QUALITY OF CARE AT DELIVERY

A CONTEXTUAL QUALITATIVE REVIEW OF CLIENT EXPERIENCE AT JARAMOGI OGINGA ODINGA TEACHING AND REFERRAL HOSPITAL, KISUMU - KENYA

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A thesis submitted in partial fulfillment of the requirement for the degree of Master in International Health by:

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Declaration:

Where other people's work has been used (from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis "**A CONTEXTUAL QUALITATIVE REVIEW OF CLIENT EXPERIENCE AT JARAMOGI OGINGA ODINGA TEACHING AND REFERRAL HOSPITAL, KISUMU – KENYA"** is my own work.

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Table of Contents

List of Figures and Tables iii
Dedication iv
Acknowledgements v
List of Abbreviations/Acronyms Used vi
Glossary of Key Terms vii
Abstract ix
INTRODUCTION 1
Local Context 3
THE STUDY 6
Problem Statement 6
Motivation 6
Objectives 6
General Objective 6
Specific Objectives 6
Design 6
Conceptual Framework 7
Methods 8
Primary Data 8
Literature Review 10
Ethical Considerations 11
Study Limitations 11
Presentation 11
CLIENTS, RESPONSIVENESS, SATISFACTION AND QUALITY 12
Background 12
Role of Responsiveness and Client Satisfaction in Health Care 13
Link to Quality of Care 13
Link to Service Uptake 14
Link to Worker Productivity 14
PRIMARY FINDINGS 15
Structures 15
Processes 17
Outcomes 20
Direct Output 20

Client Experience 21
Community Perspective 22
DISCUSSION 24
Structures 24
Processes 26
Outcomes 27
CONCLUSION 27
RECOMMENDATIONS 28
Hospital Level 28
Health System Policy Planners 29
REFERENCES 30
ANNEXES 35
1. Map of Kenya 35
2. Participant Profiles 36
3. Delivery Statistics at JOOTRH (2010 - 2012) 38
4. Samples of the Study Tools 39

List of Figures and Tables

Figure 1: World Map of Maternal Mortality Ratio, 2010[13] 1
Figure 2: Causes of Maternal Mortality in Africa[15] 2
Figure 3: Organisation of Health Facilities in Kenya 3
Figure 4: Quality of Care Conceptual Framework 7
Figure 6: Map of Kenya Locating Kisumu 35

Table 1: Maternity Unit Statistics at JOOTRH 21
Table 2: Profile of Nurse-Interviewees 36
Table 3: Profile of Patient-Interviewees 36
Table 4: Profile of focus group discussants 37

Dedication

To my dear late father,

Rapenda James N. Owuor,

whose sudden demise on September 2, 2012

gave me unspeakable pain but also the drive to carry on.

Your memories and counsel remain fresh in my mind.

My tears never seem to dry.

Rest in Peace

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At the tail end of the journey, I had the privilege of a thesis supervisor with a heart of gold and a back stopper ready to fit her shoes. I say thanks to you both. My research colleagues, participants and the entire hospital fraternity at Jaramogi Referral in Kisumu, my gratitude to you is profound.

My friends and family in Kenya have continued to make their presence in my life a gift I cannot exchange. My dear mum Beatrice and siblings Dennis, Emma, Clinton and Anne; your love gives life all reason. My wonderful wife Hellen and daughter Audrey, I am glad we were in this together.

Finally, to God be all the glory.

List of Abbreviations/Acronyms Used

ANC	Antenatal Care
C-section	Caesarean section
FGD	Focus Group Discussion
FSB	Fresh Still Birth
JOOTRH	Jaramogi Oginga Odinga Teaching and Referral Hospital
KIT	Royal Tropical Institute
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
OBA	Output-Based Aid
TBA	Traditional Birth Attendant
UN	United Nations

Glossary of Key Terms

Client: Refers to both consumers (patients) and providers (health workers) of health care in the hospital.

Client experience:
"The sum of all interactions, shaped by an organization's culture, that influence patient (client) perceptions across the continuum of care"[1]

Delivery care: Services rendered in the period from the onset of labour to 24 hours after delivery.

Quality care: Safe, clinically and cost-effective services that meet client needs and achieve a good client experience[2–4].

Traditional Birth Attendant (TBA):
An unregistered and unlicensed home practitioner (usually female) who helps pregnant women deliver outside the formal healthcare system[5].

Responsiveness: A measure of the performance of a health system/unit relative to non-health aspects of care. The eight dimensions proposed by the World Health Organization (WHO) to measure responsiveness include information, dignity, autonomy, confidentiality, prompt attention, social support, basic amenities, and choices of providers/procedures[6,7].

In the sick room,
ten cents' worth of human understanding
equals ten dollars' worth of medical science.

~ Martin H. Fischer
(German-born American physician and author, 1879-1962)

Abstract

Background

Maternal health remains a major challenge in developing countries, which account for 99% of annual global maternal deaths. Less than half the women deliver in hospital across most of Africa. Quality of care at delivery institutions has been cited as partly responsible for this poor performance.

Objective

To investigate the role of client experience of care as a factor of quality of care at delivery and a determinant for the uptake of institutional delivery services.

Methods

Using a descriptive-qualitative approach, semi-structured in-depth interviews were conducted with 10 obstetric patients and 4 nurses at Jaramogi Oginga Odinga Teaching and Referral Hospital in Kisumu, Kenya and a focus group discussion held with 17 local community members.

Findings

The outcome of childbirth is a significant determinant of mothers' satisfaction with the care process in and outside the hospital. However, interpersonal factors between mothers and their care providers modulate patient perceptions of the care process and inform their ultimate experience. A poor experience of care in hospital is likely to drive pregnant women to consider alternative providers (TBA) and contribute to a delay in seeking care in subsequent pregnancies. Health workers on the other have adopted a more task-oriented than patient-centered approach to care hence not meeting patients' individual needs.

Conclusion

Continued uptake of institutional delivery will remain pegged (at least partly) on a good experience of the care process by current patients.

Recommendation

There needs to be a re-orientation of delivery care to women from a task perspective to a patient-centered approach.

Key words

Maternal health, maternal mortality, quality of care, institutional delivery, patient experience, client satisfaction, perceived quality of care.

INTRODUCTION

Maternal health is one the main global public health concerns today alongside others like non-communicable diseases, HIV and tuberculosis. The United Nations' (UN) 5th Millennium Development Goal (MDG) focuses on the improvement of maternal health with two targets; the reduction of maternal mortality ratio by 75% in the 15 years between 1990 and 2015 and achievement of universal access to reproductive health services by 2015[8].

The maternal mortality ratio (MMR) has a commonly been used as a measure of women's health status and priority within and across countries. However, as traumatic and grave as a maternal death is, it remains a relatively rare event at the institutional level even in countries with high maternal mortality ratios[9]. A high national maternal mortality ratio of say 500 women/100,000 live births is equivalent to an average chance of 0.005 deaths per live birth. This implies estimates of the ratio are bound to be unreliable if methods used do not capture (nearly) all the cases (births and deaths) in the equation. In developing countries where most of the births occur outside the formal health system and civil registers are not well developed, the accuracy of the estimated maternal mortality ratio may be called to question[9]. Moreover, one study estimates that for every maternal mortality there are nearly 20 cases of near-misses and morbidity of various degrees; which portend even greater negative impact on women's health[10]. With this in mind, it follows that evaluating the quality of maternal health services goes beyond mere counts of mortality and morbidity into assessing the entire continuum of maternal care.

Indeed, focus is now in this direction. The WHO (in conjunction with several other partners) is currently piloting the 'Safe Childbirth Checklist'[11]; a simple quality of care initiative based on a checklist for minimum service requirements for a safe delivery. Initial field results indicate that adoption of such simple strategies not only saves lives but also improves the quality of care delivered to clients, their satisfaction with the care process and their quality of life post-delivery[12]. In many developing countries, poor maternal health remains a major health problem; contributing to 99% of all maternal deaths worldwide (Figure 1)[13,14].

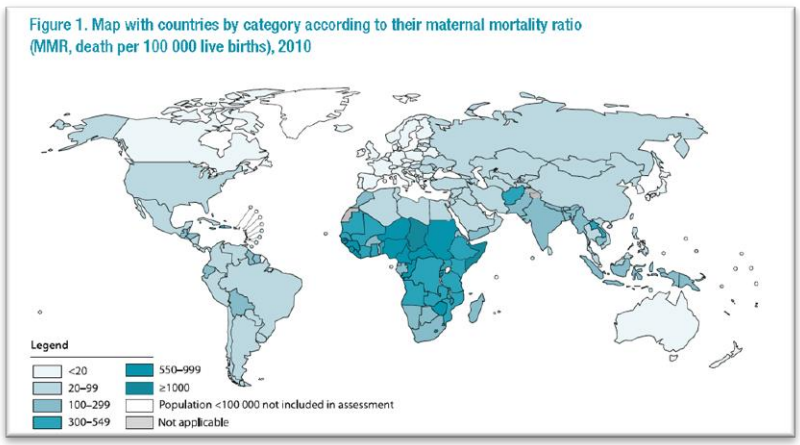

Figure 1: World Map of Maternal Mortality Ratio, 2010[13]

Up to 24 times more women die from complications of pregnancy and childbirth in Sub-Saharan Africa than in Europe. Kenya alone loses over 5,500 women (MMR – 350/100,000 live births) in such circumstances annually[13].

Of the leading causes of maternal mortality; bleeding complications, hypertensive disorders and infections account for just over half of all deaths in most developing nations[15] (Figure 2). Majority of these deaths occur during labour, delivery and the immediate post-partum period. Regrettably, these conditions are easily avoidable and can be appropriately managed in all the developing countries when presented in time[16].

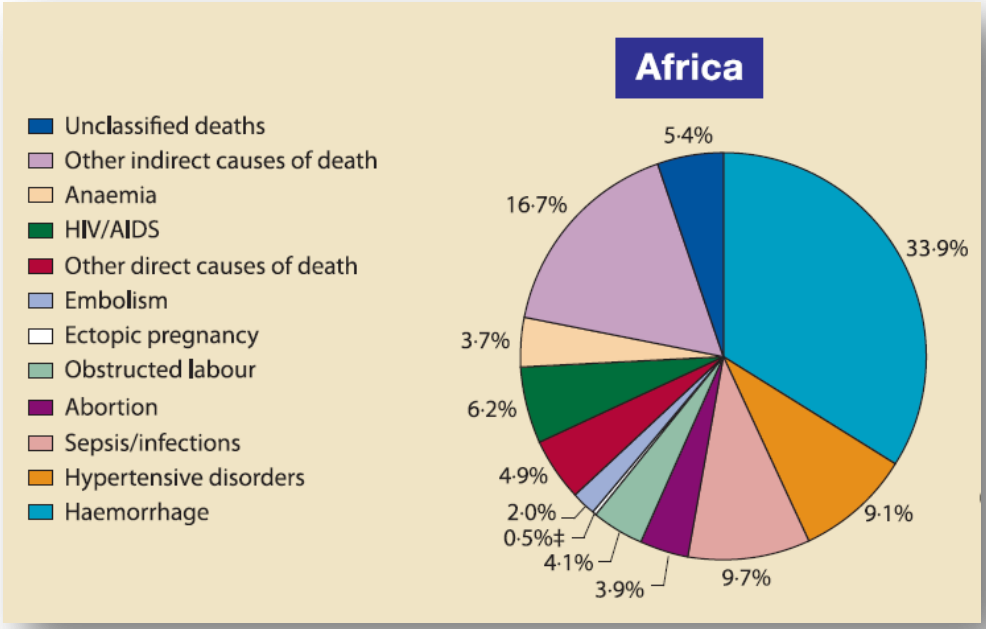

Figure 2: Causes of Maternal Mortality in Africa[15]

In spite of these grim figures, the number of women dying from pregnancy and childbirth has fallen by half between 1990 and 2010. Asia and Latin America have made the largest gains. Several factors are attributable to this decline, among others; the statistical methods applied in estimation, a general fall in total fertility rates, increased female income and education and a greater access to skilled birth attendants. A number of African countries are also on course to meet MDG5 including Ethiopia, Eritrea and Guinea. However, a good number are still lagging behind especially in Southern Africa. Mortality has actually gone up if not remained the same in countries like Lesotho, Zimbabwe and Namibia[13,17,18]. Reasons for this poor performance include physical and financial barriers of access to and utilization of care. Other underlying structural constraints like low-level female education, high female fertility, lack of female autonomy in decision making and the burden of HIV/AIDS also contribute[18]. In addition, poor quality of care at health institutions has been documented as one factor of this poor performance[12,16,19]. This sub-optimal quality of care is a result of several factors: inadequate training, poor work ethic, staffing constraints, lack of proper equipment and perhaps even more important; patients' own perceptions of quality care[20]. A less apparent barrier of access to skilled delivery is the lack of responsiveness by health institutions to their clients[5].

In Kenya, nearly 92% of all pregnant women make at least a single antenatal visit to a skilled health-worker but only 47% make it to the WHO-recommended minimum of 4 visits. Even then, only a dismal 43% of the attendees know about signs of pregnancy complications while only 85% have at least one blood pressure measurement. At term, 56% of the deliveries occur at home without skilled attendants and only 43% in health facilities[21]. These figures raise questions of access, utilization and quality of service.

Maternal care institutions inherently share the desire of every pregnant mother: a delivery that is safe for both mother and newborn. However, it should be an additional aspiration for every such institution to not just secure a safe delivery for her clients, but also make the delivery as comfortable and dignifying as reasonably possible. The WHO has since 2000 been advocating 'responsiveness' as part of its broader concept of health systems[6,7]. Together with fairness in financial contribution to the health service and health improvement, the WHO identified responsiveness as one of a triad of essential components of a functional health system. This thesis work sought to investigate the role responsiveness as a component of the quality of care at delivery and as a factor of service uptake and utilization: both being determinants of maternal mortality.

Local Context

Jaramogi Oginga Odinga Teaching and Referral Hospital, JOOTRH (formerly Nyanza Provincial General Hospital), is a level 5 general health facility in Western Kenya at the Lakeside city of Kisumu (see map in annex 1). The hospital sits at the apex of care in the region and serves as the regional referral hospital as well as the local primary care hospital (Figure 3). In Kenya, the public-funded health service is organized on a tier basis with progressively fewer facilities up the pyramid but increasing complexity and range of services on offer. Major surgical services (including emergency obstetric care) are offered in Level 4 facilities and above[22].

Figure 3: Organisation of Health Facilities in Kenya

JOOTRH's immediate catchment area of Kisumu city is a sprawling urban area with a population of about 420,000 of whom 27% are females of reproductive age. The maternal mortality ratio remains high at nearly 450/100,000 live births with major co-morbidities being HIV (15% adult prevalence rate; twice the national average) and malaria[23]. Both HIV and malaria are known to aggravate maternal obstetric complications and have poorer outcomes on themselves in pregnancy[24]. Only 30% of the mothers attend 4 antenatal visits while institutional delivery remains low at 33%. The contraceptive use prevalence stands at 27%[23].

Structural inadequacies within the broader national health system further compound the health needs gap in Kisumu region. There is only one doctor for every 15,000 residents in Kisumu; well short of the 1:5,000 recommended by the WHO[23]. Health-workers' attrition rate has been particularly high at Level 5 hospitals in the recent past. Hardest hit cadre are doctors who are lost at an annual average rate of 8% mainly to resignations[25]. Nurses, who also perform midwifery duties, are perennially in short supply. In 2010, there was a 50% deficit in the number of nurses needed across the country[26]. In addition to the shortage of health-workers, a national survey reported a skills and training deficit and lack of professionalism among some health-workers[27]. Communication failures between clients and health workers have also been highlighted as weakness in the care process in Kisumu[26,28].

Like in the rest of Kenya, health services in Kisumu are predominantly offered at government facilities on a cost-sharing basis[22]. This has contributed to a reduced financial access to care in a region with a poverty rate of nearly 50%[29]. In mitigation, several initiatives are in place to combat some of the constraints mentioned above by both state and non-state actors. In a partnership between UNICEF, the people of Norway and the Government of Kenya; a new purpose-built maternity wing was opened in 2012 at JOOTRH and is projected to go a great length in improving the quality of maternal and neonatal care in the region[30].

Second, the Government of Kenya, in conjunction with the German development partners BMZ (Federal Ministry for Economic Cooperation and Development) and KfW Banking Group, is currently piloting a voucher system called Output-Based Aid (OBA) in Kisumu and other parts of the country[31]. Through this program, poor women pay a token fee of KSh 200.00 (£1.70) for a voucher that can redeem obstetric services at no extra fee at participating prequalified health institutions. These institutions then prepare invoices for services rendered for reimbursement.
Finally, the Kenyan government has since June 2013 waived all user-fees on normal maternal deliveries in all public hospitals. In this scheme, public hospitals are reimbursed the 'lost' fees by the ministry of health based on monthly delivery returns[32]. It will take a while before the full impact of these interventions becomes apparent.

In the meantime, home deliveries still occur. These deliveries are conducted under the care of traditional birth attendants (TBA). The TBA is often an older female who offers childbirth services at the client's or her own home (usually) at a fee. Other than assisting in childbirth, they invariably offer other services to women and their communities. Their level of knowledge of childbirth and pregnancy is varied and not standardized. They are neither licensed nor registered hence unregulated[5].

TBA's have remained generally accepted in their communities for their services. The main reasons given for their continued acceptance include their proximity to clients, their perceived friendly and social demeanor and a perception that the quality of their clinical services matches that of hospitals for normal deliveries[5].

The above local context informed my choice of this hospital for this study: to find out how the client experience affects the quality of care and the utilization of services.

THE STUDY

Problem Statement

Focus has mainly been on lowering maternal deaths as a proxy to improving the quality of care mothers receive at childbirth[12]. However, much as the clinical process informs to a great extent the outcome of an individual case; subtle and explicit nuances of the patient's experience of care may determine the success of the individual clinical intervention as well as the acceptability of the service in the wider population[33]. Health systems and institutions in many developing countries have not paid nearly as much attention to satisfying their clients as they have to achieving favorable clinical outcomes[20]. A poor client experience of the care process is thus a factor in the quality of care at delivery and the low uptake of institutional delivery. This ultimately contributes to the dismally high maternal mortality rates in Kenya and beyond.

Motivation

My motivation for studying client experience as a component of quality of care draws from my own experience as a general practitioner in Kenya. I noticed the ease and success with which the clinical process occurred when both the patient and I as a service provider were satisfied with our particular circumstances and connected at personal level. I also listened to tales of patients and health workers who had experienced the care process in less satisfying and often humiliating ways. Having studied (in the MIH program) concepts and methods on a wide range of areas geared towards improving healthcare in low income countries, my interest in undertaking this study found wings. This study is the beginning of a journey that I hope will contribute to better healthcare in Kenya, particularly to women and their unborn & newborns.

Objectives

General Objective

To demonstrate the role of client satisfaction to the success and quality of care at childbirth as a step towards improving service (hospital delivery) utilization and effectiveness.

Specific Objectives

1. Demonstrate the role of client experience in quality of care.
2. Analyze the role of client experience of care on service uptake and utilization.
3. Explore the client perception of delivery care in the context of a regional hospital in Kenya (Jaramogi Oginga Odinga Teaching and Referral Hospital, Kisumu - JOOTRH)
4. Justify a raft of recommendations on improving client experience (and thus quality of care) at delivery based on the study findings.

Design

The study takes a descriptive-qualitative approach. This was supported by in-depth interviews, a focus group discussion, observations and review of literature and secondary data.

Conceptual Framework

I adopted the Donabedian Framework of Quality of Care[34]. In this framework (Figure 4), structures and processes determine the outcomes. **Structures** refer to the physical infrastructure, equipment and human resource input into the delivery of quality care. These are the basis upon which processes rely to effect outcomes. The **processes** are the institutional organizational and cultural practices that aim to make optimal use of the structures for specific desired outcomes. **Outcomes** are the results; intended or otherwise, of the interaction between structures and processes in the delivery of care to the client. While structures and processes can be independently influenced or adjusted, outcomes cannot.

In the case of maternal patients, the universally desired outcome of the care process at childbirth is a safe delivery in which neither the mother nor the newborn acquires any avoidable morbidity or worse, mortality. In this study, I include the satisfaction of both the mother and her caregiver (the health worker) with the care process as part of the outcome. I consider health workers as internal clients to the hospital on their own right; whose needs if not provided for would make for a poorer experience to themselves as workers and to the external clients (patients)[2,35].

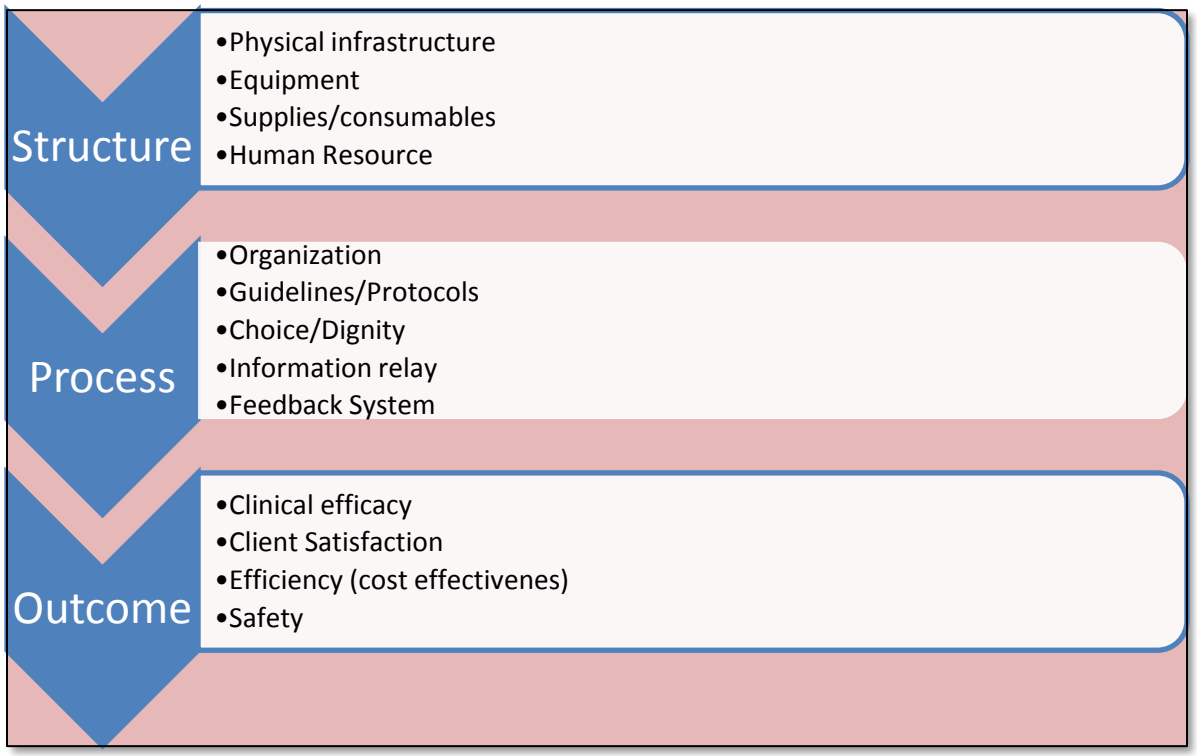

Figure 4: Quality of Care Conceptual Framework

Methods

I employed a descriptive-qualitative approach. By the working definition of quality care, - safe, efficacious and cost-effective services that satisfy patient needs while achieving a good client experience[2–4] - I investigated two (client safety and satisfaction) of the four aspects of quality. A cost-effectiveness analysis was not part of this study neither was a clinical audit of any procedures or protocols in use at the institution.

My choice of a descriptive-qualitative approach was informed by the nature of the issues at hand. The perception of satisfaction as well as the measure of responsiveness are continuous and highly individualized variables. They are also dependent on many other factors operating simultaneously, either independently or in conjunction. It was therefore necessary that I use an equally individualized and flexible method in order to understand the subject of investigation. These are outlined below.

Primary Data

The data collected in this section answers the third objective. In order to understand the client experience of care at JOOTRH, its dynamics and context, it was necessary to first carry out an assessment of the structural and process factors. Assessment of the structural and process factors at the institution was done using a checklist and by interviews with health workers, patients and community representatives.

Direct Observations

Using quality of care parameters derived from review of literature, a 160-point checklist of the minimum 'structural' and 'process' input required for a safe and satisfactory normal delivery was developed. This checklist (see annex 4) was used to enumerate the physical and human resource infrastructure at the JOOTRH by direct observation. The checklist did not include an assessment of the surgical facilities in the operating theatre(s).

Confidential In-depth Interviews and Group Discussion

Semi-structured interview guides (topic guides) were prepared (see annex 4) to collect a range of information on structural and processes factors of client satisfaction from patients, health workers and community members. In total, there were 15 confidential interviews at JOOTRH; one with an administrator, four with midwives (nurses) and 10 with obstetric patients. A focus group discussion with 17 male and female community representatives of various profiles (see annex 2) was also held.

The inclusion/exclusion criteria were as follows.

- Patients;
    - Be over the age 18 years,
    - Be admitted into the maternity unit for reason of a delivery,
    - Have delivered in the last 12 hours (36 hours for C-sections)
    - Preferably two of the respondents should have been referred into the facility from another hospital.

- Midwives/nurses
  - Licensed/registered midwife practicing at this particular hospital,
  - Must have been stationed in the delivery unit for at least six consecutive months in the last one year
- Community members (desired profiles)
  - Females aged between 18-35 years
    - 2 nulliparous, 4 multiparas of whom at least 2 have delivered at a Traditional Birth Attendant (TBA) and 2 lost a child during delivery.
  - Males aged between 18-45 years
    - 2 bachelors (no children), 4 men whose partners satisfy the criteria set out for the 4 multiparas above.
  - Drawn from the hospital's immediate local community (Kisumu)
- Administrator
  - Any individual at the hospital whose administrative functions have an influence on the delivery unit

Sampling and Data Collection

Purposive sampling technique was used to select potential participants from the community. Three community health workers were involved as 'gatekeepers' through whom potential participants were reached. The aim of doing purposive sampling was to achieve as much variation among participants as would have been possible in order to have divergent opinions at the discussion.

Once selected, potential participants were informed about the study orally and in text in English, Kiswahili or Dholuo. Those who gave consent assembled on a later date at a venue within the community (Kosawo Social Hall - Manyatta, Kisumu) for the discussion. The group discussion lasted 97 minutes and was moderated by the investigator (myself) in conjunction with the 3 community health workers. There were both male and female participants discussing together. The main focal point was 'hospital vs. TBA delivery'.

The midwives were also purposefully selected for the interviews. Those who have served longest were preferred for the interviews on the presumption they would have a more in-depth understanding of the care process at the particular hospital. These interviews were held within the unit, each over an average of 20 minutes on different days over a two-week period.

Patients who met the inclusion criteria were randomly picked on diverse days over the same two-week period. Only those who gave informed consent were interviewed. Every confidential patient-interview lasted about 20 minutes on average. Interviews were held within the facility. A counselor was on hand for all the interviews/discussion but fortunately, his services never became necessary during/after any of the sessions.

As there is only one administrator, her participation in the study cannot be adequately masked. Her input therefore is only used to the extent that it does not infringe the ethical and confidentiality requirements, as is the case for every other participant.

Quality Control

For quality assurance, all interviews and the group discussion were electronically recorded and are available in audio in the languages they were obtained: English, Kiswahili or Dholuo. The transcripts (in English) have also been preserved, as have the study checklist and all other tools used. The thesis supervisor and local supervisor were kept abreast at every stage and their input factored in as it came.

Qualitative Analysis

With the primary data from the interviews above, the audio recordings were transcribed and developed into narratives. These narratives were used to develop code frames/themes from which emerging issues were triangulated for associations. Since the data set was small, analysis was done manually.

Literature Review

Objectives 1 and 2 have been investigated by review of existing literature in this filed. Information from peer-reviewed published articles was used to define the concepts around the subject of client satisfaction and quality of care. Search for literature was done online on Biomed Central, PubMed, Google scholar, science direct and from the web portals of the Universities of Bergen, Heidelberg and Copenhagen. The key search terms were;

- Maternal health, maternal mortality, quality of care, institutional delivery, patient experience, client satisfaction, hospital checklist, hospital accreditation and perceived quality of care.

The main search limitation on the literature was to material in English language and articles published after 2008. Exceptions on dates were made where the material was of exceptional or historical value or in the absence of more recent data.

In addition textbooks, grey literature and statistics were obtained directly from the websites of the WHO, Kenya National Bureau of Statistics, Ministry of Health (Kenya) and Jaramogi Oginga Odinga Teaching and Referral Hospital. Some of this literature was used to develop the tools for primary data collection.

Reference quality standards were obtained from Kenya's national standards (Standards of Maternal Care in Kenya [SMCK] and Standards–Based Management and Recognition [SBMR]) and the WHO Safe Childbirth Checklist. Other sources include Tanzania's Quality Improvement Standards for Hospitals Assessment Tool, JHPIEGO's (John Hopkins Program for International Education in Gynecology and Obstetrics) Performance Standards for Maternal and Neonatal Health, Jordanian Health Care Accreditation Council's Hospital Accreditation Standards and the Egyptian Hospital Accreditation Standards.

Finally, consultations were made with friends, professionals and faculty during this exercise.

Ethical Considerations

The study involved interviews with actual patients. Ethical approval was sought and granted by both KIT (Royal Tropical Institute) and the hospital research committee in Kenya. Accordingly, every respondent only took part after they gave a signed informed consent in a language suitable for them. There were no inducements/compensations whatsoever and participation was anonymous and voluntary. At the end of the group discussion, it was explicitly made certain to participants that the recommended place of delivery, in all circumstances, is at the hospital.

Study Limitations

Quality of care is an extremely wide and complex topic. A single researcher working on a tight resource budget cannot adequately investigate it. Even by narrowing the study scope to client safety and satisfaction, I remain alive to the fact that at best I merely scratched the surface of a pressing and complex issue. Further, the number of participants is small for the reasons given above. These findings are therefore not a strong enough ground for generalization and may bear little external validity. However, as a start, these findings form the justification for further activity on a greater scale. I hope that such future work shall translate into better responsive delivery institutions, improved quality of care and greater utilization of institutional delivery services.

Presentation

The study findings are presented in line with the conceptual framework above and the methods used. An initial part (below) of mostly literature review describes in the concepts around the subject and builds the basis for the qualitative study. This part attempts to meet objectives 1 and 2 and give foundation to the rest of the thesis. These findings also contribute to the discussion and recommendations.

The second part presents the primary findings segregated as structural, process and outcome components of the client experience. This part describes the client experience in the context of JOOTRH followed by a discussion.

CLIENTS, RESPONSIVENESS, SATISFACTION AND QUALITY

Background

In management practice, employees of an institution are as much clients as are the consumers of the organization's products/services[2,35]. The employees' needs include the direct tools that go into the production process as well as indirect needs that enhance their welfare so they can produce more and better of the organization's product/service. Consumers keep the organization in business by sustaining demand for the organization's products/services. A third player, the entrepreneur, provides the means of production to the internal clients so as to generate a product for the external client/consumer. In theory, a perfect free market atmosphere would drive the best workers to organizations that offered them the best terms of service. In turn, consumers would largely be driven to products that best meet their needs and circumstances. This cycle is sustained at each level by economic incentives and motives for financial gain. This hypothetical free market assumes each player to be perfectly informed of what constitutes their needs and thus able to make a free and rational choice for maximum gain[36].

Public health institutions in developing countries have some parallels to the above structure: governments provide the capital investment and hire workers to produce a service that consumers (patients) need. However, major differences exist; the healthcare market is not a perfect free market. Public institutions are often run without a profit motive. In addition, there always exists a great information asymmetry between providers and consumers[37]. Patients often have little knowledge of what would be best for them thus denying them the chance to make informed choices. Even when they do have information, there is often little by way of choice of providers[36]. In economic terms, this becomes a sellers' market; one in which providers have the upper hand on information about the product, have little competition between them hence lack the impetus to improve their quality: a market failure. This situation is present on varying scales in several low income countries[35].

Despite the above, governments still have an inherent duty to provide the best healthcare to their citizens. In Kenya, this duty is even enshrined in the constitution thus.

> *"Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care"*[38].

Similarly, health workers have a moral and professional obligation to offer high quality services in a safe and enabling environment. Patients, on the other hand, have the right to safe, efficacious, dignifying and cost effective care[6,7]. The confluence of these interests, duties and rights defines the quality of care at an institution. It also determines the institution's responsiveness and whether or not her clients are satisfied.

The eight WHO components of responsiveness include autonomy, choice, information, dignity, confidentiality, prompt attention, social support networks and quality basic amenities[6]. When an institution offers her clients these aspects during the clinical process in the right context, such an institution is being responsive to her clients. Satisfaction occurs when clients, by their own admission, acknowledge perception of responsiveness. The entire continuum of clinically effective, responsive, cost effective and satisfactory care constitutes quality of care[2–4]. Clients' interaction with this continuum is the client experience[1].

Role of Responsiveness and Client Satisfaction in Health Care

Medicine has been described as an art from its early beginnings. Writing in the Journal of American Medical Association (JAMA) in 1988, Avedis Donabedian reiterated this age-old concept thus.

> *"The interpersonal process is the vehicle by which technical care is implemented and on which its success depends."*[39]

Responsiveness is more about the interpersonal process than the technical. It involves health workers striking a relationship with their patients, showing empathy and understanding and communicating effectively[3,40]. Better technical results are achieved when patients participate in their care process[3]. Such participation occurs during history taking, physical examination and in follow-up measures like taking medication or following other prescribed instructions. Atree asserts that responsiveness by health workers to patients is an essential rather than an optional requirement for good quality care. Patients in her study acknowledged great satisfaction with the care process when the nurses practiced the ideals of responsiveness (besides the technical aspects) when attending to them[41].

Hospitals or employers on the other hand need their medical staff to deliver quality services efficiently. By creating conditions that respond both to patients' individual preferences and uniqueness as well as health workers' needs and welfare, hospitals/employers can greatly improve the success of the technical and interpersonal aspects of the care process[34,35]. Responsiveness to workers and patients therefore not only improves the perceived and actual quality of care, it also improves health worker productivity as well as patient satisfaction. In time, this leads to improved service utilization and a return on investment on the entire process of care for all parties [42–44].

Link to Quality of Care

That quality of care has been variously defined is probably testimony to the lack of a universal understanding of the term. Indeed, quality of care encompasses not just the universal technical standards of care but also local contexts of culture, society and economics[26,39]. Increasingly, health researchers, practitioners and managers agree that client perception of care and satisfaction form as much an integral part of the care process as do the technical aspects. This school of thought is much more grounded in the US where initial attempts at incorporating patient satisfaction into the care process began[35]. The concept has spread to the rest of the developed world and some developing countries have made concrete steps in this direction.

Experience now shows that care that is responsive to client needs is much more likely to achieve its intended goals than otherwise[3,45]. Conversely, unresponsive care destroys the care process from the beginning and often leads to failures of the technical aspects as well[26,28,46]. As an illustration, provider relationship with patients was found to be one of the determinants in HIV drug compliance in one study[33]. In yet another large study encompassing 12 countries across Europe and the US, the results were confirmatory; a responsive care environment improved clinical outcomes and nurse and patient satisfaction[47].

Link to Service Uptake

In Mbeya district of Tanzania, an improvement in the client experience translated into increased uptake of reproductive health services. This was achieved through an operational research project in which multiple components of care were simultaneously enhanced[42]. The health workers were given continuous clinical skills training as well as interpersonal skills training to enhance their relationship with their supervisors, patients and the community. Where necessary, equipment and infrastructure was improved as well as supply systems. Services were consolidated so patients did not have to move about unnecessarily and outreach teams actively made links with the community. At the end of this 5-year project, there was a doubling in the number of people utilizing the service among other benefits like better-skilled and motivated staff, greater patient satisfaction, improved infrastructure and greater community participation in their healthcare management.

In a related study in Sierra Leone on barriers to the uptake of emergency obstetric services, respondents listed a number of issues that fall squarely in the domain of client experience.

> *"When I had my first child at the hospital, they cut me with a blade to allow passage for the baby. When I delivered my second child at the grannies [elderly relative], they were patient until I delivered on my own"- [adult female discussant]*[48].

The above statement illustrates a client who was not well informed on a medical intervention and therefore was dissatisfied with it. The procedure could have been unnecessary, as she seems to think, or could have been life-saving; the lack of information is what made the difference about her perception of the care process. As a result, this patient was lost to an alternative form of care at her next delivery.

These examples illustrate that clients do not just want technically effective solutions in isolation. The user experience of care impacts on the continued acceptability of services and their future uptake[16].

Link to Worker Productivity

Even with good technical and interpersonal skills, the care process is incomplete without equipment for the health worker and amenities for the both health worker and patient. In resource limited settings, amenities for patients and service providers are often a second thought. Part of the reason health workers leave the public sector in developing countries is the lack of equipment and amenities that would support their productivity[49]. Health workers need not just the direct tools of their trade but also amenities like washrooms, reading rooms, rest rooms, desks, seats and even food. An even more obvious aspect of responsiveness to health workers and patients is staffing. Health institutions in developing countries have to do with sub-optimal staff numbers for various local and systemic reasons. The association between staff numbers and quality of the care process as well as effect on the service provider is an obvious one. Studies in Kenya, Europe and America confirm that the clinical output takes a dip in quality when workers are stretched out thin[26,47]. Patients are less likely to be satisfied with such care as are service providers themselves. Being responsive to the health worker is thus as rewarding to the care process as is responsiveness to the patient.

PRIMARY FINDINGS

Data was collected at JOOTRH on three broad areas in line with the conceptual framework: structures, processes and outcomes. This involved the use of a checklist as well as confidential interviews with 5 staff members as key informants, 10 patients and an FGD with 17 community representatives. Relative quantifiers have been widely used rather than absolute numbers to quantify responses from the interviews. Where more than half the respondents had a similar opinion, this has been stated as 'most' or 'majority' and 'a few' for less than half the respondents. In a few cases, absolute numbers have been used.

Structures

Structural-Factors Assessment by Checklist

Of the 160 points on the checklist, 100 were dedicated to structural aspects of the care process. Of these, the institution registered a positive score on 84 points (See annex 4 for full report). A positive score means the assessed item/quality was present. The delivery rooms in particular registered positive scores on all points. These include cleanliness, space, privacy, ventilation, floor drains, lighting and placenta disposal among other qualities. In terms of capacity, there are 4 fitted delivery suites, a newborn resuscitation table (Resuscitaire®) and 14 beds for perinatal mothers.

Also scoring high were the toilet and shower facilities for patients as well as fixtures like beds, sinks and the availability of running water. Other broad areas of positive note were the presence of a suitable waiting bay, disabled persons access, a reliable communication system and the availability of clinical equipment such as sphygmomanometers, thermometers, baby warmers, etc. in good working order.

The 16 shortcomings were an assortment of issues. The most outstanding were on emergency readiness. The emergency kit/tray had a number of key components missing including volume expanders, antispasmodics, potassium chloride vials, gloves, endotracheal tube placement equipment and syringes and needles. There was no uterine vacuum aspirator dedicated to the unit as well as no suture packs on the ready. A phlebotomy kit was not assembled either. Drip stands were shared across beds, as were gooseneck lamps across examination rooms. Some beds were not made in the prescribed manner.

Emergency exit from the building in case of a fire or some other mass-evacuation incident was hampered in two ways; there was no floor plan posted anywhere in the building and one emergency exit was locked. While there were "EXIT" signs over the exit ways, these were not lit hence illegible at night or in the dark. Floor-cleaning support staff did not have a trolley cart for their equipment and the staff reading room lacked books and internet connectivity. A most conspicuous shortage was that of staff. There were only two nurses working 12-hour shifts most nights and up to 3 for the day time shifts.

Others include the lack of a restroom for nurses, patient storage cabinets and soap at the sinks.

Structural-Factors Assessment by Interviews with Patients and Nurses

The physical amenities at the maternity unit attracted most mention by both nurses and patients. Nurses reported ease of work as well as an improvement in their service output to patients because of the physical environment. As one nurse put it,

> *"The facility is presentable, spacious and clean. I feel comfortable working here as a nurse. I think we have enough equipment for our work. There are enough delivery beds and good lighting and our clients also say they like the place."* – Nurse Interview C04.

In addition, most patients singled out the availability of a waiting bay with seats and the fact they did not need to bring any items (cotton wool, cord clamps, etc.) to the unit or pay any fees before care could be initiated.

> *"They did not ask me for anything or payment. I only carried a shawl for my baby and the clinic card."* – Patient Interview B02

Even more importantly, all the four nurses interviewed expressed confidence at their skills and ability to handle any obstetric emergencies.

> *"I am confident I can handle any case in the unit. My training and experience both contribute to my confidence"* – Nurse Interview C05

However, there were a number of constraints noted as well. The most pressing constraint for the nurses was their perceived small number. The nurses interviewed remarked that because of their number in comparison to the patients, they were unable to offer care as well as they would like. They recounted moments when they would be outstripped by patients who simultaneously needed their care.

> *"The work is overwhelming. We have few staff against many clients coming to deliver. This makes me unable to deliver good quality care to every client because at times one patient could deliver by herself as I attend to another. If we were many, this would not happen."*
>
> - Nurse Interview CO4

Another structural hindrance mentioned by the nurses is the distance to the operating theatres. They felt the process of transferring a patient to theatre is a drain on time and physical energy. The only way to the operating theatre is via a ramp up the first floor and round a route through the old facility.

> *"We are a bit far from theatre and it takes us between 15 – 20 minutes to get a patient there. We have to go up the ramp and even though a porter assists us, it is still heavy work and time consuming."* – Nurse Interview C02/03

Patients' most noted structural concern was the lack of water (at the time of the interviews) in the postnatal wards.

> *"I am glad to have had a successful delivery but lack of water in this ward is the biggest problem I had. The sink is broken: I saw patients wash their plates in the bathrooms, which is not good.* – Patient Interview B06

> *"The toilets at the delivery unit are clean, spacious, well lit and with running water but the ones up here* (post-natal ward on the first floor) *have no water. We have to fetch water downstairs for use in the toilet and to clean the baby. I find that very difficult for me especially now just after delivery."* – Patient Interview B08

However, all the 10 patients interviewed expressed satisfaction with the physical state of the delivery rooms. They mentioned the same attributes enumerated under the checklist above as factors that contributed to a pleasant experience of their care at delivery. Additionally, they were glad that the lavatory facilities were available, adequate and functional in the delivery unit.

> *"The delivery room was clean; I found it clean and as soon as I had delivered it was cleaned again. There was adequate space and light and the air was well conditioned. The delivery bed was also comfortable. I think the room was fine"* – Patient Interview B01

Processes

Process-Factor Results from Checklist Assessment by Observation

The checklist had 60 checkpoints on process factors; covering issues ranging from safe clinical practices like hand washing to organizational factors like duty rosters and responsiveness to clients (patients and staff). A positive score was entered for 45 of these points.

Amongst the observed process factors was that patients were attended to without having to make any spot payments of provide any materials. There was good entry of patient data in the various forms examined; partographs, consent forms, theatre checklists and admission forms. These forms were filled in completely and appropriately for the files checked. In addition, there were blank copies of these forms available at hand at the nurses' station. Daily ward rounds were recorded as were audits for maternal deaths. Signage within the unit was adequate and every room was used for what it was labeled. On hand was a security guard who doubled as a receptionist and would assist new clients with general information.

On the flipside, a number of areas for improvement were recorded. Hand washing was not practiced routinely before and after procedures. There was no sepsis register. Waste was collected in properly lined and covered bins but was not segregated. All solid waste would go into any container except for 'sharps' that had a special box and placentas that would be macerated by a machine in the unit.

Even though some protocols/guidelines were available, these were not in fixed positions and would have to be looked for when needed. There was no system of reporting, recording and reviewing critical clinical events within the unit. Storage of files within the unit exposed the files to unauthorized access or outright loss. There were no means of giving anonymous feedback within the unit (e.g. suggestion box) even though one was available in a separate wing of the hospital. In addition, there were no posted schedules of meals for the patients.

Process-Factor Results from Interviews with Patients and Nurses

The most common process factor theme among patients was courtesy. Save for two patients, the rest reported being received in a friendly manner and were given the information they needed at reception.

The first point of contact with the facility for most patients were the security guards at the gates. Patients reported they were able to get directions to the unit from them in all instances. At admission, most patients reported they were given information by the nurses on their examination findings and care plans.

> *"I was attended to first by a male nurse and he was kind to me. He examined me and told me his findings then gave me a bed. He reassured me that I was not in active labour but would wait in the ward for a few hours before proper labour set in."* – Patient Interview B06

All patients reported receiving their babies within 30 minutes of birth on average and starting breastfeeding within the hour. Assistance during delivery was rated well by all the 10 patients interviewed. They felt the nurses were friendly and helpful to them during the actual process of childbirth and in the immediate ensuing period.

An important mention was the role of student nurses. Nurses were unequivocal of the contribution students made to the care process. By assuming certain duties, they relieved the trained nurses to concentrate on core nursing functions whenever this was called for.

> *"Staffing is our main problem. Especially when students go on recess, the night shifts become really heavy on us because only two nurses are usually on duty for the entire night and they handle all the duties between themselves."* – Nurse Interview C05

Two patients who were attended to by students had disparate opinions however on their experience, as illustrated below.

> *"The nurse handed me over to a student nurse. The student told me she would ask me some questions and then examine me. At every point, I too asked her questions and she answered all my questions. The nurse later confirmed her findings. They were very friendly."*
>
> - Patient Interview B11

> *"I was attended to by some students but I did not like them. They examined me but their findings were in conflict with the nurses' so they caused some confusion. They kept returning me to the examination room in turns."* – Patient Interview B12

Nurses reported they were free and able to make contact with the administration on any issues. Doctors were available for their consultation round the clock. The nurses mentioned teamwork between themselves, doctors, students and support staff as a process factor that enhanced their service delivery. In general, the nurses were confident of the quality of the clinical care they offered but noted shortcomings in other areas.

> *"I think the quality of our clinical care is good but overall quality suffers because of other things."* – Nurse Interview C01

Of the shortcomings, most of the patients interviewed expressed reservations at the catering system. One patient had gone over 12 hours post-delivery without food because she did not bring a plate and cup with her to the hospital.

> *"I have not eaten anything since I came (2000h) because I did not have my own cup and plate. I left home in a huff when I felt the first signs of labour but I thank God I delivered successfully at about 0100h. I asked my husband to bring me the plates this morning but the person he sent arrived late after the visiting hours had lapsed so she could not come in. The only thing I have had is a bottle of soda that was brought to me by a nurse-friend who works here after I told her my plight. Even now (1400h), I did not get lunch."*
>
> – Patient Interview B06

All the patients were of the opinion that it would be better if they had a schedule of meals showing when to expect what food. A post-operative patient was advised by the health workers on particular foodstuff to eat in the first few postoperative days but observed these were not provided by the hospital. There were also no substitutes available for those who did not eat the foods served.

The perception of lack of adequate information post-delivery was the next most common theme. Five of the patients interviewed thought they did not receive as much information about their babies and themselves soon after delivery as they would have liked.

> *"My baby was given to me after about 45 minutes because I had to take a bath first after delivery. In fact, I actually found the baby on my bed. Then I began wondering what I was supposed to do for it. There was no nurse in sight so I called my sister. She told me carry the baby and start breastfeeding."* – Patient Interview B01

> *"Immediately after delivery, I was shown my baby and the sex and then I went to take a bath. The nurse brought me the baby me after about 30 minutes and told to breastfeed him and keep him warm. She did not show me how to breastfeed until about 3 hours later when another nurse did."* – Patient Interview B04

Nurses reported they did not always give patients as much information as they would like because of pressure on their time due to their small number. They also attributed this reason to the non-observance of strict hand washing between procedures. However, one nurse felt there really was no proper reason for the non-observance of hand washing.

> *"The taps are often far from the procedure point and the beds are usually just next to each other so it becomes convenient to just move on to the next patient".* – Nurse Interview C01

> *"At times, I may not wash my hands if I am alone on duty with several patients to attend to in a short time"* – Nurse Interview C02/03

> *"We really don't have a reason not to wash hands because we have sinks with running water in every room."* – Nurse Interview C05

Even though majority of patients interviewed had high ratings for the care process in the first hour of arrival, two patients had different experiences. One mother had to wait nearly 8 hours before an intervention was made and another for 3 hours.

"I waited a very long time. I arrived at 0700h but went to theatre at 1530h. The nurses were very hesitant to attend to me. I had the OBA voucher which I have been using to pay for services but the nurses said it could not be used to pay for the ultrasound scan which was required before I could be admitted. Therefore, I had to wait for my husband to come from home with money. During that period, I was in the waiting bay because the nurse said she could not admit me without the ultrasound scan. I was in labour but she said she did not see any signs of labour. She did not examine me.
At 1400h when the nurses changed shift, the security guard asked the new nurse who had just come to listen to my case. The nurse took me to the examination room saying she did not require an ultrasound scan to help me. Then the doctor came and when he heard about the ultrasound scan, he asked us not to pay. The nurse took me to another room within the unit where she performed the scan and they read it together with the doctor. They told me I had twins and they were not lying well so I needed to go to theatre. I was then taken to theatre at about 1530h."– Patient Interview B03

Save for these two, the remaining patients had a mean waiting time of about 8 minutes (range = 0 – 15mins).

Most patients reported they did not know how to raise complaints or give feedback. Those who mentioned they could approach a nurse knew a nurse at a personal level and only one reported knowledge of the location of a suggestion box in the institution.

During shift change times, 2 of the nurses said lapses in care could occur especially when an incoming nurse was late in arriving. This would leave just one nurse in charge of the whole unit for some time.

Finally, on processes, there were problems noted by nurses in the supply chain to the delivery unit. On occasion, they would miss one item or another (gloves, sanitary pads, drugs, etc.). Even though these would usually be found within, they felt the additional time spent in looking for such essential supplies such as gloves not only added to their work burden but also jeopardized the care process.

Outcomes

Direct Output

In the last three years, the hospital registered an average maternal mortality rate of 6.5/1 000 live births (See annex 3 for full report). The C-section rate is 19% over the same period. Some of this data is summarized below (Table 1).

YEAR	ADMISSIONS	C-SECTIONS	LIVE BIRTHS	MATERNAL DEATHS	NEONATAL DEATHS (Incl FSB)	TOTAL BIRTHS
2010	4423	874	4563	33	265	4821
2011	**4998**	**962**	**4820**	**33**	**250**	**5031**
2012	5019	900	4909	28	209	5123
MONTHLY AV	**401**	**76**	**397**	**2**	**20**	**415**
ANNUAL AV.	4813	912	4764	31	241	4991

Table 1: Maternity Unit Statistics at JOOTRH

Client Experience

Health workers' satisfaction

Health workers interviewed were generally satisfied with their working environment. The availability of equipment and tools in a good physical environment was a huge factor in their feeling satisfied with the work environment. Nurses reported team spirit and a consultative atmosphere amongst and between co-workers and the administration as factors that improved their experience of the care process.

However, they were concerned at their small number. This was a major source of dissatisfaction since they felt they had to do more work than they should. As a result, the nurses felt they did not offer their patients as good care as they could. In addition, some had incurred physical injury due to the strain of busy shifts. In particular, nurses decried moving patients along the ramp to theatre on the first floor as one source of great physical strain and demand on their time. Other causes for dissatisfaction include missed training opportunities because there would be no one to remain at work, lack of a restroom for the night shift and lack of lockers for patients' personal belongings.

Patients' Satisfaction

The most reported source of satisfaction among the patients was care during delivery. Patients reported friendly treatment during delivery. Most were happy with the reception too and the general physical environment of the facility. The availability of equipment and supplies was mentioned with satisfaction. The greatest satisfaction however came from a successful delivery. All patients were glad for their successful deliveries.

A need for more information was a recurrent theme, particularly in the post-delivery period for the first-time mothers. Most of this deficit was related to breastfeeding and baby care information. Food evoked most of the dissatisfaction on many aspects as already noted above. Many patients were unhappy that food would come at any time and without notice of what to expect. Lack of water in the postnatal wards made some patients unhappy, as were the restrictions on visiting hours. A few patients did not have a kind reception and had to wait several hours before care was initiated.

Community Perspective

The group discussion with members of the community raised a numbers of points. It is important to point out that participants gave accounts of their experiences at JOOTRH. The main focal point of discussion was hospital vs. TBA delivery. It was apparent that TBA's are generally well accepted and recognized by the community as a part of their care process. The main reasons for the continued acceptance of TBA's were their proximity, their 'friendliness' and general convenience of their services. A previous negative experience in hospital was strongly associated with opinion that supported deliveries at the TBA.

> *"Hospitals and TBA's should just co-exist. Sometimes a woman lives very far from hospital and labor begins at night when it is unsafe to travel and there are no means of transport. Because the TBA is usually just nearby, they would be the ones to help such a woman."* – FGD Speaker 10

> *"I gave birth to my first child at a TBA and that child is alive to date but the second one that I delivered in hospital died at childbirth. Even if the TBA does not wear gloves, she cannot abandon me during childbirth the way I was abandoned in hospital. The TBA treats you like her own daughter.* – FGD Speaker 3

However, the community also mentioned certain inadequacies at the TBA as illustrated below.

> *"I don't think it is proper to deliver at the TBA's. For instance, if a baby is born prematurely and needs an incubator, the TBA does not have such facilities. Second, in this era of HIV, TBA's do not test mothers for HIV and that could lead to mother to child transmission."*
>
> - FGD Speaker 7

> *"TBA's are important when a woman in labor cannot reach hospital in time but they should be trained to recognize emergencies. They should also be linked to hospital so they can call for help when a client's condition is poor.* - FGD Speaker 15

Participants felt hospitals offer superior clinical services because of the equipment at their disposal and their ability to handle obstetric emergencies. Opinions in support of hospital delivery were less associated with previous pleasant experiences in hospital than they were with the fear of a TBA delivery. It was a popular opinion that health workers are repulsive and dismissive of women in labour. This among other factors was mentioned as one of the reasons a hospital delivery was not a quick choice for many.

> *"I think health workers simply lack commitment. They should listen to mothers and examine them to confirm anything they say instead of making assumptions."* FGD Speaker 8

> *"Some doctors are too quick to take mothers to theatre."* – Speaker 7

> *"Nurses' poor attitude towards us discourages us from going to deliver in hospital."*
>
> – Speaker 12

Most participants felt they did not have recourse for redress when they encountered difficulties at the hospital. A common perception that came to the fore was that it is not proper to complain about health workers.

> *"There was nothing I could do after I lost my baby because the nurses apologized to me and asked me to forgive them."* – FGD Speaker 3

> *"If the nurse says your time to deliver is not yet, that is it. There is nothing else you can do."*
> - FGD Speaker 10

> *"I know there is a suggestion box, but I am not sure the hospital opens it to check what people write."* – FGD Speaker 11

When the issue of costs was raised, participants who had delivered at TBA's noted there was not much difference between them and hospitals. However, they pointed out that the payments at the TBA are flexible and less formal. They could pay in kind and in installments unlike in hospital.

DISCUSSION

Client satisfaction is a continuous, dynamic and individualized process that depends on the entire continuum of care. In a critical review of patient satisfaction literature, Gill and White argue that despite several years of work in this field, there remains little standardization, reliability and validity of the construct of patient satisfaction; particularly as a proxy to quality of care[50]. This probably serves to illustrate the highly variable nature of the topic and the need for caution in interpreting any findings. Rather than be studied for standardization, validity and reliability, client satisfaction should really be viewed as an endeavor towards achieving the best care to every individual patient according to their needs and circumstances within the broader standards of service delivery. Looked at this way, it immediately becomes apparent that client satisfaction cannot be standardized or be measured in the traditional sense of evaluating technical aspects of care. Only broad measures can be prescribed within which every client finds his or her locus.

This study only interviewed mothers who had had a normal delivery. This bias probably had an effect in mothers being more positive about their experiences than they otherwise would. The fact that interviews were held with patients in the hospital could also have modified responses. It is not uncommon for patients to rationalize their responses especially when discussing their care near their caregivers. Certain studies have ran into this pitfall before[40]. Even though in this study mothers who had lost babies were not interviewed at the hospital, this perspective was included in the focus group discussion. However, an immediately apparent schism between the narratives of the patients and the community members was the time differential. It appears community members who had had a poor experience at the hospital in the past still harbor strong negative views of the hospital care system.

Structures

All participant groups recognized the necessity of equipment and infrastructure in the provision of quality care. Community members who have never delivered in hospital acknowledged that hospitals offer superior services partly because of the available equipment. Many patients based their decision of choosing the hospital on (among other reasons) the availability of equipment. Nurses on the other hand reported ease of work because of the facilities at their disposal. In a tiered healthcare system like Kenya's (see figure 3), this could present an opportunity as well as a challenge. While lower tier hospitals may have enough equipment for their range of services, their comparatively less equipment than their upper level counterparts' may influence patient choices and health worker practices. Patients may opt for higher-level facilities in consideration of the better equipment. Health workers in these higher-level hospitals may also be better motivated by the improved working environment and therefore more responsive to their clients.

If this preference were the case among patients, these upper level hospitals may end up with more patients at the cost of the lower level hospitals. It would therefore tie in with the main structural constraint at JOOTRH that is the lack of adequate numbers of nursing staff. The number of nurses available at the unit (2-3 per shift) appears low for the deliveries handled (about 14/day). This translates to an average nurse: patient ratio of about 1:7, a figure that reflects the nationwide shortfall of nurses in public facilities estimated at 50% deficit[22].

Compared to the state of California, US where by law maternity units cannot exceed a nurse: patient ratio of 1:4[51], it becomes immediately apparent that not only are the nurses stretched out thin, the quality of care provided cannot remain optimal. Evidence suggests that lower nurse: patient ratios translate to better quality care, higher nurse productivity, job satisfaction and staff [36,52]. As illustrated earlier, health workers working in environments that do not respond to their needs are themselves seldom responsive to the needs of patients[53]. In such settings, clinical work tends to take a more task-oriented than patient-centered approach[40,54]. This was evident when nurses reported not having enough time to give information to patients or wash hands after a procedure so they could carry out the next task. It is for this reason that patients would find the actual delivery service satisfactory but feel like they were not well taken care of after delivery. However, McCabe submits that staff shortages need not be a reason for less than adequate care when it comes to patient satisfaction. She argues it only takes recognition of the need and a commitment to it for health workers to be able to be responsive to their patients[40]. Ideals like respect for patients' autonomy, dignity and confidentiality do not require any more investment into the health system as they already fall within health workers' sworn obligation to patients in the Hippocratic Oath.

In the face of such staff constraints, task-shifting has been proposed and used in other settings[10,16]. By this, lower cadre workers assume non-critical functions to enable the few skilled staff available concentrate on the core duties. This was best demonstrated at JOOTRH by the arrangement in which the security guards offered general assistance and information at the entrances and other non-clinical areas. Patients therefore did not feel the absence of a dedicated receptionist. On a different scale, this initiative was evident in the relationship between nurses and students. Students were observed to be part of the care process and a level of supervision was discernible from the interviews with patients. By performing certain duties under the watch of nurses, a third of fourth hand was introduced where there would only be two. However, it appears some students (like some nurses) focus on the tasks forgetting the patient. Managing and optimizing the interaction between students, patients and nurses would not only further enhance the care process and offload some work from the nurses; it would also be beneficial to the students themselves. Cases of patients feeling 'used' by students would not arise if there was proper communication and respect for individual autonomy from and between either party. The benefit of having students pick 'best practice' ideals is recurrent and long term. A study among Finnish-nurse students found that student's quality of work was largely dependent on their clinical work experiences and exposure than lecture-room work at school[55]. As the next generation of workers, there are probably no better people to be encouraged to adopt and practice patient-centered care than students.

Most structural gaps in the provision of responsive care involve major capital investments and take some time to improve. However, some are critical to client safety. Emergency preparedness for instance is an indicator of an institution's organizational culture[4]. Preparation for non-clinical emergencies needs as much weight as for the clinical ones. It is unfortunate that in Kenya fire preparedness is not entrenched in to public infrastructure but good practice advises that any dwelling has contingency measures on the ready in case of a fire or other emergency. A grim example comes to mind when over 80 patients died in an Indian hospital following a fire in 2011[56]. Most deaths occurred because of locked exits.

Processes

The initiation of care on arrival was expedited. The average time to attendance was less than 10 minutes. In Thaddeus and Maine's *Three Delays* model of the causes of maternal mortality, the time taken between arrival in hospital and initiation of care (Third delay) has a bearing on clinical obstetric outcomes[57]. Provision of care without imposing prerequisites like fees and consumables (gloves, cotton wool, etc.) considerably reduces the third delay and can save lives. However, even with all supplies available and no fees required upfront, health workers must still commit themselves to being responsive to patients to avoid delays at this stage. The third delay was significantly long for two patients interviewed in the study; running up to 8 hours for one of them. Such negligence can not only cost lives of the patients involved, they also give the institution a bad reputation which then makes other patients delay/debate their decision to come to hospital (First Delay)[57]. In a region where half the women deliver at TBA's[21], making hospitals friendly to pregnant women cannot be over emphasized. The hospital is in direct competition for clients with the TBA's and must not only offer better services to her clients, but appeal to their senses and sensitivities. An earlier research done in Nairobi, Kenya among TBA's confirms why TBA's remain popular among some clients.

> *'The issue is that TBA's treat women well. They relate with them. This is very important because it makes them come and even refer others to us. If you are not very . . . understanding, patient and good to them . . . and you refer one to a fellow TBA, the woman will refuse because of her treatment or* [prior] *experience she had with the other one. These women are the ones who sell us to others. If your service is bad, then expect everyone to know about it. We also show them love, sometimes the hospitals do not have time for them. We respect them and they respect us ...''*[5] - (A TBA respondent in Nairobi, Kenya)

It follows thus that hospitals must offer better responsiveness to retain and win over more clients.

Even though most patients decried the lack of adequate information post-delivery, all initiated breastfeeding within an hour of their delivery as per WHO recommendations[58]. This illustrates how the technical process can be successful but still not satisfy patients. It also illustrates a task-centered approach to care in which a successful birth is considered the end of the service. Although much of newborn care information is given at ANC, research shows that patients retain little of what health workers tell them. Up to 80% of information given is lost immediately and half of what is recalled is incorrect![59] This means patients need repeat information to reinforce messages. It is known that verbal messages are recalled better and retained longer when they are reinforced by some other mode; written text, pictographs or video[59,60]. Leaflets, posters, audio and visual media have been successfully employed to complement and reinforce health workers' messages. The advantage of additional communication aids lies in less time spent on repeat communication while devices like posters and short videos can effectively reach several individuals simultaneously with less manpower[60]. A novel tool that presents opportunity in conveying information is the mobile platform[61]. With 75% mobile device penetration in Kenya[62], this remains a potential option to consider inasmuch as the cost may be significant.

Outcomes

From the data in table 1 above, the average maternal mortality ratio at the institution in the last 3 years is to 6.5/1000 live births; slightly above the average for the region which is 4.5/1000[23]. This higher-than-average maternal mortality ratio would be partly explained by the fact that the institution is a referral center hence has an adverse selection of complicated referral clients from lower level facilities. Such cases ordinarily would carry greater chance of mortality due to their complexity and the lapse in time. A possible second reason for the higher mortality links to the caesarean rates. Caesarean sections accounted for 19% of all the births. This is slightly above WHO's 5-15% recommendation for health institutions[63]. Some studies have indicated that institutional caesarean rates beyond 15% in developing countries are associated with increasing risks of mortality and complications from the procedure[64]. On the contrary, C-sections are one of the most important life-saving surgical procedures in obstetric care. Caesarean rates therefore point to the availability and utilization of a critical life-saving intervention rather than an escalation of risk of mortality[63,65]. Further, 75% of C-sections in African health institutions are performed due to maternal complications as emergencies unlike elsewhere where elective cases make the bulk[66]. It would be necessary to further probe into the institution's maternal mortality figures and differentiate those arising from normal deliveries from those arising from C-sections to get a clearer explanation for the mortalities.

Beyond the regrettable deaths, there are always women who suffered various levels of morbidity: transient and long term, physical and psychological. Many institutions seldom keep records of these events. Indeed, the psychological ones may never be known unless patients (were) are empowered to speak out[9]. A single client experiencing less than satisfactory care in hospital is probably one too many. Empowering patients and giving them a strong voice in the care process is one way of not just reducing the incidence non-responsiveness to patients but also bringing up these occurrences to for redress[53]. The lack of empowerment was most clearly demonstrated by community members who felt they had no way for redress for whatever happens at the hospital. It was also manifest by patient when they reported not knowing how to give feedback especially when it was negative feedback. For effective feedback system, it is important that the hospital has an avenue of communicating back to her clients. This way, clients realize their feedback is valued and welcome.

CONCLUSION

Improving the quality of clinical care remains a health system agenda that involves multiple players at various levels. 'Structural' components like the procurement of new/better equipment or hiring more staff are some examples that require not just significant resource input but also elaborate procedures. However, many 'process' aspects of client responsiveness can be implemented immediately and at little or no cost[7,40]. Quality of care can be greatly improved when health workers attend to patients with respect, dignity and courtesy, in confidence and in respect of patients' right to information and autonomy[33,42]. To achieve this, workers need not focus on their roles as tasks to be completed but focus on patients as clients in need. In turn, health workers' own productivity and job satisfaction improves in a work atmosphere that accords them not just the tools of the trade (skills and equipment) but also the same ideals above expected of them to patients[42,49]. These skills can be practiced as part of every health institution's 'process' culture if the awareness is upheld amongst workers.

As workers play their role, patients too have responsibilities in the process. Empowering patients to ask questions and provide any feedback goes a long way in engaging them in the care process[53]. This engagement must be carried on into the communities and be cultivated into an interactive relationship. This is certainly one way to guarantee continuous improvement in the quality of care and win the confidence of our citizens in our services as health workers.

RECOMMENDATIONS

Hospital Level

At the hospital level, the following short-term measures can contribute to an enhancement of the care process, client satisfaction and improve utilization.

1. Continuously sensitize all staff to center their activities on satisfying the patient while observing the core ideals of responsiveness: courtesy, respect, autonomy, dignity, information, choice, confidentiality and prompt service.
    - To achieve this, it would be prudent to start with small meetings by various groups of staff and present the relationship between responsiveness to clients, improved outcomes of care and client satisfaction. From these meetings, workers can then identify what aspects of responsiveness they can instill in the roles. A timetable can then be made on goals to be met for responsiveness by every group of workers. Regular appraisals and reminders will keep up the momentum.

2. Empower patients through more, regular and clear information on their rights, responsibilities and the organization of services.
    - By observing the first recommendation, workers can already start being more informative at each of their workstations/roles. This should not cost anything. Subject to availability of finances, posters informing patients of the organization of care, their obligations and rights can be posted within the department; preferably with the local language translation. Better still, small leaflets or brochures can be used for this. These leaflets could have some space for giving feedback.

3. Provide avenues for anonymous client feedback within the unit.
    - A suggestion box is necessary within the delivery unit. The box should be located closer to patient areas than nursing/administration areas. Some paper and pen should be fixed nearby to invite anyone willing to give feedback to do so.

4. Urgently improve on fire safety.
    - A floor-plan should be posted in the units' public areas with clear directions on the evacuation plan.
    - Emergency exits need to be kept readily accessible (not locked) and the signs leading to them be clearly legible in daylight and in darkness.
    - Periodic fire-drills

5. Direct regular community engagement to communicate positive changes at the hospital and give information about the hospital.
    - Reaching out to the community is a potential way of correcting negative perceptions some residents could harbor about services at the hospital. It would also project the hospital as having an open policy and welcoming to its immediate catchment population. This might be costly because of the need for a mass communication system such as a regular radio program or outreach events.

Health System Policy Planners

1. A concerted nation-wide effort to make hospitals responsive to clients should be considered along the recommendations for the hospital above.
2. Public health education should also be sustained to encourage institutional delivery.
3. Finally, on a longer-term outlook, collaboration with other non-health sectors to improve certain barriers (security & transport) to physical access to health institutions may complement efforts to improve uptake of institutional delivery. Attention should also be paid to TBA's at least in areas where their acceptance is high. They could be used as ambassadors for hospitals. This will require a longer–term outlook that also considers the income they get from their informal trade.

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ANNEXES

1. Map of Kenya

Figure 5: Map of Kenya Locating Kisumu

2. Participant Profiles

Nurses (All female)

CODE	Total years' experience	Period at JOOTRH
C11	20	9
C02/3	11	2
C04	22	10
C05	19	10

Table 2: Profile of Nurse-Interviewees

Patients

CODE	AGE				PARITY (At time of interview)	ADMISSION	OTHER
	18-24	**25-29**	**30-34**	**35-39**			
B01	X				1+0	Walk-in	Attended ANC at a mission institution closer home but chose to deliver at JOOTRH
B02	X				1+1	Walk-in	Last pregnancy miscarried 2nd trimester at JOOTRH
B03			X		6+0	Referral	First 2 deliveries at TBA, Had c-section for twins at this delivery
B04	X				1+0	Walk-in	ANC at a different publicinstitution
B05		X			4+0	Walk-in	3rd born at TBA
B06		X			4+0	Walk-in	First 2 deliveries at TBA
B08	X				3+1	Walk-in	First born lost at TBA
B09		X			1+2	Walk-in	Last 2 pregnancies miscaried 2nd trimester; 1st at another public hospital and later at JOOTRH
B11			X		3+0	Walk-in	-
B12		X			1+0	Walk-in	ANC at private for profit institution

Table 3: Profile of Patient-Interviewees

Community Representatives

Speaker	Sex		Age					Parity	Other
	M	F	18-24	25-29	30-34	35-39	40-44		
1	X			X					-
2	X			X					-
3		X	X					Biparous	1st born delivered at TBA, alive; 2nd born died at delivery in hospital
4		X	X					Primipara	Delivered at TBA
5		X			X			Multipara	Delivered at TBA once, Community health worker
6		X				X		Multipara	Community health worker
7		X	X					Nullipara	-
8	X				X				Wife delivered at TBA
9		X	X					Multipara	-
10	X			X					-
11	X				X				Community health worker
12		X	X					Multipara	-
13		X				X		Multipara	-
14		X	X					Nullipara	-
15	X				X				-
16		X			X			Multipara	1st delivery in hospital, twice at TBA
17	X						X		Community child protection officer
Total	7	10	6	3	5	2	1		

Table 4: Profile of Focus Group Discussants

3. Delivery Statistics at JOOTRH (2010 - 2012)

MONTH	ANC	ADM	SVD	C-SEC	MATN DEATH	LIVE BIRTH	NEONT DEATH	STILL BIRTH	TOTAL BIRTHS
JAN2010	693	412	307	88	3	386	15	25	**411**
FEB	664	327	277	44	4	311	5	25	**336**
MAR	783	357	299	72	3	372	13	15	**387**
APR	725	388	306	71	2	378	11	15	**393**
MAY	677	339	363	72	3	421	1	25	**446**
JUN	643	344	271	78	2	333	9	21	**354**
JUL	602	346	358	72	2	424	15	16	**440**
AUG	529	388	341	59	2	388	8	22	**410**
SEP	508	372	298	73	7	365	12	21	**386**
OCT	649	360	289	101	2	379	12	24	**403**
NOV	733	376	294	88	2	363	6	25	**388**
DEC	639	414	394	56	1	443	18	24	**467**
TOTAL	**7845**	**4423**	**3797**	**874**	**33**	**4563**	**125**	**258**	**4821**
JAN2011	507	428	336	72	6	407	19	22	**429**
FEB	480	388	170	68	3	230	13	16	**246**
MAR	618	353	318	85	0	394	15	16	**410**
APR	518	440	326	114	4	429	6	19	**448**
MAY	652	588	393	104	4	480	5	22	**502**
JUN	491	412	339	70	5	405	0	10	**415**
JUL	559	353	323	60	2	374	8	16	**390**
AUG	516	430	366	69	1	427	12	15	**442**
SEP	603	440	385	86	3	454	11	26	**480**
OCT	532	392	341	92	2	422	14	16	**438**
NOV	636	398	322	74	3	389	9	13	**402**
DEC	589	376	348	68	0	409	15	20	**429**
TOTAL	**6701**	**4998**	**3967**	**962**	**33**	**4820**	**127**	**211**	**5031**
JAN2012	603	447	338	84	3	419	8	15	**434**
FEB	709	418	330	77	1	393	3	23	**416**
MAR	494	289	220	46	3	265	2	8	**273**
APR	618	493	389	71	0	458	1	11	**469**
MAY	725	407	423	85	2	499	9	18	**517**
JUN	711	466	404	95	8	488	11	21	**509**
JUL	621	450	418	75	4	478	3	29	**507**
AUG	742	530	418	90	2	505	3	17	**522**
SEP	538	526	418	97	2	499	11	22	**521**
OCT	676	507	321	75	1	389	7	23	**412**
NOV	585	421	371	91	1	451	13	19	**470**
DEC	153	65	57	14	1	65	0	8	**73**
TOTAL	**7175**	**5019**	**4107**	**900**	**28**	**4909**	**71**	**214**	**5123**

4. Samples of the Study Tools

QUALITY OF DELIVERY CARE ASSESSMENT CHECKLIST

PART I: QUALITY OF CARE

This checklist has 2 broad sections that address the areas of institutional structures and systems. Structures refer to the material and human resource available to the institution to enable the delivery of quality obstetric care for safe maternal and neonatal outcomes. The systems (processes) are the organizational procedures that enable optimal use of the inputs in order to achieve the intended results: a safe maternal and neonatal outcome. Lastly, the outcomes are the combined result of structures and systems/processes on service delivery. The default intended outcome for delivery care is a healthy mother and neonate but deviations can occur for various reasons; often as a result of the quality of care (a factor of institutional structures and systems) but occasionally may be unrelated to the institutional quality of care. This tool is not a clinical audit tool.

A. STRUCTURES

1. **PHYSICAL ENVIRONMENT**

ITEM	QUALITY (mark ✓/ × for presence/absence)		ADDITIONAL COMMENTS
1. Waiting Bay	Spacious	✓	Well lit at night: not ambient in the day. Lights kept off for costs.
3 separate areas present for obstetric client, VCT services and visitors	Well ventilated (open windows/ air-con)	✓	
	Well lit (day and night)	✓	
	Adequate seats available	✓	
2. Delivery Room	Clean floors and walls	✓	
	Spacious	✓	
	Well ventilated (window/s)	✓	
	Well lit (day and night)	✓	
	Goose-neck lamp	✓	1pc shared in 3 rooms
	Emergency light source	✓	Automatic-on power backup, off-unit
	Private rooms/curtains	✓	
	Climate control (heating/ cooling)	✓	Fans working; no heating present
	Sink with running water and soap	✓	Have hot and cold water. All had no soap available.
	Sluice room	✓	Clean
	Placenta disposal system	✓	Electrical macerator, working
	Floor drains/ slant	✓	No pools

QUALITY	3. ADMISSION/ EXAMINATION/ CONSULTATION ROOM(S)	4. PRE/POST DELIVERY WARDS	5. TOILET/ SHOWER/ BATH FACILITIES
Facility available	Number 2	Beds 18	Number 4
Clean floors and walls	✓	✓	✓
Spacious	✓	✓	✓
Well ventilated (window/s)	✓	✓	✓
Well lit (day and night)	✓	✓	✓
Goose-neck lamp	✓	×	
Emergency light source	Stand-by generator, no in-house source		
Private rooms/curtains	✓	✓	✓
Sink with running water and soap	✓ (No soap)	✓ (No soap)	✓ (No soap)

ITEM		COMMENTS
6. Communication system/ telephone network	With patients	Physical; by staff
	Within hospital	Fixed line, mobile
	Beyond hospital	Fixed line, mobile
	Emergency hotline	Present; mobile
7. Examination room with desk, two seats and couch with plastic	✓	No partner's seat provided
8. Ward beds made with at least 2 pcs linen each	×	Some beds without linen
9. Drip stands for each bed		6 stands shared across beds
10. Nurses' station with adequate chairs, desks and cabinets	Station present; seats, cabinets inadequate	
11. Adequate staff personal storage cabinets	Adequate;	
12. Separate staff toilet with sink, running water and soap	Present, shower curtains absent	
13. Beds for staff on call (Room available for the doctor only)		
14. Staff reading/ common room Has 3 seats and desktop computer	✓	Books × Internet connectivity ×

Additional Comments

15. Emergency access/exit	Quality (mark ✓/×)		Comments
	Free of obstruction/ unlocked	×	Locked
	Labeled	✓	
	Label legible day and night	×	Not lit
	Floor plan posted	×	
16. Access to other departments and support services (laundry, kitchen, laboratory, wards, theatre, radiology)	Access from unit to rest of hospital is cumbersome; detached – ramp, staircase, walkway		

2. EQUIPMENT AND SUPPLIES

ITEM		QUALITY (mark ✓ / × / No.)		COMMENT
1. Standard delivery beds	X 4	Foldable to semi-sitting position	✓	
		Has removable stirrups	✓	
		Drip stand	✓	
		2 – step ladder	✓	
2. Options for other delivery positions			✓	Bed, floor
3. Lined covered segregated waste bins			✓	No waste segregation
4. Dedicated sharps box			✓	
5. Complete emergency tray (see annex)			No list, see annex	
6. Refrigerator in working condition			✓	2 units
7. Essential meds complete list (see annex)			See annex	
8. Routine diagnostic/ monitoring/ examination/ intervention equipment (at designated marked points)		Delivery packs	✓	
		MVA Kit	×	
		Speculum packs	✓	
		Suture packs	×	
		VE packs	✓	
		Oxygen source with masks and tubing, ambubag	✓	1 piece of portable concentrator, no central piping, cylinders available at hand
		Clinical thermometer	✓	
		Fetoscope	✓	
		BP machine + stethoscope	✓	
		Phlebotomy kit	×	Available individually for user-assembly
		HIV rapid test kits	✓	Locked away at night
9. Infant warmer with resuscitation equipment (oxygen, tubing, masks, suction, ambubag)			✓	
10. Wall clock with second hand			✓	Position away from the procedure
11. Instrument decontamination buckets/ system (disinfectant, detergent, clean water)			✓	
12. Floor cleaning equipment and supplies		Disinfectant, soap	✓	
		Mops and bucket	✓	
		Cart/trolley	×	

3. HUMAN RESOURCE

CADRES	No.	No. STAFFING PLAN PROJECTED	JOB DESCRIPTION DISCUSSED	WORK SHIFTS AND CONTACTS POSTED (Present)		UNIFORMS/ BADGES WORN		COMMENTS
1. Receptionists	0							
2. Records clerks	1							
3. Porters	1							
4. Social workers								
5. Nurse assistants	0							
6. Counselors	1							
7. Nurses	18							
8. Midwives								
9. Doctors	5							
10. Consultants	4							

B. SYSTEMS/PROCESSES

1. CLINICAL ASPECTS

ITEM	QUALITY (mark ✓ / ×)		COMMENTS
1. Infection control	Hand-washing practiced between patients	×	
	Gloves at user points	✓	
	Infection/sepsis register	×	
	Dirty linen segregated from clean	✓	
2. Partographs	Blank copies available	✓	
	Filled-in in files	✓	
3. Clinical protocols present at designated points	Eclampsia		
	Obstetric Hemorrhage	✓	PNW
	Infection/Sepsis		
	Obstructed labor	✓	
	Other		Infant BF, Pregnancy danger
4. Clinical checklists for individual patients in use	Admission	✓	
	Normal Delivery	✓	
	Transfusion	✓	
	Cesarean delivery	✓	
	Anesthesia	✓	
	Discharge	✓	
5. Policy on birth assistants	Allowed	✓	
	Displayed/communicated	✓	
6. Baby essentials at mother's bedside	Present	✓	
7. Policy on breastfeeding posted	Present	✓	
8. Consent forms	Blank forms available		
	Patients informed		
	Forms correctly used		
9. Consent policy available	Refusal of treatment	×	No prescribed forms
	Surgery	✓	
	Anesthesia	✓	
	Liability policy		
10. Critical event reporting system	Present		Not posted
	Clinical audits		
	Near-miss audits		
	Mortality audits	✓	
11. Evidence of daily ward rounds	Files	✓	
	Register	✓	

2. CUSTOMER FOCUS

ITEM	QUALITY (mark ✓ / ×)		COMMENTS
1. Access	Signage to unit clear from gate	✓	Recently broken, not fixed
	Adequate signage within unit	✓	
	Wheelchair access	✓	
	Ambulance access	✓	
2. Courtesy	Courtesy on arrival	✓	Security personnel
	Service delivery within 30 minutes of arrival	✓	
	Systematic patient flow cycle	×	Back-forth; reception, exam,
3. Social worker services	Confidential	✓	
4. Records	Record capture at admission	✓	
	Unique filling system	✓	
	Safe storage	×	On work desk, not locked
	Policy on access	✓	
	Easy/quick retrieval	✓	
5. Client feedback system	Suggestion boxes	×	None in unit
	Patient satisfaction surveys	✓	Quarterly
	Employee satisfaction surveys	×	Monthly interactive meetings
	Complaint management system	Not explicitly communicated	
	Supportive supervision system	For students, new staff	
6. Billing/ fees payment	Does not impede service delivery	✓	
	Itemized	✓	
	Explained	×	Unless inquiry made
7. IEC	Individual sessions	✓	Counselors
	Brochures/ leaflets	×	Occasional
	Posters	✓	BF, HIV
	Group sessions	✓	At clinic
	Follow-up information	✓	At clinic
8. Patient charter (Fees, rights and responsibilities)	Available	✓	
	Posted prominently	×	Not prominent, A4 size
	Ethics/ research committee	✓	
9. Employee training	Policy available	✓	
	In-service/ CME's	✓	Weekly
10. Hospitality	Posted schedule for meals	×	
	Special diet provision	✓	Omissions; salt, sugar
	Posted policy on food by visitors	✓	

ANNEX TO THE QUALITY ASSESSMENT TOOL

ABBREVIATIONS USED IN TOOL

CME Continuous Medical Education
EDD Estimated date of delivery
IEC Information, Education and Communication
INDIC Indication
LMP Last menstrual period
LOS Length of stay
MVA Manual Vacuum Aspiration
NLD Normal Labor and Delivery **VE** Vaginal Examination
SMC-Kenya - Standards for Maternal Care in Kenya

KEY

1. Obstetric Hemorrhage
2. Pre/Eclampsia and Hypertension
3. Obstructed/Prolonged labor
4. Infections
5. Other indications

VERIFICATION CRITERIA

For most indicators, a tick or cross will indicated presence or absence of the indicator as stated in the tool with a brief description of any additional information where necessary.

Verification and definitions of some of the indicators are listed below.

Spacious - no obstruction to movement
Well ventilated - no odor's, free air flow
Well lit - ambient day and night time light for ease of reading

Adequate seats - no standing clients for lack of seats

B.1.2.2 – Correctly used partographs are plotted from when cervix ≥ 4 cm, then cervix should dilate ≥ 1 cm/hr. Every 30 min: plot heart rate, contractions, fetal heart rate. Every 2 hours: plot temperature. Every 4 hours: plot blood pressure. (WHO)

B.1.6 – Baby essentials include a clean towel, cord clamp, sterile blade

B.1.7.3 – Correctly used consent forms are filled in completely and signed with a legible name.

B.1.9.2, 3, 4 – Registers and or minutes of audits are the verification criteria

B.2.2.1 – Courtesy refers to pleasantries, greetings and assistance where needed

B.2.2.3 – Systematic patient flow is a forward moving cycle rather than back and forth movements

B.2.4.1 – Records capture should include a minimum of name, address, unique number, date and time and next of kin, age, parity, complaints, LMP, EDD, vital signs, condition of fetus, discharge notes, lab results, previous history and examination findings (SMC-KENYA)

B.2.4.2 – Identification number has department unique code

B.2.4.3 – Safe storage from damage, loss, unauthorized access

List of Essential Medicines (SMC-Kenya)

Parenteral broad-spectrum antibiotics
IV fluids
Parenteral anticonvulsants
Anti-hypertensive
Oxytocic
Analgesics

Anesthetics (Local) Anti-emetics
Anti-spasmodic
Antimalarial-available on order
Hematinic
Tetracycline eye ointment

Components of Emergency Tray (SMC-Kenya)

Endotracheal tubes, 2.5, 3.5, 4.0 - oropharyngeal tubes available
Hypodermic needles
Syringes
Blood collection vacutainers
Nasogastric tubes
Meconium aspirator
Warm clean dry linen
Vitamin K Acyclovir
Potassium chloride injection
Sodium bicarbonate injection
Adrenalin 1:10 000 injection
Ergometrine injection
Disposable gloves
Oxytocin injection
Face masks (adult/baby)
Laryngoscope with blade and working light
Ambu bags (adult/baby)
Atropine
Diazepam Naloxone
10% Calcium gluconate injection
Volume expanders
Phenobarbitone

Additional Information

These standards and indicators are based on the Standards for Maternal Care in Kenya (2002) guidelines with additional input from the WHO Safe Childbirth Checklist. Other information was adapted from Tanzania's Quality Improvement Standards for Hospitals Assessment Tool, JHPIEGO's (John Hopkins Program for International Education in Gynecology and Obstetrics) Performance Standards for Maternal and Neonatal Health, Jordanian Health Care Accreditation Council's Hospital Accreditation Standards and the Egyptian Hospital Accreditation Standards.

PERCEIVED QUALITY OF DELIVERY CARE

FACILITY ADMINISTRATOR CONFIDENTIAL INTERVIEW TOPIC GUIDE

The researcher administers this topic guide and the order and wording of the questions may differ from the print.

1. BACKGROUND INFORMATION

CADRE_____QUALIFICATION _____
EXPERIENCE IN YEARS_____PERIOD AT INSTITUTION _____

2. What is your opinion on your facility's ability to offer quality delivery care to clients?

Physical environment (delivery rooms, equipment, bed space)

Staff numbers, skills, training

Supplies, utilities

Administration, organization, emergency preparedness

Other

3. Do you think your facility satisfies clients beyond their clinical needs/ roles?

Physical environment (waiting rooms, delivery room, beds)

Supplies, utilities

Administration, organization

Hospitality, support services (food, ergonomics, and social services)

Other

4. How does your feedback system work? Supervision? Community participation? IEC?

5. Are there quality benchmarks/ targets your institution strives to?

6. What is your opinion on your current charges? Affordability to clients, enough revenue for inputs/services, complaints from clients/suppliers etc.

7. Additional information?

PERCEIVED QUALITY OF DELIVERY CARE

FOCUS GROUP DISCUSSION TOPIC GUIDE

This is a general guide to the discussion and may change as circumstances demand.

1. BACKGROUND INFORMATION OF PARTICIPANTS

AGE CLUSTER	**1 (18-24)**	**2 (25-29)**	**3 (30-34)**	**4 (35-39)**	**5 (40-44)**
FEMALE	_____	_____	_____	_____	_____
MALE	_____	_____	_____	_____	_____

2. What is your opinion on where women should deliver; home, TBA, hospital? Why? Why not?

3. What is your encounter of delivery services at JOOTRH ?

4. Are there things you would like maintained/improved/avoided at the hospital to maintain/promote high quality of care at delivery?

5. How do you give compliments/ lodge complaints at the hospital? (Feedback system)

6. Additional information

PERCEIVED QUALITY OF DELIVERY CARE

HEALTH WORKER CONFIDENTIAL INTERVIEW TOPIC GUIDE

The researcher administers this topic guide and the order and wording of the questions may differ from the print.

1. BACKGROUND INFORMATION

CADRE_____QUALIFICATION _____
EXPERIENCE IN YEARS_____PERIOD AT INSTITUTION _____

2. What are the enablers at your current job? (Probe further as below)

Physical environment/Equipment

Supplies

Organisation/Protocols/Guidelines

Administration

Other

1

3. What are the constraints? (Probe further as below)

Physical environment/Equipment

Supplies

Organisation/Protocols/Guidelines

Administration

Other

4. How do you feel about your skills and ability to deliver at your job?

Qualifications/Training

Support from colleagues, books, administration, etc.

5. What is the workload like? Effects on you?

6. Does the department carry out any audits/reviews you know of? Which? How? Why? Value?

7. How prepared do you think is your department for emergencies? (Team-leaders, guidelines,)

8. What is your opinion on the attitude of clients towards you as a health worker in the delivery room/ward?

9. How would you rate the overall quality of care at delivery?

10. Do you wash hands between every patient/ procedure? (Probe)

11. Do you always use the partograph? (Probe)

12. Do you always fill in checklists/ consent forms? (Probe)

13. Do you follow any protocols for certain conditions? (Probe)

14. Additional information

B08

PERCEIVED QUALITY OF DELIVERY CARE

PATIENT CONFIDENTIAL INTERVIEW TOPIC GUIDE

The researcher administers this topic guide and the order and wording of the questions may differ from the print.

1. BACKGROUND INFORMATION

AGE CLUSTER **1 (18-24)** **2 (25-29)** **3 (30-34)** **4 (35-39)** **5 (40-44)**

PARITY 3+1 **DELIVERY STATUS AT INTERVIEW:** ANTENATAL POSTNATAL

OUTCOME OF DELIVERY: LIVE BORN BABY DECEASED

ADMISSION STATUS: REFERRAL WALK-IN

2. Was it your decision to deliver at this hospital? (Expand; whose, when, why) What difficulties did you encounter?

I was my decision to deliver in hospital because I think it is safer in hospital than at home. If an emergency arises like excessive loss of blood, one will get help in hospital unlike at home. I delivered my first-born at home because labour set in at night and I could not go to hospital at that time because of lack of transportation. I was not happy with the way the TBA attended to me. She had no gloves and the blade she used to cut the cord was not sharp enough. She was also slow and left my baby in the cold.

My choice for this hospital is due to the good care they offer. Even if a complication arises, one will not be referred; they will handle it right here.

3. Is this your first visit to this facility? How did you locate the department/delivery room? (Signs, access)

This is my second visit here. I knew my way round because the hospital organized a tour of maternity for us during ANC.

4. What was the reception like? Waiting room, time? Payment before service?

I was attended to after about 20 mins. I had a place to wait and as soon as the nurse was available, she came to me straight away. I was not asked to pay anything or to give any materials.

5. How did the staff treat you on arrival? Attitudes, information

She was kind to me introduced herself to me but I cannot recall her name now. She examined me after writing down my details and told me the findings. She asked me to wait in bed as labour would begin anytime thereafter.

6. Which health cadres have attended to you so far? How often? How were the encounters (attitudes)?

Nurses attended to me. They took measurements of my blood pressure and recorded. They were friendly.

7. Did/do you get help whenever you need(ed) it? (How, from whom, time of day)

The nurses were nearby and I would call out to them whenever I needed help even during the night.

8. How was the delivery room/ward? (Privacy, space, light, cleanliness, convenience, bed, assistance)

The delivery room was private and well lit. It was also spacious and clean. The bed made my delivery easier and the two nurses who assisted me during delivery were quick. One received the baby as the other gave me an injection and helped me to the bathroom.

9. How was your baby cared for? (When given baby, Breastfeeding information)

I received my baby after about 30 mins. I went to bath first and the nurse brought the baby to me when I returned. I was not given any information on the baby at that time but we were taught at ANC about breastfeeding. This morning we were also taught on breastfeeding and vaccination.

10. What is your opinion on the food and drink? (Food/drink quantity and quality, schedules, rations, special needs, from visitors, dietary restrictions)

I have not eaten anything since I came because I usually don't like hospital food. I feel like it has the odor of medicine. At admission, I was asked if I have any food allergies. There is no schedule of mealtimes but it would be good to know so that one can prepare for mealtimes.

11. How were the toilet and bath facilities?

The toilets at the delivery unit are clean, spacious and well lit with running water but the ones up have no water. Therefore, we have to go downstairs for water to use in the toilet, wash the baby or wash clothes. That, I find very difficult for me especially now just after delivery.

12. What information have you received about yourself or baby as you go home? (What, when)

(Breastfeeding, vaccination – mentioned earlier)

13. Do you know what to do if you had a complaint? (Expand)

I don't know what I would have done if I had a complaint. I am glad I was well taken care of during delivery. The only problem I saw was the lack of water in the toilet up here.

END