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Clients' Perspectives on the Quality of Maternal and Neonatal Care in Banke, Nepal

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Abstract

Introduction: Maternal and neonatal health is a crucial issue on public health and the morbidity and mortality rates related to safe motherhood remains challenging in Nepal. This study aimed to explore expectations of mothers concerning maternal and neonatal care from the local health care facilities; to find-out prevailing problems and suggestions for corrective measures for potential problems encountered.

Methods and Materials: Both Qualitative and quantitative study was conducted comprising 24 mothers from three Primary Health Care Centers (PHCCs), Eight Health Posts (HP) and eight Sub-Health Posts (SHP) of Banke district Nepal. The despondence was selected using the purposive sampling techniques and a thematic analysis was employed. The SPSS-16 statistical software was used to analyze the data collected in 2010.

Results: The 89% of mothers were agreed that Auxiliary Nurses Midwives (ANM) having adequate maternal and neonatal knowledge and being able to properly use safe delivery kits. But less than half (29%) of the mothers had proper understanding about the primary health care outreach clinic services, similarly eight (33%) of the mothers preferred institution delivery. Mothers emphasized the importance to improve the quality of maternal and neonatal health care through the process of timely services (54%), provision of cost-effective medicines (54%), separate delivery room (71%), adequate staff, accountability of staff (58%), provision of transportation (42%), need to be responsive in their behavior (46%), and need for support from the local government (29%).

Conclusion: To react to these experiences and to address these expectations, there should be effective communication system between ANMs and mothers about the service but also provision of adequate resources, establishing credibility, good monitoring, and supervision system. Health policy and guideline implementation should be enhanced also at the local service level.

Keywords: Client perspective; Satisfaction; Maternal care; Quality of care; Nepal

Introduction

Health services provided to pregnant and lactating mothers during antenatal, natal and postnatal phase are essential for maternal and child health in the population. Taking into account the perspective of clients of the maternal and neonatal health care services enables ensuring client satisfaction concerning health care providers, resources, technology and time. The client satisfaction fulfills three main distinguishing functions: (1) understanding patients' experiences of health care; (2) identifying problems in health care; and (3) evaluation of the services [1]. Annually 358,000 women die during pregnancy and child birth in the world among them one-third in South Asia region [2].

High maternal mortality ratios (MMR): 539/100000 live births in 2001 and 281/100000 live births in 2006 [3]. The MMR is on decreasing way 170/100000 live birth in 2013 that have to be reduced to 134 by 2015 to meet the health Millenium Development Goal (MDG) [4]. At a same time higher neonatal mortality rate 33/1000 live births in Nepal indicate that there are problems with the quality of care [3]. The main reasons for poor quality of maternal health care have been reported to be a lack of access to medical care, low priority to health education and the low status of women [5]. Inadequate skilled health workers, insufficient logistics supply, poor infrastructure and weak supportive supervision and monitoring system, lack of coordination among staff and between stakeholders are also associate factors. Similarly, unresponsive behavior of health staff and lack of accountability and prompt practice in field supervision, slow and inadequate decentralization are further challenges in ensuring quality of maternal and neonatal care [1]. Because of these reasons, only 18.7% in 2008 and 35% in 2011 of the births take place at health facilities by skilled health workers in Nepal [6]. Thirty six percent of babies are delivered by a doctor or nurse/midwife indicating that Nepal has a long way to go to meet the MDG target of 60% births attended by a skilled provider [7]. Newborn survivals are not only dependent on the health sector; inter-sectoral collaboration is necessary to empower girls and deliver long-term health benefits, which will then be passed on to their families [8]. Nepal's safe Motherhood Program has failed to deliver expected gains in maternal and child health [9]. However, Nepal has received MDGs award for outstanding national leadership; commitment and progress towards the achievement to improve maternal health. Indeed, MMR has decreased by 47% by 2006; by 58% by 2010 [7,10]. On the other hand, neonatal deaths decreased only by 12% by 2001 and by 23% by 2006, which means a rather modest decrease in the neonatal mortality rates and it is still a challenging for the government of Nepal [2]. The major causes for maternal death are haemorrhage (25%), sepsis (15%), eclampsia (12%), unsafe abortion (13%), obstructed labour (8%) and other direct (8%) and indirect (20%) causes [11]. The Neonatal deaths are due to prematurity, low birth weight, severe infection, birth asphyxia, birth trauma and congenital abnormalities [7].

The aim of this study was to explore expectations of mothers concerning maternal and neonatal care from the local health care facilities. In addition, the aim was to find out prevailing problems and suggestions for corrective measures for potential problems encountered.

Methods

The study was carried out using face–to-face interviews and focus group discussion (FGD) with pregnant and lactating mothers up to 42 days of child birth at Banke district, Nepal in 2010. The participants were selected from the sub-health posts (SHP), health posts (HP) and primary health care centers (PHCC) in the area. Convenience sampling technique was applied for the selection of mothers. Twenty-four mothers who came for maternal and neonatal services participated in the interviews and seven in focus group discussion (FGD) session, which were recorded and monitored by the first author. The ethical permission was obtained from Nepal Health Research Council, Kathmandu. The interview guide was piloted before the actual study. The interviews and notes were translated from Nepali to English.

Eleven mothers were higher caste i.e., nine were Chhetri and two were Brahmin. The rest were lower caste i.e., five dalit, one janjati and six indigenous. Ten respondents were between 20-24 years; 17 women worked at home in agriculture and husbands of six mothers worked at office. Six out of 23 women were illiterate, five had literacy, five had primary and five had secondary level of education. Further, Proficiency Certificate Level and Bachelor's degree holder respondents were few, two and one respectively. About half of the women lived in nuclear families.

Results

Individual interview results

The interview results of mothers were categorized by themes: mothers' familiarity with the maternity and neonatal care, with staff's work and services as well as level of satisfaction; perceptions concerning received maternal service credibility, availability, outreach clinic; and prevailing problems and suggestions for corrective measures.

Mothers' familiarity with the maternity and neonatal care staff's work and services

Eleven out of 24 mothers interviewed were aware of the main staff group, Auxiliary Nurse Midwives (ANM) and knew their designation and accurate working place (**Table 1**). The rest misinterpreted them as either doctors or nurses. ANMs talked about antenatal, natal and postnatal issues when meeting mothers. The common discussion issues were importance of health check-up, diet, nutrition, breastfeeding and vitamin A intake, personal hygiene, infection prevention, health education, safe delivery, emergency fund, transportation, arrangement of blood and delivery kit boxes (**Table 1**). Nine respondents answered that ANMs talked to mothers about possible danger signs during pregnancy, delivery and post-partum period. Only four respondents believed that ANMs did field visits between four and 10 times a year. Eight respondents were satisfied with the ANM service because they received better pre and postnatal care, good counseling, safe delivery and medicines. However, three mothers were dissatisfied because of irregular services (lack of punctuality), irritating behaviour, careless service, low accountability and not feeling having ownership in own maternal issues. Majority of the respondents agreed ANMs having adequate maternal and neonatal knowledge and being able to properly use safe delivery kit boxes. They also saw that ANMs could respect the values of the local culture. Only five mothers perceived that ANMs notified and responded quickly to maternal and neonatal problems in case of emergency.

Perceptions of mothers concerning received maternal service credibility, availability and outreach clinic

The three mothers (who knew about ORC program) answered

Table 1 Knowledge about ANM staff and level of satisfaction with their services among mothers (n=24) in Banke, Nepal

Variables	Response options	N (%) of options chosen
Knowledge about Auxiliary Nurse Midwives (ANMs)		
	Yes	11 (46%)
	No	13 (64%)
	Total	24 (100%)
Knowledge about working place of ANMs		
	HPs and PHCCs	8 (33%)
	Hospital	3 (13%)
	Missing	13 (54%)
	Total	24 (100%)
Discussion matters with mother during pregnancy*		
	ANCcheck-up	8 (33%)
	Diet and nutritional advice	7 (29%)
	Immunization	3 (13%)
	Health education and counselling	2 (7%)
	Other (hygiene, environmental sanitation, emergency fund)	4 (17%)
	Total	24 (100%)
Provision of necessary things by ANMs for safe delivery*		
	Emergency funds	7 29%)
	Transportation	6 (25%)
	Blood arrangement	3 (13%)
	Delivery kit boxes	10 (42%)
Satisfaction with ANM's work on maternal and neonatal care		
	Entirely satisfied	1 (13%)
	Satisfied	7 (29%)
	Not satisfied	3 (13%)
Causes for being satisfied*		
	Better pre & post natal care	10 (42%)
	Good counselling	4 (17%)
	Safer delivery services	2 (75)
	Provide medicine	3 (13%)
Causes for being dissatisfied*		
	Irregular service	4 (17%)
	Irritating behaviour	3 (13%)
	Careless services	3 (13%)
	Less responsefull behaviour	2 (7%)
*The numbers do not sum-up to 100 % due to multiple options answers		

that ANMs conduct ORC one to three times per month in villages (**Table 2**). The mothers interviewed were asked about the state of maternal service received from local health institutions during their last visit. Eighteen mothers visited to receive check-up and the rest of them visited for growth monitoring, delivery services, postnatal care and general health check-up (**Table 2**). Mostly mothers visited ANM and support staff as their first contacts in the health institutions.

Mothers were also asked about their preference of the delivery place; nine mothers would like to give birth at home, eight at health institution and seven either at home and health institution. The distance from clients' home to local health institutions and waiting time for maternal and neonatal service was asked. Walking took between 5 and 120 minutes and the waiting time varied from 5 to 30 minutes. The level of service quality from ANM was rated as 'normal' by eight mothers, good by nine and bad by eight.

Prevailing problems and suggestions for corrective measures

Common causes reported for the failure of the health care facilities and PHC/ORC program in communities were: lack of medicines and buildings, poor management and community support, low accountability, lack of security and poor supervision and monitoring. Among those who knew about ANMs, reasons for poor field visit performance were: lack of credibility establishment, weak field facilities for ANMs, low accountability.

The expected ways of improving quality of maternal and neonatal health care were: separate delivery room or building, need to feel responsibility and ownership by staff, punctuality and regular services with responsive attitude and cooperative behavior of staff, need to have full staff based on the population ratio and establishment of good relationship with community people for support in maternal and neonatal service (**Table 2**).

Focus group discussion results

In the focus group discussion most of the mothers were shy to express their feelings and expectations from health institutions. Few mothers reported attending four times the antenatal clinic during pregnancy. Reasons given for this included knowledge barriers and service delivery gaps, cultural and traditional beliefs and practices as well as geographical constraints. Women preferred institutional delivery but still practiced home delivery because of labour starting at night when there is no transportation and maternal care units are inaccessible since they are often closed at night. Other perceived barriers were health workers' rudeness and absenteeism from work, traditional beliefs, geographical difficulties, and trust on Traditional Birth Attendant (TBA) services in the community:

"We practice our delivery by TBA in the community. TBA can provide better service in the community and they did the delivery"- FGD mother

The mothers were not knowledgeable of the available maternal services for them at the local health institution such as nutritional advice, health check-up, Vitamin A during delivery, checking the position of the foetus and health condition of the mother and provision of iron tablets. They visited health institutions especially for their new borne baby rather than for their own health needs. The mothers were not aware of ANM job description and their

Table 2 Mothers' understanding of Primary Health Care/ Outreach Clinic (PHC/ORC), received services, prevailing problems and corrective measures in service, n=24, Banke, Nepal

Variables	Response options	N (%) of options chosen
Understanding about PHC/ORC		7 (29%)
Causes of failure PHC/ ORC		

core services. They also expressed dissatisfaction with the work of ANMs and other health staff because of their unresponsive behaviour and poor home visit frequency.

It was generally agreed that mothers-in-law at home did the newborn care practice. Later Nwaran (Occusation of celebrating in the Hindu religion on the 11th day of the child birth) went for BCG vaccination and during that time village health workers normally took baby weight. A mother, 32 years, expressed her experiences and said:

"I do not know about ANM; I delivered three babies at home without any maternal assistant. Nobody told me about health services".

Discussion

The study was done on three levels of health care settings of Nepal: Primary Health Care Centers, Health Posts and Sub Health Post, as well as among their registered clients. The pregnant and post-partum mother were included in this study.

This study addressed the gap between clients and health care staff on maternal and neonatal health care services. Further, this study sensitized mothers for utilization of available safe motherhood services at the primary health care settings of Nepal. This qualitative interview study among pregnant mothers and those recently given birth in Nepal showed that mothers were not well aware of the role and responsibilities of the auxiliary nurse midwives, who are the main professional group responsible for maternity and neonatal care in the country [12].

Only 11 (45%) out of 24 mothers interviewed knew the real post, job and responsibilities of this professional group. Most of the mothers perceived them as doctors. Low level of knowledge is because of the lack of education among mothers in the community. It is however contrary to the finding in the study in Nigeria, where there was the 68% of mothers had positive knowledge about quality of maternal and child health services [13]. Almost the same with this present study where the 46% of mother had good knowledge on maternal neonatal and child health in India [14]. The poor relationship between health care providers and clients leads to barriers for quality of care where in India also not satisfactory relationship between health care providers and client. Therefore, the health staff should establish a good relationship with local people and clients. This study showed that the health message was received by 25% of the ANMs which was similar with the study done in India but better information was taken from 36% ANM in Nigeria [13]. The waiting time for receiving maternal and neonatal health care service by mother was 5 to 30 minutes of this present study where 15 minutes of waiting times was reported in India [14].

Most of the nationally, regionally and globally recommended maternal and neonatal health care practices are acceptable to mothers [15]. However, health care providers in this study did not promote them, which might be the explanation for low coverage of 4th antenatal and post-natal check-up and institutional delivery by SBA. This is because of the lack of credibility towards services and lack of trained staff available in time for delivery. Health providers may not be promoting antenatal, natal and post-natal as well as neonatal care practices in ways that enable mothers to comprehend the importance of these services.

Institutional delivery has been increasing in the last three years from 37 percent to 45 percent which aimed to reach by 60% by 2015 in Nepal [16]. However, in this study majority of the mothers reported that they would prefer to have a home delivery. Efforts to increase institutional deliveries by establishing birthing centers at all health facilities as well as continued investment in basic Emergency Obstetric Care and Comprehensive Emergency Obstetric Care with adequate resources and skilled health manpower would make safer life for the mothers and babies, which again would lead to decreased maternal and neonatal deaths [10,11]. Mothers who preferred institutional delivery, in practice often did not manage it, mainly because of a number of barriers, including costs, transport, and challenges of accessing health care at night. It is important to improve road and communication access to all health facilities, provide SBA at all health facilities, and strengthen the referral system as well as of the overall health care system. Further, there is a need to improve the level of economic status and education at all levels of the target people.

The mothers both individually and in the focus group discussion described how health workers were rude and careless and all these issues decrease credibility of the ANM services. This is mainly because the staff has no accountability, has poor supervision and monitoring system and there is political instability. It would stabilize the care if there was a permanent government, effective supervision, monitoring and possibilities to make health staff accountability using rewards and/or sanctions.

According to the mothers interviewed nearly half of the ANMs applied individual, group and mass education to motivate them into active participation in maternal and neonatal campaigns. Criticism was presented that the staff did not provide good service in terms of timeliness, medicines and other logistics and behaviour. The satisfaction level of clients was 33% in this study and it is nonetheless discrepancies to finding in a study in India where there was the 42% of clients and 88% in Nigeria were satisfied from ANMs because of low cost of services, the drugs and registration card also cheaper [13,14]. The common reasons for dissatisfaction among mothers were irregular service, not being in time, irritating behaviour, and low accountability, unresponsive and rude behaviour. These results are similar barriers for good quality care as presented in the interim three-year health plan of Nepal [10]. In line with our results, a similar study in Bangladesh found staff absenteeism, rude behaviour, and low accountability; the study recommended changing their behaviour [16]. This indicates that the health care staff and their services in these resource poor neighboring countries have same problems because of poor monitoring and supervision system, political instability, low salaries and discrimination among staff. A study about participatory evaluation on reproductive health in Tanzania showed the same lacks; the authors emphasized how participatory techniques are essential if the real needs of clients are to be met through sustained change and continuous quality improvement at the target level [17].

To improve maternal and neonatal care in Nepal and to meet client perspectives and needs, several challenges need to be faced. Technical training for maternal and neonatal health staff; also general education of clients is a basic way to solve poor information and communication problems. Further issues to be dealt with are practical help, culturally sensitive interventions e.g. due to long distances, mother-in-law influence in the delivery issues, and women's dependence on the husband's family in general. The service credibility is established by giving good quality services. Talking about the quality of maternal care from the perspective of clients, the clients have the right to information, access, choice, safe services, privacy and confidentiality, dignity and comfort and continuity of services [17].

To reach these there are tremendous challenges in awareness raising, training and quality improvement in the Nepalese maternal health care. By incorporating the perspectives of both clients and providers into efforts to improve the quality of health care, policymakers and program managers can develop a deeper understanding of the needs and constraints faced by both groups [18]. Based on this present study and other reports shows that the maternal and neonatal health outcome is positive [19]. Nevertheless, it has to be required further study with diversity manner.

Conclusion

This qualitative interview study is one of the few empirical attempts to describe mothers' opinion on the quality of care on maternal and neonatal care in Nepal. The study findings highlight the importance of service receivers' feedback in maternal and neonatal services. The key findings effectively indicate areas of all stages ranging from antenatal to postnatal services. Mothers emphasized the improvement of the quality of maternal and neonatal health care through the process of timely services, provision of cost-effective medicines, separate delivery room, provision of adequately skilled health staff, accountability of health staff, provision of transportation, responsiveness in the staff behaviour, and need for support from the local government.

To address these expectations or demands of clients, there should be an effective communication system between health staff (i.e. ANM) and mothers about the service but also provision of adequate resources, establishing credibility, good monitoring, and supervision system. Health policy and guideline implementation should be enhanced also at the local service level.

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