. What is your marital status?

Annex 8: Sample interview transcript from a woman

I: Auntie Josephine [not real name], as I discussed with you earlier when I was introducing myself to you, we are going to have some discussions on your experiences from ante-natal clinic to delivery here was. Please tell me about your experiences with this childbirth from the time you arrived during labour till your discharge home. You can start from when you decided to use delivery services in this hospital.

R: Well, I wasn't attending [name of hospital], where I was, they told me they don't have the necessary things for delivery so I can't deliver there, when my time was due the scan showed that I have one month more to deliver, but it got to a time I wasn't feeling well so I came here directly so that made me deliver here.

I: Were you referred by a doctor or you came by yourself?

R: I came by myself.

I: So the time you were attending the ante-natal here, how was the reception like. How were you receive?

R: They do talk to us well. But the point is we are many sometimes. And it's like sometimes, we quarrel among ourselves because of the queue. You are in front of me, I'm behind you, and all that. That's what brings about quarrel, but the nurses themselves really take good care of us.

I: What about the place that you sit, the reception area was it comfortable for you?

R: No, it seems that place is a bit small. That we are not able, it's not able to contain the number of people that come to ante-natal. Some will have to sit outside. Hmm, it the size, we are not able to comfortably occupy the place, so we always have to press ourselves on the chair but we manage it. it is the chairs that are not enough and there is discomfort, when you come you would have to put your card here and sit down then maybe they call you. And you don't really know if they are calling you while you are sitting at a different place, that's the bother.

I: And what about the, the, the workers who sit at the table, who receive you and give you folder, ... how did you find their relation with you?

R: I would say they are not that nice, it isn't that friendly, well, it isn't that friendly. But it's, it's not harsh too. I will say maybe it's the nature of the job. We are many so sometimes when they come, they will, they will have to be fast a bit. Because sometimes when they mention your name and you are not around, they will have to put it [folder] down. If they can show some courtesy and respect.

I: I see, please can you tell me about how you were received when you came in labour?

R: You mean when I came to deliver?

I: Yes, did you have to wait before you were seen or how promptly did the staff attend to you?

R: Well, it started in the house. That's when I came and it was 4cm. So I had to await for it to be 10cm before. And honestly speaking, we were many. And honestly I will applaud the nurses who attended to us that day. Because, we were many and in fact they come

and they go. People come to give birth and they go and there are some also the wailing and all that. And we were many, so when you come you will have to wait. There were no beds. You will be asked to sit. Me like this I was asked to lie on there, because there were no beds. So I laid on the floor there.

I: Did they tell you, did they explain to you the reason why you had to wait?

R: They, they said. Ok, when I came, they checked and they said 4cm. So I, I can't sit. There said I can't sit. I will have to lie on the left side, but those who will be able to sit, you have to sit and wait, for somebody to be attended to, before it will get to your turn. Because it seems they were only two. Two midwives, yes.

I: Please, what about the interpersonal communication? How did they talk to you? Do they talk to you in language that you understand, or you they talk to you, need someone to interpret it to you?

R: No, they spoke Twi. And with Twi, I believe everybody understands Twi. But I was speaking English with them.

I: So was there any, was there a situation that they said something that you needed somebody to interpret it?

R: No, no.

I: What the interpersonal relationship?

R: oo for here, it is not everyone who is hospitable but the one she is attended to, she is her client. So if you go to the person and you respect, she will also respect you fine.

I: How will you describe ideal relationship that should exist between the health worker and mothers?

R: Well, I, I, believe labour itself is something that makes people go mad. And it seems our nurses are used to. So when you come and you are screaming, it's like it is normal. So they don't care. But I would entreat if they can be a bit patient. Because some of them have been through. So if they can be a bit patient with us, because it's not so easy. So when you come and you are, at least they should say something nice. But it's like, and they will be like "there is nothing I can do about it, inspite of your shouting. I say lie down, go and lie down. " And at least if you say "sorry, it will be over soon" and all that. That is a bit good. But if you are telling me it's painful and all that, you are rather adding salt to my injury.

I: Now I will want us to discuss some issues about the information that was given to you during pregnancy and others about decision- making during pregnancy. Please when you were pregnant and was coming for the ante-natal care, which category of staff took care of you?

R: Auntie Drena took care of me. She was my midwife all the time.

I: Is she a midwife or doctor?

R: Yes she is midwife. oo she did well. She did her part.

I: Ok. Please, if you were given the chance during the time you used to come for ante-natal care, which category of staff would you want to take care of you? The doctor or midwife?

R: eh.. I will say the midwife is also good. The only thing she did against me was that, after she attended to me till I was just about to deliver, the child wasn't coming. The time was also up. She just took me to the doctor and didn't explain to me why she sent me. She just told me to go and see the doctor and when I came she didn't take care of me again. She said she is finished with her part and have given me to them. That was where I didn't understand so well.

I: So during delivery, who delivered your baby?

R: It was the midwife.

I: So that time too, if you were to be given to choose, who would you have chosen to deliver your baby for you?

R: Well, I, I will choose a midwife, because I don't think the doctor is always there delivering pregnant women, but the midwife is always there. Sometimes experience also counts, yes.

I: What about your preference on the following? Place of birth. If you were to be asked where to give birth, where would you have chosen? Private hospital, maternity home, public hospital, that is government hospital and others, which one do you prefer?

R: I will choose a public hospital, like this one.

I: Any reason?

R: The reason is that normally, when complications do come, they do refer to the public hospitals. So I wouldn't wait for me to go for any private, before I will be referred. I want to do everything here. Whatever complications, yes, I will be attended to.

I: Public hospital. You know we have different modes of child delivery or childbirth. You can use Caesarean session, it can be vaginal delivery. What's your preference?

R: Well, I'll, honestly speaking, the SVC is, the SVD rather is really painful. I have not, this is my first child, so I don't know about the CS. But I believe nature has its own way of doing things. So I, I, will choose the natural way even if it is painful.

I: What about pain management? Labour pain is not an easy thing.

R: Yes, yes.

I: And if you were to be given the opportunity, what, what will be your preference of management of pain?

R: Ehn, can you explain a bit?

I: Natural one means no medication and somebody will be massaging your back. They will ask you when the pain comes to open your mouth and be breathing. Or you could be given medication to drink or an injection.

R: Yeah, yeah you know when I was. I, I have a sister abroad and when I was about to deliver, she told me she said, she is going for epidural section, whereby they will inject in. But they say it requires the services of a midwife who will always be by your side to attend to you. Because you will not feel the pain, but you will have to check to see if the baby is coming and all that. But I realise, here is not like that. We are even many than

the midwives. So who will have time to sit by me, if I go to do the epidural section and the. So I decided to go natural.

I: Ok, now the birth position. You can sit down like this. They position you sitting up, down, you give birth. You can lie down, at your back, if you...

R: Honestly that bed there [delivery bed] is too high, so if can sit like this, I believe that one. Because you will have to climb. Nobody will help you to climb. They will ask you to do everything yourself. You will go and lay your, your, your, the rubber on, the delivery sheet on the bed, the cloth, you will climb. You will do everything yourself. Nobody will help you. So if it's a chair like this, and I believe you can sit on. That one will even ease our pain a bit.

I: What of movement during labour? What is your preference on that? Is it good for a mother to be walking around when you are in labour? Or you lie down till it is time for you to deliver?

R: Well, when I came, they said 4cm, my baby's head was down. So I'm supposed to lie on my left for it to come fast. But I wasn't able to do so. I was walking up and down. But I really don't know any importance of. All I know, what I can say is, as a pregnant woman, you need to exercise, yes. But for labour, I don't, I can't really tell why you have to move or I can't even say anything about that.

I: We want also to find out your preference of labour companion. You can, whether it is good for somebody to stay with a labouring mother in the delivery room or who should that person be?

R: I, I believe the appropriate people to be our husbands. They should be closer to see what we go through. But here, they don't give them the chance. It's because the place is small. You don't go in alone. Infact, when it was my turn, that night, we were inside two, two and the midwives were two. So would, should my husband, come and you see we are always, we are naked too. If it is me alone, he can come but, the nature of the place, will not permit him to get closer.

I: My next question is the length of stay after delivery. How long did you stay after delivery?

R: 24 hours.

I: 24 hours?

R: Yeah.

I: Do you have preference, would you have chosen more than that? Longer period or days like that?

R: Yes, yes, I, I believe since there are other complications, after birth, I believe a new mother should be attended to properly. So at least spending about three days there, if there are enough beds and enough space even to really cause anything for the nurse to check, then if you are ok, then you move, but you deliver, you go home, honestly I'm not so happy about it.

I: What about the payment of service? Which one did you go through? Was it Health Insurance...?

R: Yes, it was Health Insurance.

I: Now lets discuss a bit about the way of information is given or education of women is done at the facility. Through ante-natal, through labour, how did you find it?

R: The way of ...?

I: Information- giving. Health information, health education from ante-natal. If they were giving the health education talk, and when you went to labour, after delivery and coming here, how do you find it?

R: Yes, because I was a new mother. Even though my Mummy is around, but I will say things are changing now. So they taught us a, a, new ways of trying to handle issues and all that. So I will say the mode of communication is, is ok.

I: Can you expand a bit on this?

R: When they finish, they ask us how do we understand it? Any suggestion you have and any language you can speak, then you voice your mind, if its good, then we tell you, if not too, we tell you, that is not how it is done. This is how it is supposed to be. So for that one, it is good.

I: What are some of the issues discussed during pregnancy? did your midwife give you option on place of birth, place to go, though you are attending clinic here. Did the midwife give you the options that you can choose where to go and deliver?

R: No.

I: please did they give you the chance to choose who to help you deliver? Doctor or midwife? Did they give you the chance?

R: No. No discussion.

I: What about the mode of birth? Were you given the option to choose that me, I want my delivery, I want Caesarean section, I want, or I want to give birth myself?

R: No.

I: You were not given that option. What about pain management? During ante-natal, did your midwife discuss pain management during labour and ask you to choose an option?

R: No.

I: What about the birth position? Sitting down, lying down, squatting. Now there is a new one in Ghana now. I will say, we Ghana we say it's new. That's water birthing. Were you given that option to?

R: No

I: What about the movement, mobility during labour? Were you given any education?

R: No.

I: What about birth companion? Labour companion. Somebody staying with you?

R: Ok, normally, they do advice about the companionship. So that place, when you bring your husband, you are attended to and then you go. The ante-natal.

I: The ante-natal.

R: So for that, yes, they do tell us.

I: But what of you opting that I want my relation, somebody who can help. Somebody to stay with me in the labour, in the delivery room.

R: No, we were not given that option.

I: What about the length of stay after delivery? Were you given the option to choose?

R: No.

I: But, what about the mode of payment. Were you given the option? How we will pay your service after pay for the services that they will render to you.

R: Yes, it seems Ghana here or I should say when you are pregnant you go for National Health, so when we go there, they ask of the National Health card, yes.

I: So can you describe how you were involved in decision-making process during pregnancy?

R: From the questions you asked and the answers were no. I will say yes, we were not given that option. So, I, I, I wasn't really involved much in.

I: So there was not a, a, an occasion that the midwife sought your, your, your, your take or your counsel or decision on something that she wanted to do for you concerning your pregnancy and childbirth?

R: No.

I: So were you able to discuss issues with the, the midwife who was giving care to you during...?

R: That I do, but not...

I: Like, can you give an example?

R: That epidural session I asked her and she laughed. And the problem was, it's not one midwife to a mother. So, it, it can't be possible. And we all laughed and that was all.

I: So looking at things, how much control do you feel you had in decision-making concerning your pregnancy and childbirth?

R: You know normally when I'm being given medicines, I want to know why I'm taking this...

I: My next question is who do you think should be the key decision-maker regarding issues on your pregnancy and childbirth?

R: Like is it, are you asking? Is it between the pregnant woman and the midwife?

I: Taking yourself, like what you going through ante-natal, labour and now postnatal, who do you think should be the key decision-maker regarding your childbirth?

R: My childbirth? A key decision-maker. I should, I should say the midwife. Because they always attend to us. It is when you have a problem that you will be referred to the, a doctor. Yes, but you always come to see the midwife, she should be the key decision-maker.

I: During your ante-natal period, how was information given? Was information given to you individually or they put it in...

R: Writing.

I: Writing.

R: Sometimes, they, they, they we have talks. And that is as a group. And when you get into your cubicles too, yes and she also have a little chat with you.

I: How, how do you find that mode? Is it ok?

R: Yes, yes, yes, yes. Because sometimes they talk to us about the kind of food we are supposed to eat and some of the, I should say changes that takes place in our body. Sometimes we are new to it, and then you easily run to the hospital, you feel you are sick, but sometimes, when they, they inform us, you are aware that it's a change. So you are able to contain that. So it's good.

I: There is something we call pregnancy club or pregnancy school, where a pregnant woman and the husband attends. It's not ante-natal, but the ... Did you get the opportunity to attend?

R: No. A friend of mine invited me to, her husband is at Korle- Bu. I think it's around Dansoman or so. But Spintex to Dansoman was too far, so I wasn't able to attend at all.

I: Can you describe some major issues that were discussed with you during pregnancy by your midwife that really helped you?

R: Yes, formally I was. I, because of the bitterness in my mouth, so I take Coke and all that. But later when I came for ante-natal and they, she said we are not supposed to take Coke, because of the caffeine and then what. She said it can also decrease your blood, yes. And honestly that time, when I went to check my blood, it, it was a bit low. So I stopped taking Coke, Fanta and the rest. And I resorted to rather taking things to boost my blood and it really helped.

I: Was there any issue you would have loved the midwife to discuss with you?

R: Like the, the choices we have during childbirth. I believe they should give, they should discuss that with you. You have a choice to go for Caesarean section and you have the choice whether to go the natural way and all that. But, it seems they don't.

I: Let look again at support during labour and childbirth. Was there any support person with you during labour?

R: My mum was there, but not closer. They asked her to go. As for that time, I would have wished my husband was there.

I: She didn't come into the delivery room?

R: No.

I: Were you able to talk to any of the health care providers about your concerns, your worries during labour time? Did you ask questions that were worrying you?

R: Yes, yes for me I did worry them a bit. Yes, because anything, I would want to ask the reason you are injecting me. Why you are, why are you asking me to lie on my left

and not on my right. Why are you asking me to do this? Yeah. For that I, I, did worry them. And I did ask them a whole lot of questions.

I: I want to find out, did you have help that you needed for yourself and your baby after delivery?

R: You know, no. but I, I wouldn't want to put much blame on them, because we were many. After me, somebody also came, yes. So I had to come and lie small before my mother came. I was, the blood was coming, my things were soiled, but she was also attending to someone. So it was my mummy who came to change my things. So I wouldn't put the blame on her much.

I: Can you discuss with me the type of assistance, you needed, but you didn't get from the midwife immediately after delivery?

R: That was the reason why I, I, said that I wouldn't want to blame them much. But honestly when I went to deliver and I came back, they laid my bed. One of the midwives laid my bed. But because we were many, so I had to walk and come alone to come and lie down. And then they brought my baby and they were attending to someone. So I didn't get all the assistance. But I do understand them also.

I: We want to look at respect, courtesy, respect and dignity. How would have liked health care workers to demonstrate respect to the client and others who come to the clinic?

R: Respect, they should, they should treat us with individual differences. Some will be able to control their pain, whilst other will not be able to control. So, if somebody is not shouting and I'm shouting, that doesn't mean that maybe you should shout on me or talk to me. We are all different. The way somebody will be able to manage his or her pain will not be the same way I will be able to manage mine, mine. So on that, yes, I would love if they would also look at that. Because those who attended to us in the morning, they were a bit, I will say harsh. "If you come in and cry, I don't care. It is painful. The crying will not have any positive effect on you. So what should I do, when you cry." Like, some of them said something like that. But those in the night, were, were nicer.

I: In your, looking at things, what are some of the factors that hinder or hinder the expected behaviour to be put up by health care providers to mothers?

R: As I said earlier on, it's because we are many than them. We are much. So, she is always tired. So if you come and then you want to prove stubborn a bit and she would have to just say something to you, in order to attend to the next person. And also if you need some assistance too, because there is somebody on the waiting list too, when she is done with you, you have to go for somebody else to come. So we are many. So if they would also address that.

I: My next question is provision of privacy, provision of privacy during your visit and stay at the hospital. How was it provided? For example, when they wanted to talk to you, did they talk to you undertone?

R: They do not shout but, their talking too is not undertone. Like if somebody, somebody will hear what they are saying, but they don't shout. But it is not undertone for somebody sitting next to be able to hear. If you are next you will hear.

I: What about if they want to attend to you? Do they do it exclusively like drawing curtains?

R: No, no, no, no. As for the delivery room, we are there. It's just a table and a chair like this. No curtains, no screens. You only. You go and sit in the chair and then they attend to you.

I: please you know our hospital work, when you come in the morning, you close in the afternoon. Some people also come in the afternoon and close in the evening. After you came to deliver and was admitted at the hospital, did they put you in the hands of those who come later?

R: No one will tell you anything. Am really happy with the questions you are asking me because I was going to deliver, those who were there, when I sent my bags, they received me fine. So I was very happy with them but by the time I realized, they are leaving that their time is up. So that disturbed me a bit but those who also came, by Gods grace.

I: If we look at continuity of care and transition. Before you went into labour, did you know the midwife there? Before you went into the labour ward, did you know the midwife there?

R: No. But because, I'm always inquisitive, when I went there and they were mentioning their names. And this person will call this person and this person will call this, so I was also calling them by their names, yes.

I: But you didn't know them before hand?

R: No.

I: Ok. So what do you think about that? Would you prefer that ante-natal mothers know the labour ward and to know the nurses there?

R: Yes, because I, I, read, sometimes when you come for ante-natals, that they are supposed to take us to the labour wards. Yes, go and show us things over there especially the new ones. But nothing of that sort was done. But my questions were based on because I read, yes. So I was asking them questions on what I read and then maybe what I heard on the TV and all that, what I saw.

I: How happy are you overall with services provision here? During ante-natal, labour and delivery.

R: I wouldn't want to. I am not happy though, but I wouldn't want to blame them, because we are many. Today like this, we are many. I came here since morning. And then it's, it's past twelve and I'm still here. And then even the, the, the lady, the woman attending to us too, you could see she is tired. So even if I'm, if I'm not happy. If maybe they are many and then they attend to us on is to s, one is to one mapping, I believe that maybe the work would have been faster. But because we are many, you come and then you spend all your time here.

I: So can you share with me something that happened during labour that you, you, that you like so much. That you would like to share with me?

R: Well, the, the midwife who attended to me was nice, yes. You know she, she place the drip on my right hand. And I was struggling. Anytime she put it there, I will take it off.

Any time she puts it there, I will take it off. I was thinking, that should rather make her angry. But she wasn't. Any time I take it off, she would just put it back there. And because the...

I: Why, why were you?

R: Because what I was going through was so painful, so I was just struggling and then just taking everything off, but she was also patient with me.

I: Was there anything that happened that you did not like, enough to share with me?

R: Is it during the labour or the ante-natal?

I: It can be during the ante-natal or during the labour period.

R: I don't know, but here if you are coming for ante-natal, you have to wake up early and come. Honestly, around 5 am. Because we are many. So anytime it gets to my turn and I need to come to ante-natal, when I sleep I'm not able to sleep. Because it is as if, I'm put on a cloth and then it's sticking, it's sticking. You have to wake up, come early. You have to come and sit and wait for them also. And if that would be changed, I would love that, yes. Because as early as 5am, as early as 4:30 am, you come here, you meet pregnant women sitting down, just because they want to come early and go early because we are many.

I: Is there any else you would like to share with me? Anything you would want to comment on? General, anything general?

R: I want to ask, why is it that they don't circumcise male babies, like when you deliver. Like the way they just pierce. Why don't they just circumcise them before you go home? I want...

I: Have you asked them? I may not know the reason why they don't do it that way.

R: They say I should wait for the cord to, but...

I: Is this your first time of delivering in this hospital?

R: Yes.

I: How many children do you have? This is the first one.

R: First one.

I: How did you pay your hospital bills?

R: It was through the National Health.

I: Did you make any payment, which you, you were not given any receipt?

R: They gave me some, they said it's for, I was part. So they said they injected me with some something, something.

I: And they, they supplied you?

R: Yes and I paid for.

I: Were you given any receipt?

R: Yes, she showed me the paper.

I: Ok, please where do you live?

R: Spintex road.

I: Spintex road. Please may I know your age?

R: I'm 26.

I: What is your highest educational level?

R: Tertiary.

I: Are you married?

R: Yes, please.

I: Whom are you staying with?

R: I'm with my parent's currently.

I: Auntie Josephine, thank you very much for your time. I really enjoyed your conversation.

Annex 9: Interview guide for doctors and midwives

1. Describe your understanding of the concept of client-centered or patient-centered care, its attributes, and how your experience has been in implementing it in your hospital?
Probes: How did you get to know about client-centered care? How attributes mentioned are applied in practice? How prepared are you to delivery client-centered care?
2. What in your view are qualities or skills should health care worker have so as to offer client-centered care
3. What organisational factors facilitated the implementation of client-centered care?
Probes: What preparations were made at the initial stages for the implementation (training, provision of guidelines, etc.)?
4. Describe your opinion about the systems for monitoring and feedback in the hospital? **Probes:** How is quality of care is assessed? How is feedback obtained from client? How is feedback given to clients and staff?
5. What are the major barriers that you have encountered in provision of patient or client-centered childbirth care?
6. Now we will discuss some specific issues on provision of childbirth services. Overall, what are your views on women having control over decision-making and informed choice in childbirth?
Probes: views on the following: choice of place of birth, choice of birth attendant, choice of mode of birth, choice of birth position, choice of labour support person or companion, choice of pain management method, choice of length of stay after delivery
7. Is there any other thing you would like to add or suggest regarding the issues we have discussed?

Demographic

8. May I know your age?
9. Which professional category?
10. What is your grade?
11. How long have you worked in your current position?
12. Can you tell me your key area of work?

Annex 10: Sample transcript form interview with doctors and midwives

I: I'm starting my second interview today. Good afternoon.

R: Good afternoon.

I: Please, I will like you to describe your understanding of the concept of client-centered care, it's attributed and how your experience has been in implementing it in your hospital. You can start with telling me about your understanding of the concept.

R: What it means to me is, making sure that you, you attain the needs of the client. As in like when a patient comes to you, you make sure you focus everything on the patient. Even if you have to pull strings to go out of your way to get things for the patient to make sure the patient is well cared for at the end of that day. So that the patient goes home safely or healthily. So that is what I understand.

I: When you are offering client centered care. What will be some of the key attributes or elements of that care?

R: So the key attri, elements of that I will say is first the beds of the patients, do you have enough to be able to be able to take all the patients? And even if you do, do you have enough equipment's and drugs. Are you able to procure some drugs from the pharmacy to be able to take care of the patient? Blood for example are you able to get blood for patient who needs to be transfused. I think those basic things are things that are those basic things that.

I: Can you talk a bit more about the attributes? For example, another attribute is respect for the dignity of the woman. How do you assure this in your practice?

R: Ok, so in our practice, I'm talking based on my personal. Friendliness, they should put up friendly behaviour. They should be friendly to the clients, so that the client would be able confide in them to tell them all their problems. So that they help them to solve them.

I: Yes.

R: Me most of the time, I make sure I'm very polite with my patient. And especially you talk to them. Maybe the things you want to do for the patient, you have to tell the patient, ok. Your condition, I'm managing you for this, this, this, this. I need to do this for you. I need to that for you. So do you want me to go ahead to do this for you? And I also have this rapport with almost all my patients. So basically, yeah.

I: Have you had any training on client centered care?

R: Personally, no.

I: Do you know of any guideline either by Ministry of Health or Ghana Health Service in client centered care?

R: I think, the Safe Motherhood protocol, I think these things are added to it .You know, it's very useful. And you know to be frank to you, it guides us mostly to take care of our clients, in the hospital and it's a protocol that gives you at least directive as to what to do when you see a particular condition

I: There is this notion that women should be given the opportunity to have control over decisions regarding their pregnancies and childbirth. What are your views on this?

R: Yes I personally think it's, it's, it's that best. Because sometimes, you can't force a procedure or a mode of delivery. What you want to do on the patient for patient. The patient has the right to choose that I want this way. I want my pregnancy to go this way. I want maybe at the end of the day, I deliver by Caesarean or by SVD. But occasionally, there are high risk patients that you now that they can't go through vaginal, that is spontaneous vaginal delivery. So those few ones, you always make you counsel them that definitely, if you go and have elective CS, because of this, this, this, that. Some will also tell you, no I still want to go ahead and try if I can have vaginal delivery. And know, knowing the risk, we tell them that these are the risk. Just like a week or two ago, we had a similar problem. We had a case that we had to do surgery for a patient. But she still insisted that she wanted to do, she wanted to give birth by herself. So then I went and told her that. Ok, I put everything on a table for her. I told her the risk involved if she goes through a normal vaginal delivery. She said she was going to think about it. Some few minutes she came back and then she consented to the surgery. But in the case that there are no contraindications to particular mode of delivery. Or how a pregnancy should, the outcome should be, then we leave that to the patient to decide. And then if there is a problem with that decision, we just go ahead. And then I tell you this, that, this that. So it's good for you to do it this way or that way. But we will never force it on you. We've had several cases like that. Example, a patient, complete breach, can't deliver by vaginal delivery. They still said their God will do it for them they will deliver. We were like no still. They even became my friends. They even see me sometimes and they call me and they wave at me. And we, we, she was like 38 weeks. So we, waited, waited she got to 39, after a week she was, they realised that still baby not coming. Then they finally decide that they want us to go ahead with the CS and then we went like that. Also, I think the position of the Ghana Society for Obstetricians and Gynaecologists, I think primary indication for CS is, is still not approved, the standard says the vaginal delivery should be the option for everyone.

I: You mentioned the mode of delivery. Is it an option that is given to women especially during ante-natal period? Whereby the pros and cons of CS is given and then that of other methods are given and the woman is given the opportunity to choose?

R: Ok. For ante-natal here, it's the midwives who handle ante-natal care in this hospital. It's when they have a problem with a patient that they refer to see us the doctors. So I don't know if during the booking visit, the midwives go through all that with them. That one I can't say on that. But what I can say is when they come to us, and we look at the risk involved. If this is going to be a better outcome, if we do CS or vaginal delivery. We look at all that and we tell them. But until that indication comes in, we really don't say anything to them. Because mostly the normal is, the go through vaginal delivery. It's occasionally that some educated patients will say ok, "no" I want CS. That's how I want it. That one there's nothing. We just go ahead and just counsel them before every surgery, that these are complications that can arise, this, that, this, that, this, that.

I: Do you think that women, most of them have the capability of making this kind of informed decisions?

R: Personally I think they do. But a lot of cases, you see them and they will be like, "ok, I'm waiting for my husband. To come and make that decision." And I'm like you don't need your husband to make that decision. It's your personal, it's yourself. It's your body. So personally, I think they have that. But they try to say that ok, it's my husband who

has to make that decision for me and that. So I even sometimes tell them, why do you need your husband to make that decision for you? It's your personal decision that you have to make. So they do have the capability, just that they sometimes don't want to make that decision by themselves.

I: Ok, what of giving them the opportunity to choose the place of birth?

R: Well, most patients who come here don't request to go elsewhere to deliver. Rather they come from places. They choose to come here. Because sometimes they refer them here on account of client request. So for patient coming here and asking to go elsewhere hardly do we, do I come across such cases. But yes, if a patient wants to go elsewhere, to deliver, why not.

I: So what are your views on home delivery?

R: Because I'm, I'm a trained medical professional, I really, I think hospital delivery is, is the best. Because anything can happen. It could be that you've had home delivery for all your pregnancies. But one day, anything can happen. So it's always best to go for the hospital delivery. Unless I mean in the villages you have traditional birth attendants, they come home to deliver and some deliver successfully. But I think it's always best to, to go to the hospital, personally.

I: Should women be allowed to choose their own birth attendants, even in the health facility?

R: Yes and no. Yes, because sometimes, you feel more comfortable with a particular person delivering you. So why not. And no because you choose maybe, during your pregnancy you choose that you want this person to deliver you. But what if that day you come, and the person you want to deliver, maybe for some reasons, is not, is ill or has travelled or is not around, then what happens. So I think, I think generally, when you come to the hospital, whoever attends to you, I think it's fine.

I: Do you mean women should not be given a choice?.

R: I don't have a choice. That's why I said yes, yes and no. Because I really can't tell.

I: What of birth position? Should women be given the options available whether to lie, to squat, to stand or whatever position they want during delivery?

R: Well, the normal position we all use is the lithotomy position. Lying prone and delivering. But I, I, really, well I haven't tried the other modes; standing, squatting, so I don't know what goes into those ones. Because it is the normal ones that I know. And that's the normal one we all know. So...

I: Really, there are some benefits with the upright positions such as standing or squatting.

R: Really, well, well since, since I started medical school, I started practicing, I have never. The squatting some, occasionally, you see a patient coming in the second stage and baby is already coming out. And then you see them, they squat or we even tell them to lie down, because sometimes, standing the baby can just drop like that. So that's what I see as the normal one, maybe.

I: Ok, but do you think it's something that should be promoted?

R: You know because birth position, you know there are so many publications now about giving birth in the water, giving birth standing, giving birth. But you see in our training, we've only been trained in one way. Or we've had training specifically in the normal position we know a woman should lie down and give birth the lithotomy position, yeah, or the gynaecological position. Now, when they change I don't know how the outcome will be. I have not had that experience, in other positions. I know that the other day I heard on the news there's a facility in Accra that they give them the water bath delivery. I have not had experience with that. If I have, I have had a training on that I think that's the best way, fine. Then we can also opt for that...

I: labour companion. Somebody who stays with the woman throughout labour to do the massaging, encouragement. Do you think that it should be something that should be promoted in our facility?

R: I strongly, I strongly think it should be. Because sometimes you just need someone to make you feel loved. To make you feel like you are not going through the pain alone. I think it helps a lot. Even watching movies, you realise that it helps. But here you see patient screaming. And how many midwives do you have per patient. The ratio is very, very. I mean the gap is very, very wide. So, you can't have every one midwife per client. So if they have a companion, maybe a mother, a brother or a sister or their spouses, I think it would be good. And it would help. At least psychologically, it makes them feel like they are not going through all that. So I think it should be promoted.

I: And so do you practice it here?

R: In this hospital, I really can't tell why it's not being practised. And even the space, even the surrounding. Our labour wards are not so like you know conducive to even bring more people in. because infection and all that, so. Because the space, the space is very limited. If everybody should come in with a companion, it would be crowded. But if we had a system. I mean I don't know how realistic it is. But elsewhere, abroad, you know sometimes even in the. Whilst the patient is going through labour. Maybe it's only one per room or cubicle. So at least it's well covered and well shielded. But here is the case that everybody is seeing. This patient is seeing the next patient. That patient is seeing that patient. It's, it's, it's not possible, yeah. So if maybe our labour wards can be well constructed such that we have. Even if we have only, not specifically maybe patient or two or three patients per room, but if they are partitioned very well and a chair by every bed, for a companion to sit in. I think it being practised or advocated would be a good idea.

I: Ok, the other one is pain management. Labour pain management. Should the options be given to women?

R: Yes it should be.

I: Is it being practised here?

R: No.

I: Any reason why?

R: I have no idea why.

I: No, you, you, you are working in the maternity.

R: I'm working here but.

I: So maybe, why are the women not being offered labour pain relief?

R: You know, one thing about this. Not just this hospital but I think it's everywhere. It's like they are always focused on the same thing. Because it's always being done this way, you need to continue doing it this way. So it's like there is no room for additions. It's like they've, we've all tuned our minds that ok, this is how it's being done this way, so I will follow it that way. So it's probably that is why it's probably not being...

I: But you could be the one to bring in the change?

R: Maybe, but I have, I have bosses. I can't just bring in that change.

I: Have you discussed with your boss about the possibility of bringing in some of these changes?

R: No, I haven't, I haven't.

I: Why?

R: Or maybe it's has never crossed my mind. Maybe.

I: Ok, this afternoon when I came in you were talking about the length of stay. Do you think women should be allowed to choose how long they stay here after delivery?

R: Well, it's a very, very dicey one because it's like one of my bosses mentioned, they used to discharge the patients immediately after. Then some came, came back, they would have collapsed and all that. So I think it all depends on the. It should depend on the physician. To make a good judgement. Whether this patient can go home or not. Because, the patient. If, if we allow the patient to make their own decision, that they want to go home, maybe, maybe an hour or two after delivery, she goes home something happens, who is to be blamed? At least when the patient stays here at least like we said 8 to 12 hours or 24 hours. At least you know that everything has settled or close to settling down. Like system, systemically. I mean talking about the patient as a whole. So I think it should depend on the physician or the health professional to make that informed decision.

I: At the beginning of this interview you said it's the patient's body.

R: No, no it's the patient's

I: It's, it's, it's the

R: But we are also here

I: Shouldn't it be their decision to say that "ok, you've told me everything, but I still want to go home".

R: Yes, but in terms of this, you are here to save a patient's life. You don't want to, you don't want to do anything that would put the patients at risk. And you being a health professional or a health worker, you know what may or may not happen. Because some patients bleed after sur, after delivery. Sometimes, immediately delivery, you can't tell. But when the patient stays at least for some hours. That is why sometimes they move patients to the third stage and then the fourth stage room, up there at the labour ward. They have the first, second stage, third and fourth stage. All these stages, they monitor the patient. If the bleeding is fine, then patient moves to the fourth stage. Then comes down to the ward. If patient still bleeding, even, they come and call doctor to assess.

So, that's why I'm saying that it's best if at least we monitor the patient some few hours before we discharge. But not immediately. Because most patients would say ok, because of the state of that bathroom, or the environment, I want to go home immediately after delivery. If you leave that to the patient to decide, trust me. It may or may not go well.

I: Ok, once you've mentioned the state of the bathroom and the toilet. I will quickly go on to the built environment, which is the infrastructure. How does it facilitate or hinder the provision of client centered care?

R: You know generally, it's, it's, it is, it's terrible. Because even, sorry to deviate a bit. But even we the staff if you see the state of our washrooms, it's, it's appalling. Sometime ago, I had a retained placenta. I had to do manual removal of the placenta. Unfortunately for me, the blood splashed on me. We don't have a bathroom that if you can say ok, quickly you want to wash off the blood until you get home and do it. Fortunately for me, my house, before I married and moved, my house was 7 minutes away from the hospital. So immediately after, I just used Savlon and things to clean. Quickly rushed home to go and take a shower and I came back and came to work. So, even if health workers, the staff our bathroom is in this state, how much more the patient. And you know the patients, they are many. Everybody and the way they, they keep themselves in terms of their surroundings. Some will go and use the bathroom, make sure that it is clean. Even if it is not clean and they won't be able to use it, some will go whether clean or dirty they still use it and leave the place in a bad state. So infrastructure in this hospital in terms of our hospital, I mean our washrooms, it's , it's, it's an eye- saw, it's an eye- saw.

I: What about the wards.

R: And the wards too, it's, it's, it's not the best. We can do better. We can do better.

I: I, I, went to your triage area and I was quite...

R: Yeah.

I: Worried...

R: Disappointed or yeah.

I: Any suggestions as to how that place can be improved?

R: I think it has to do with space. It's, it's the place is too small for an emergency. It's, it's too small. It's all about the space. Cause, if we have space, then we can partition the place. Cause even, you saw the table we consult on? Two doctors on a table. So two patients being seen at a time. One pa, the patient that it's just their backs that are facing, are touching. So, whatever this patient tells the doctor, the next patient can hear. Patient- doctor confidentiality is breached. So it's all about spacing. Cause, we don't have enough space to say that ok, this doctor is consulting on this side. This other doctor is consulting. So it all has to do with space and even initially, we had only one emergency bed there. Until we made some adjustments and we were able to put two beds in the emergency. And even that it's not enough. Because sometimes, you have a lot of emergencies coming in at the same time. And like we said earlier on during the meeting, sometimes the patient sits and is being transfused blood, which is not the best. So, it's all about the space. If there's, we have, we had enough space, I think it would be better. And if we had the space to, I think it should be partitioned. That's the beds it should be partitioned. At least with screens, so that this patient lie here and know that

ok, I'm comfortable. And then we can get maybe a two consulting rooms, see the patients there. Instead of having two patients consulted by two doctors at the same time.

I: Ok. So now that you say you want a new, a new building ...

R: Yes.

I: Will you go for general ward or a private ward for your clients?

R: As in general ward like?

I: General ward, where you have like big ward with several beds. And then private room, is where you have, indivi, single beds.

R: It can be a general ward with a lot of patients, but can be partitioned. So at least you have your privacy. Maybe you want to change, you don't have to. It's not everybody who is comfortable, changing in front of people they don't know or they are no familiar with. So it can be a big ward, but there should be partitions. And if we get a new building, we will be, it will be nice. At least if we have a whole maternity block. Because, La, we see a lot of O&, Obs. and Gynae. Obstetrics and gynaecology cases a lot. So if we have a whole unit for obstetrics and gynae., I think. And then I think, we, there should be expansion too. In terms of the beds and all that. Because, we even have patients lying on the floor. Which, it's, it's not the best. Because sometimes, they would have even had surgery. And the pain, even when you are on the bed. Because I have had surgery before, I know what, I know, I know the pain they've, they go through. Even getting out of bed, which is high, is so painful. How much more lying on the floor. It's, it's, it's sad. And I feel for them.

I: One of the key attributes of client centered care is making services accessible to our mothers and then their families. Including having a good reception and then issues regarding waiting. How is this organised in this hospital? The services, how are they organised? To make it accessible for mothers and their families.

R: Example of service, like family planning?

I: Ok maternity services that...

R: Services.

I: As a whole. And our focus really, is on ante-natal, intrapartum and postnatal.

R: Ok.

I: Yeah.

R: Ok, so ante-natal like, is like I said, I can't really comment much about it. Because it's handled mainly by midwives. But I can, I can say for sure that as for the waiting times, they wait so long. Because, when you see the number of patients that come every day for ante-natal services, you can tell that. You can come, even if you get here as early as 7 or 8 or 10 am, trust me, you won't leave till like maybe 2 or 3. Which is I think is a lot of hours, just coming for ante-natal care. In terms of other services, we have a family planning unit. So for that it's, it's well handled by our midwives at the family planning Unit and it's accessible to every patient. And then emergency care, is also, we also we doctors, nurses we are up here to also render all those services for the patients, so...

I: You don't even have a waiting area.

R: The waiting area is the same place. You, you saw it yourself?

I: Yes, I saw it.

R: The benches. The same benches that the. So even when relatives come with patients, the relatives have to stand. They have to stand because the bench, we have only two benches there and then two beds. So if the two beds are filled with patients, then the bench we also have filling the whole bench. And the relatives, where would you? You have to stand, just probably on the corridor and wait till maybe your, your relative or your wife or your sister is seen and we need you to buy medications, then we ask them to call you. Then you give you the medications or the labs. Then you go and do those things. But waiting area for relatives we don't.

I: You don't have it.

R: They stand. Those who can't stand, you probably go downstairs to sit on the stairs or by the stairs and wait till the relatives call them. If they are not on the corridor, they call them on phone to probably come back up for the prescription.

I: Communication and information giving is one key area in service delivery. How do you normally go about doing this?

R: Most of the education, goes on at the ante-natal clinic, before the patient come. That one, even though, even though I'm not there, I know they educate them a lot. But I don't know whether they have any materials for educating them. But for some procedures, I sometimes, that has to do with maybe the uterus of the patient. The womb of the patient. I sometimes just try to make some sketch on a paper. And I explain to them, what will be done on the uterus. So that's how. But as to having materials or any learning, aids to use, that ok, this is the structure of your uterus, this is what I'm going to do. Here this is this, this is that. No, I usually draw and tell them maybe I will cut here. Ex, example if I have to do bi- lateral tubal ligation, because lots of patients assume that doing BTL, means you are trying everything. Or they become like men. So I just draw the womb with the fallopian tubes. And I tell that ok, this is the womb. This is the tubes. This is the egg on a paper. This is what I will do. Maybe I will just tie, here, tie here and I cut. I will tie, here, tie here and I cut. You do your nor, your period normal. As to whether we have those teaching or learning aids to show the patients ok, maybe this is how your uterus looks like. This is this, this is this. No, I haven't seen any here, since I started working here.

I: Yeah, how effective do you think the education that is provided in the ante-natal care is?

R: I wouldn't know. Like I told you, but at least, one thing that I know sticks is, usually for every patient that comes for ante-natal, they educate them to donate blood. A lot donate. But still, some don't. So I don't know whether they, they education didn't go down well for them or it's just they refused to do it. Because they felt like probably their previous pregnancies, they didn't need to transfuse, donate blood in- waiting. Should in case something happens and they need the, they need the blood to be transfused. Or it's just that some honest, genuinely, some genuinely don't have people to donate the blood for them. So in terms of education, I, I, think to some extent, it goes on. To some extent. Because sometimes, there are some things too that the patient come up, and then they, you ask them but you should know this. Don't you know this? And then, then

some of the midwives, because they know the kind of education they give to the clients at the OPD, at the ante-natal, we will even come and say, but didn't they tell you this at the ante-natal? They told you all this, so I don't know if it has to do with the patients themselves or maybe the education doesn't go down well for them. Yes, that's how far I can answer.

I: The other, how are your services, maternity services, how are they coordinated in order to meet client's needs, where they don't have to go to different places for different kinds of services in the hospital.

R: Usually for here, our my, my, you mean ante-natal?

I: Both ante-natal and intrapartum. I want to see how you integrated their and then coordinated.

R: So, usually like I said, if a woman is pregnant and comes for booking, it's ante-natal. So if they have a problem and the ante-natal, every day, we, we the doctors, we are there.. ...what we do here is, from ante-natal, the client is being served by a midwife or a doctor. But mostly, when there is a complication, that's where another, that is why they see the obstetrician. And the midwife at antenatal, she doesn't take them through labour. They come here and meet someone else, who is at the maternity who receives them. Then they start providing care and when she is in active labour, she comes to labour ward

I: Let discuss some issues regarding monitoring and feedback. Ok, how do you monitor or get feedback from patients about how client centered your services are?

R: Like I said earlier on, I establish rapport with my patients. And sometimes, the patient ends, up, they tend to, like you. They will be like doc, can I have your number? Me when you ask for my number, I will give it to you. Because this, it's a small world. You never know where you will meet someone one day. Some, as for that respect, I always give to my patients. So sometimes, a lot of them take my number and then they call me. Doc, this, this, I'm fine, I'm doing this. Or I'm not this. Then I say ok, then come back, we have to attend to you and all that. So, that's how come I'm able to get...

I: You entrust in the hospital?

R: This patient, this patient is, is very good. She is doing well. But the hospital, I don't know if they follow up. But usually after the discharge of every patient, we ask them to come for review. So they come for a number of reviews at the clinic. So when they come and everything is fine and after a while, if there is no problem, we discharge you completely. Until we have any other problem and come, yes. But as in like picking out those you know cases that you are saying you are following up no, I don't think it's done. Just that the normal thing is that when you discharge, they come for review at the clinic. It's an, it's a surgery that was done. They come for wound dressing, then the. But there is no particular way that says that maybe because it's a high risk case, I'm following up. There only follow- up is when they are on admission and we discharge them. That is it, then they do the follow- up, that is it.

I: Okay, you mentioned follow-up which is a good thing in client centered care. can you describe your views and experiences with how continuity is practiced here?

R: Well this is a difficult one, yeah, usually I'd say that it's difficult to execute that in our setting here because you have different, you have doctors at different places at different times so at one point in time, you have one at the ER, another occasion you have the

same person at the clinic and so it's difficult to monitor or take care of one patient throughout. The other ...how communication is what helps bridge that gap in that one doctor finds or see what has been done previously and may contact the doctor who gave that service and would have to make some inquiries so continuity I'd say is difficult executing in our setting as in by the same or one doctor but then it's compensate in the fact that communication amongst doctors is what helps in the continuity of patient management.

I: The documentation that they do?

R: And the documentation that they do.

I: Yeah, but is it not possible for us to recognise our service delivery approaches in order to assure this kind of continuity?

R: I'd say it would be possible, only with increase in what do we call, the number of personnel or if we bridge, no, if we improve upon the doctor to patient ratio or the health worker to patient ratio because it's where we have the number that we can provide that continuity by the same doctor. But then where we don't have, then it becomes difficult, the other thing is that communication with doctors, especially in the public sector, we hardly give our phone numbers to clients because of a lot of issues. And then also there is absence of an office line where patients can call and inquire about their doctors and what has to be done. Most often it has to be done through the doctor's private line. I think that's also not advisable or understand in certain countries it's unethical for the doctor to call a patient with his private line or to use his private line to call, it always has to be the, an office line, an office line to probably the patient's number and the patient's number to an office line but not through the doctor's private line.

I: Is there anything else you would like to discuss with me?

R: Yes, I, I think well that if you want to, if we want to achieve our aim very well, we shouldn't always look at the health workers, we should look at the client that are coming in. Because at times, you have a patient comes and anything you say is a no go area for her. What she knows how to say is no, I don't want this, I don't want that. And she wants what she likes. You go ahead and tell here the consequences, or this is what you want to do to help her, she says no. With this kind of patient, what can are you going to do for her? But at the end of the day, we always talk about maternal mortalities and all that. What part are the clients playing towards maternal mortality? Or the MDG's that we want to achieve next year. Even with the free maternal health that we do. Still we have people in the system coming in as non- attendants. They don't go to any ante-natal and they come I and all they do is come and give complications. Yes, the health workers, we have some not doing what they are supposed to do. But what about the health workers, the, the patients? What part are they playing? What part are the relatives playing? We are being trained, now and then. Yes, we want to improve, but the patient'. Sometimes when the clients come and then they are not willing to, ready to accept what we tell them to do, we find it difficult to come together and then give them the necessary care that we're supposed to give.

I: Ok, please may I know your age?

R: Age? 30, I will be 30 in May.

I: And your professional category?

R: Medical Officer.

I: Medical Officer, and your grade?

R: As in, as in s? The...

I: Whether you are a senior...

R: The single spine.

I: Senior Medical Officer.

R: No, Medical Officer.

I: Medical Officer. How long have you been on this grade?

R: Medical?

I: Yes.

R: I started my medical officer. My grade was November last year.

I: November last year. And your work area?

R: I finished my house job. My area, Obs. & Gynae.

I: Obs. & Gynae, ok. Thank you very much.

R: Thank you too Auntie.

Annex 11: Ethical clearance from Ghana Health Service ethics committee

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

*In case of reply the
number and date of this
Letter should be quoted.*

*My Ref. :GHS-ERC: 3
Your Ref. No.*



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December 19, 2012

GERTRUDE SIKA AVORTRI, Principal Investigator

Ghana Health Service
Institutional Care Division
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Accra

ETHICAL CLEARANCE - ID NO: GHS-ERC: 16/11/2012

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

“Evaluating Client Centered Childbirth Services in Ghana”

This approval requires that you submit periodic review of the protocol to the Committee and a final full review to the Ethical Review Committee (ERC) on completion of the study. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification of the project must be submitted to the ERC for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your mother organization before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this protocol

SIGNED.....
PROFESSOR FRED BINKA
(GHS-ERC CHAIRMAN)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

Annex 13: Letter of the statistician



TO WHOM IT MAY CONCERN:

I write as the CEO of this enviable consulting firm to attest to the fact that the quantitative data analysis section of the PhD work titled "Development of guidelines to improve client-centred childbirth services in Ghana" was conducted by D&D statistical consulting services in Ghana. You may please forward all continents to us via email address which is clearly stated on the letter head or contact us via +23 220786 1179.

Sincerely,

Duala Dwomoh

Chief Executive Officer

D&D Statistical Consulting Services Ltd Ghana

"Don't Relying On Statistical Results Without Applying Common Sense Equals To Loss 90"

P. O. Box 1613, Legon - Accra / Location: Ofankor - Asylum Street

Contacts: +233 207 864 479 / +233 245 198 457

Email: ddsstatconsult@yahoo.com, www.ddsconsult.com

Annex 14: Letter from the editor

EDITING AND PROOFREADING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

15 September 2015

TO WHOM IT MAY CONCERN

This letter serves to confirm that I have edited and proofread Mrs G. Avortri's thesis entitled: **"DEVELOPMENT OF GUIDELINES TO IMPROVE CLIENT-CENTRED CHILDBIRTH SERVICES IN GHANA."**

I found the work easy and enjoyable to read. Much of my editing basically dealt with obstructionist technical aspects of language which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors Group and also a lecturer in the Department of English at the University of South Africa.

Thank you.

Hereunder are my particulars:



Jack Chokwe (Mr)

Bureau for Market Research (Unisa)

Contact numbers: 072 214 5489 / 012 429 3327

jmb@executivemail.co.za

Professional
EDITORS
Group