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I Wince in Pain for a Reason: Women's Perspective of Maternity Care Services during Intrapatum and Post Delivery Insemi-Urbanindore

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Abstract: ***This study was conducted to enquire and investigate women's perception of interaction with health care providers during intrapartum and delivery and the assessment of implications for utilization, accessibility and acceptability of maternity services in rural Indore. Method: To conduct this study 20 individual in-depth-interviews and 2 focused group discussion were carried out with females of reproductive age group, who were aged between 19-39 years and who had delivered in past 5 years in areas of rural indore. Women's perception and their experiences of intrapartum care and care after delivery in terms of factors that influenced satisfaction with services, place and environment of delivery and whether they would recommend some changes for improvement in services was investigated and enquired. Results: Attitude of health care providers was the component of care which appeared to be the greatest importance to the women. on accessibility, acceptability and utilization of services this factor had considerable influence. Other factors like expenses, perceived quality of care, successful labour outcome and proximity of services were also important. Our study suggests that females do expect professional yet welcoming and courteous treatment and humane environment from health care providers. If they experience unacceptable behaviors, discrimination in terms of cast, religion, socioeconomic status and degrading, they consciously change their preferences for place of delivery and exchange their thoughts with their fellow females, friends and neighbors. Conclusion: User views and opinions are important and future investigation is warranted, our findings suggest that. We should also investigate the views of health care providers and then identify channels by which quality of care and services improvements can take place, considering women's recommendations and views. Interventions to improve intrapartum and post delivery care should also be directed to general health system for betterment and should not only e directed to health professionals.***

1. Background

The Government of India is a signatory to the United Nations (UN) Sustainable Development Goals (SDGs), which adopted a global maternal mortality ratio (MMR) target of fewer than 70 deaths per 100 000 live births by 2030. [1] This requires the reliable quantification of maternal deaths and trends and an understanding of the major causes of these deaths at the subnational level. India, similar to many countries with high maternal mortality, officially registers only a fraction of births, deaths and vital events. [2, 3]Maternal deaths are concentrated in remote rural areas and are among the least likely to be recorded.4 India, however, has had a functioning Sample Registration System (SRS) to monitor fertility and mortality covering over 1 million nationally representative homes for more than five decades.

The UN estimates that about 24 million children were born in 2017 in India, and about 35 000 mothers died during childbirth or shortly thereafter, giving an MMR of 145 per 100 000 live births.5 This rate represented 12% of global maternal deaths. According to the World Health Organization (WHO), the worldwide MMR has fallen substantially from 342 in the year 2000 to 211 in 2017, reducing global maternal deaths from 451 000 to 295 000 during this period. [5] About 40% of this absolute decline was derived from fewer maternal deaths in India. [4]

It has also been demonstrated that 99% of the world's maternal deaths occur in developing countries [6, 7, 8, 9] and India being a developing country Concerns for the significant mortality and morbidity associated with pregnancy and childbirth is therefore prominent on global health agendas [10].

Lack of success may also be related to issues of access. Maternal deaths could be prevented if women were able to access and utilise good quality services, especially when complications arise [12]. However, in reality, most women experience serious barriers to accessing services or even if they do reach them, the services themselves are often of insufficient quality or effectiveness. Interventions that generate demand for care are likely to, for example, increase the chances that women will gain this access to services. In recent years, system or sector-wide strategies focussed on skilled attendance have aimed to generate demand as well as augment supply. Skilled attendance is now widely advocated as the single most crucial intervention to reduce mortality owing to pregnancy and child-birth [11, 13, 14]. The rationale is based upon the potential for trained health workers to manage cases appropriately and prevent complications. The components of skilled attendance are well documented and include the health professional within an 'enabling environment' which comprises a functioning health system including effective transportation, drugs, equipment and supplies [11, 15, 16, 17]. The enabling environment also requires effective links between services and the community [13].

Considering the perspective of the service-user has been seen to increase the acceptability of services [18, 19]. However, the influence of inter-personal aspects of care, as acomponent of quality, has not been investigated as extensively as other, more clinical, elements. Patient satisfaction is a related concept as it aims to determine "individual

perceptions of the quality of health care delivered" [20]. Although studies of patient satisfaction, which often focus on patient-provider interactions, have increased in numbers in industrialised nations in recent years [20], considerable difficulties surround the conceptualisation and measurement of satisfaction. In addition, respondents have been seen to report unrealistically high levels of satisfaction which are likely to be prone to courtesy or gratitude biases [19, 20, 21, 22].

This study was under-taken with the objective of investigating women's accounts of interactions in delivery care and to assess their implications for acceptability and utilisation of maternity health care services in SEMI-URBAN Indore. Despite these difficulties, service planning which does recognise and address the influence of the patient-provider interaction has been seen to be an effective means by which to improve the quality of services [23]. Such service-improvements have been shown to influence utilisation and compliance and have resulted in a "larger, more committed clientele" [18]. In the longer term, this translates into better quality of care and ultimately, improvements in health outcomes.

This study was part of a research initiative called SAFE (Skilled Attendance for Everyone) which aimed to improve the knowledge base on skilled attendance at delivery in developing countries [14, 17]. The accounts of labour and delivery discussed in this paper arose out of a wider study, published elsewhere [24] investigating how women identify their delivery attendants. Our results are targeted at service providers, managers and planners as evidence suggestive of factors related to acceptability and utilisation. Possible routes for further investigation are pro-posed as are some recommendations for practice. During the course of the wider survey, women spontaneously shared their views on delivery experiences and factors were identified that warranted further investigation, prompting us to conduct this exploratory study.

2. Methods

Since the experience of labour is unique, intimate and highly personal for every woman, it was difficult for participants to freely share the details of their particular experiences especially in a group discussion. It was concluded that the study should be continued using in-depth interviewing. With this approach, women provided detailed accounts of their experiences. Focus group discussions (FGDs) and individual in-depth interviews were the techniques employed. Qualitative techniques were appropriate since women were talking about sensitive, personal issues. Although the original intention was to conduct FGDs, it was quickly established that women were reluctant to talk about their experiences using this method.

Table 1: Topics of semi-structured interviews and FGDs

- Awareness of place of delivery
- Availability of place of delivery
- Actual place of delivery
- Satisfaction with services and attitude of health care professionals
- Reasons for choice
- Recommendations of services to other women.
- Recommendations for improvement of services
- Expectations of care

Changing the methodology during the course of the study from FGDs to in-depth interviews was a reactive way to respond to the unsatisfactory results of the FGDs and maximise upon the opportunity to collect meaningful data. The results of the FGDs were used to develop the in-depth interview guide and were analysed with the results of the interviews. There were some potential problems with this approach. Analysing the FGD and interview data together ran the risk of 'diluting' the importance of factors identified in the interviews that may not have been as pertinent in the FGDs. However this risk was deemed to be favourable to the alternative of loss of key issues that arose during the FGDs. In addition, since women were asked in both the interviews and FGDs to consider the same issues, the data was sufficiently consistent. However, during the course of the analysis, we took care to maintain this consideration in terms of the conclusions we arrived at.

The theoretical basis to the methodology originates in the constructivist paradigm towards enquiry. This paradigm sets out that human beings individually and collectively interpret or construct the social and psychological world in specific social, linguistic and historical contexts. The theory asserts that knowledge and truth are created through the perspective of human beings, and are not discovered [25]. Women's perception of their care during delivery is, thus, best described and interpreted by them-selves. The interviews and FGDs used semi-structured guides and included open-ended questions (see Table 1). Open-ended questions encouraged women to describe their experiences in their own terms and using their own language. This allowed them to freely recount factors that were of importance to them without being influenced by the line of questioning.

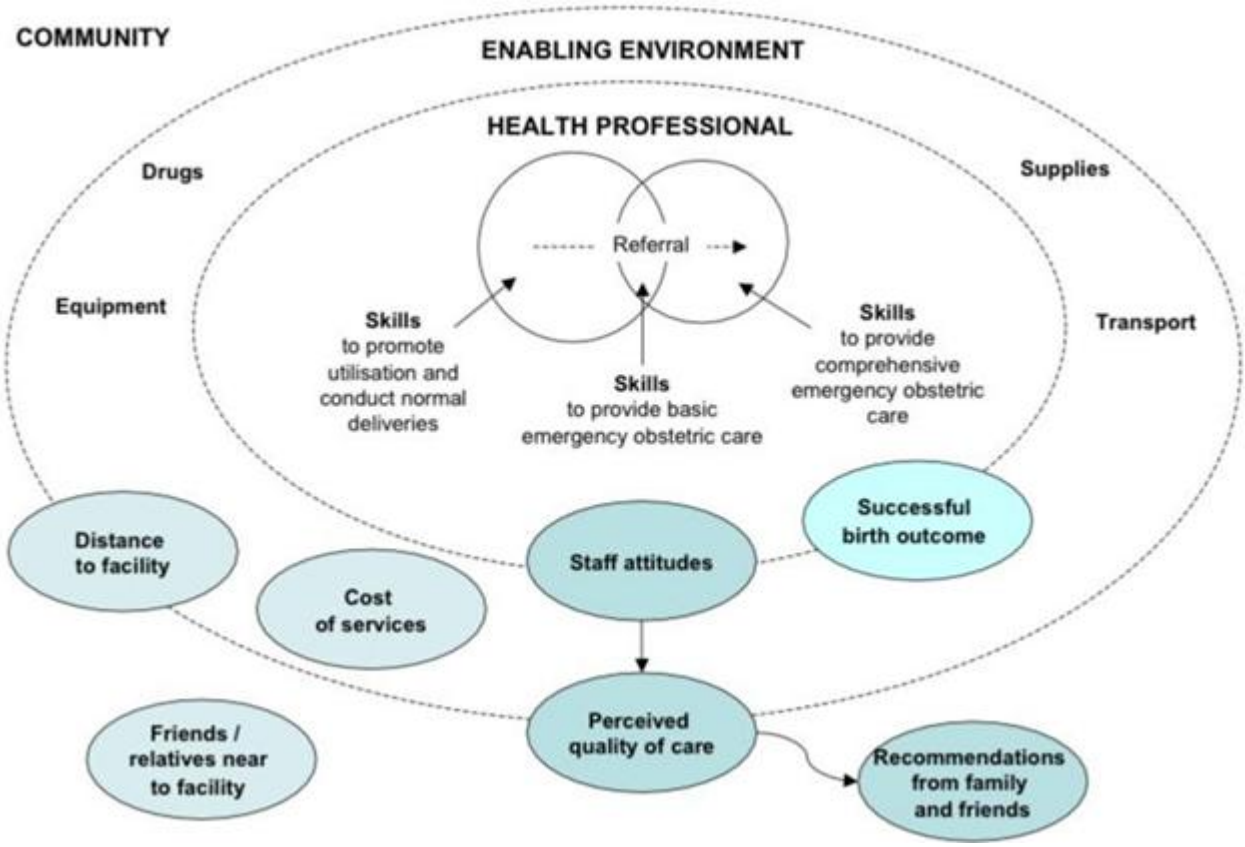

Figure 1: Categorization of components of care which women perceive as important during delivery, with indication of the influence of staff attitudes

A sample size was not calculated as this was not appropriate for the qualitative method. Women attending antenatal and child welfare clinics and who had delivered with a health professional were included in the study. The opportunity to conduct our study arose during the course of another piece of research [24] that recruited women who had delivered with a health professional in the last five years. The sample of women included in the study we report here was thus opportunistic. The five year recall period was originally chosen as women's recollection of obstetric events even over long periods of time has been demonstrated as accurate and experiences are recalled in great detail [26, 27, 28, 29, 30]. However, this may apply to more tangible events (e. g. number of births or deliveries) and subjective elements (such as feelings and satisfaction) may change over time. While acknowledging the potential for recall bias, we were able to draw upon the combined perceptions of women's birth experiences over the five year period.

Two FGDs and twenty-one individual in-depth interviews were conducted in 10 districts of Indore, areas which were semi-rural to rural in nature. Data were collected between April and September 2021. Women participating in the study gave verbal consent.

Interviews and FGDs were conducted in various locations – health facilities and women's homes, the place of the interview being chosen by the respondent. When it did not inconvenience the woman to be interviewed immediately, the interview was conducted in a quiet area in or near the facility. In other cases, women requested that the interviewer visit them at home, and so the interview was conducted there at a later date. Conducting an interview or FGD in a health facility location might have biased some respondents to give accounts of care that may have been more positive, and less reflective of their true perception. However, it was felt that it was more appropriate, and that this courtesy bias could be minimised, by offering women a choice of interview setting.

The researchers were trained in qualitative methodology and conducted both the interviews and the FGDs. A tape recorder was used to record the sessions and a transcript of the discussions was made by an independent person. The transcripts were translated into English, reviewed and coded to identify pertinent themes. The approach to both the data collection and analysis was exploratory and did not pre-suppose any relationship or significance of the factors which were identified. The analysis was thematic to draw out the main themes and contradictions. A theme needed to recur in a (non-statistically) significant proportion of the women, to indicate that it was an important issue. When emergent themes had recurred sufficiently, it was appropriate to conclude the interviews as no new themes were likely to emerge, i. e. "thematic saturation" had occurred. The results are discussed according to the prominent themes in the following sections. Some findings are presented verbatim of the in-depth interviews and FGDs, others are summarised. Our approach has been not to assign quotes to specific individuals because the small numbers of interviews allows us to represent the opinions from the entire range of women involved.

3. Results

Characteristics of women
The women included in the study were aged between 18 and 39 years. Parity was from one to five children. The outcome of pregnancy in all cases was a live birth. Most women had some basic education with the exception of a few who had never been to school. All were married and majority of them were housewives, some of them were engaged in various trades such as labourer, farmer, tailor, hairdressers.

Women's accounts of care
The FGDs and interviews were arranged around four topics (see Table 1). Recurring themes that spontaneously emerged from women's expressed opinions reflected com-ponents of care that were of importance and which influ-enced their satisfaction with services.

Place of delivery
The majority of women delivered in public health facilities like subcenters, primary health care centers and community health care centers in different districts of Indore. Some women delivered in facilities with specialist obstetric care than in public facilities with basic obstetric care. Few delivered in private facilities. Women delivered in homes were excluded from this study.

Generally women were aware of the existence of various facilities for delivery within the area of their residence. These facilities were both private and public with a range of sophistication in terms of emergency obstetric care. They included private and public maternity homes with basic obstetric care but without operating theatre facilities and a resident obstetrician, to facilities with specialist obstetric care.

Poor outcome of previous pregnancy, such as fresh still-birth, and perceptions of poor quality of care deterred women from choosing certain facilities for delivery. This was especially clear where mothers had the perception that the outcome could have been otherwise but for the care she received:

Other factors that influenced choice of facility were cost of services, access and recommendation by family and friends. Otherwise, other previous experience, administrative arrangements (i. e. an arrangement between a com-pany and a health facility for the provision of care for its employees and their families), the general environment of the facility (i. e. level of noise or orderliness, sanitation and neighbourhood), the availability of a known person or family member in that facility, proximity of a facility to family members who could assist in caring for mother and child, confidentiality and privacy influenced choices:

The availability of friends or family members for postdelivery assistance was important to women. Women indicated that they travel long distances to deliver in facilties that are close to friends or relatives.

Some women recommended continues abor companionship while some felt themselves shy to undress theirselves in front of their female relatives

Satisfaction
In describing their satisfaction with services, the women interviewed talked about delivery experiences with their last child and previous deliveries (where the woman had previous deliveries). Women accounts depicted both positive and negative encounters with staff.

Women who had appalling treatment expressed indignation. For some women, reliving their experiences caused much pain and they cried on recollection.

"The nurse put my finger into my vagina and asked what I could feel. I said it was the baby's head and I asked her whether I should push. She retorted 'What are you lying there for?'"

Other aspects of services with which women were not sat-isfied included high cost and evidence of poor quality; crowding babies on the same bed; inadequate numbers of nurses to attend to women in labour; no local anaesthetic for episiotomy suturing; unduly waiting before weighing the baby; and asking mothers to vacate beds regardless of time and inconvenience.

Expectations
"The main person who assisted me was the nurse who asked me to be patient, kept coming to see how I was faring. She was the one who treated me kindly, performed the episiotomy and sutured it. When I bled on the floor, she cleaned. She received the baby and the placenta. She cut the cord and made sure the placenta was out. "

Expectations were generally governed by experience (the woman's own and/or other's) which influenced their future expectations. All women expressed a desire to have staff with a positive attitude. Some mothers described the positive staff attitudes they would expect. These included giving reassurance, encouragement and politeness, provi-sion of mosquito nets, patience and tolerance. When asked about expectations, accounts of experiences were given to illustrate care which they would (or would not) expect:

Women expected attending midwives to provide guidance and counselling. However, the accounts indicated that providers expected women to know what to do at various stages during labour and delivery and that their lack of knowledge attracted reprimand from some attending nurses and midwives. Other descriptions of poor staff attitude included, rudeness, undeserved or inappropriate reprimand, shouting at women in labour, lack of empathy, refusal to assist, refusal to allow woman in labour to touch or hold a midwife, threatening patients in labour with poor outcomes if they did not comply with instructions, denying women service and lack of moral support and encouragement to exhausted women in labour:

Recommendations of women
When asked if they would recommend the services, women considered the performance of attendants and the services they had received. Recommendations were mainly due to positive attitudes of one or more providers. Likewise, others would not make recommendations because of negative experiences:

Women commended staff, especially those who showed respect and concern for them in labour. They showed clear abhorrence for those who were abusive and in general, were determined to avoid any further contact with them, directly or indirectly and would not recommend their services.

4. Discussion

Study limitations

Context
The study examined women's perspectives of delivery experiences with health professionals, so only women who had delivered in facilities were interviewed as home deliveries with health professionals are rare. Further-more, the study was confined to a semi-urban area where facility deliveries with health professionals are more common. The results of the study therefore, have implications primarily for care related to deliveries that occur in health facilities, attended by health professionals.

Respondents
The age range of respondents was 18–39 years. In addition, women who had a facility delivery were likely to be younger, low parity women. This may be why the age-range of the respondents fell short of the women of reproductive age-range. The age-range may have given rise to particular per-ceptions, recollection of care etc, i. e. younger, less experienced patients are likely to have fewer expectations and so be more satisfied with services. By contrast, older patients have been seen to be more satisfied and compliant with care than their younger counterparts [31, 32, 33, 34]. As recruit-ment to the study was voluntary, it is also possible that women who were most unhappy with services might have declined to be interviewed. Other factors such as wealth and education can also be influential on perceptions [31-34]. However, despite the socio-economic and demo-graphic differences between respondents, there was a considerable level of consistency in the factors that were identified as determinants of satisfaction, and consequently access to, utilisation of and compliance with care.

5. Methodology

The study has raised concerns about the appropriateness of the FGD method in capturing information on personal experiences. In the group discussions, dominant participants could set the tone about how easy their delivery had been. The outcome of the pregnancy in all cases was a live birth. This may have been sufficient to over-shadow any inconveniences experienced during labour for young, mostly primiparous, mothers. This was coupled with very little with which to compare their first experience. We therefore had to alter the method to individual in-depth interviews to provide privacy, confidentiality and non-competitiveness. Participants were more relaxed and provided detailed insight into their experiences with this method. It was concluded that the interview technique was more sensitive and effective than the focus group.

Other potential biases
Respondents' accounts of subjective events around pregnancy and childbirth may have been prone to recall bias, particularly with a recall period of up to five years. There also may have been courtesy bias – women may have felt that expressing negative feelings about their care may have implications for future care. There was an attempt to minimise the latter by allowing the women to choose the location of the interview. With regard to the potential for recall bias, studies show that recollection of various factors related to pregnancy and delivery is accurate, even over long periods [26-30].

In addition, a recent study found that dissatisfaction with care in childbirth may even emerge over time as relief or gratitude for a safe delivery subside [35]. The same study recommends that investigations of women's birth experiences are more accurate if conducted some time after delivery. The recall period, therefore, may have helped to address the courtesy bias, although the results should be interpreted with the potential for these biases in mind.

6. Theoretical Frameworks

We implicitly assumed that the accounts of women's experiences, the acceptability of and satisfaction with services reflected, to some degree, the quality of the services. As such, elements of theoretical frameworks of satisfaction and skilled attendance can be illuminating when interpreting the results.

In a review of satisfaction-theory, Sitzia and Wood infer that expectations govern satisfaction, i. e. the more a service meets with the expectations of a user, the more that user will be satisfied with that service [20]. When we examined expectations we found that women almost exclusively expect positive attitudes from staff. The influence of staff attitudes can be seen in the recommendations women made, the choice of delivery facility and their satisfaction with services. It is also noteworthy that Sitzia and Wood dispute high levels of satisfaction equate with high quality care. They infer that high levels of satisfaction commonly reported suggest that "dissatisfaction is only expressed when an extreme negative event occurs" [20], which may be cause for concern in light of our results.

The results also fit within standard theoretical frameworks of skilled care. The SAFE conceptual framework illustrates the key elements of skilled attendance as the skilled attendant and the enabling environment [17]. Figure 1 illustrates the original framework with the components of delivery care referred to by women as important, super-imposed upon the framework in shaded ellipses. This helps to reinforce the important inter-relationships and influences between the professional, the enabling envi-ronment and the wider community, particularly since the majority of important factors relate to more than one element of the framework. For example, perceived quality of care is a construct of the community, by virtue of its 'perception'. However, this perception is also governed by factors such as availability of equipment and beds etc, which are attributable to the enabling environment. The lines separating the elements of the framework are dotted to illustrate these inter-relationships.

Our findings bring an additional perspective to the frame-work – the interpersonal aspects of care, and their influence. The original framework focuses on the health professional in terms of their clinical skills and the clinical aspects of the enabling environment [15, 16, 17]. Our results help to emphasise the importance and influence of staff attitudes, which can be linked throughout the conceptualisation from the professional to the enabling environment, affecting perceived quality of care, to the community affecting the recommendations women make and receive. It should also be acknowledged that women are likely to construct their expectations on the basis of the experiences of others, as well as their own. The willingness of women to travel long distances to be close to family and friends also indicates the importance of social, com-munity and familial factors. From this diagram and the Sitzia and Wood discourse on satisfaction [20], we can infer that health professionals have the potential to influence some or all of the elements of skilled care and a major determinant of satisfaction – women's expectations, which in turn affects utilisation.

How to feed back the results of the research was discussed with district health officers and a meeting of health professionals in the study area was agreed upon. Although it was not feasible to have all health professionals attend the meeting, it was recognised that the implications for practice from the study were important and further feedback was organised via the meeting attendees to their colleagues. This approach was favourable as it may have been threatening for health professionals to receive this information from researchers and district health officers, and was more conducive to change if fed back from colleagues. At the meeting, many professionals expressed surprise and lack of awareness of these perceptions. Whether providers are even aware of women's needs and expectations as they arrive for delivery is debatable. What might seem to be a normal, rational practice, can have pronounced, detrimental effects on a woman's subsequent health seeking behaviour. .

7. Recommendations

This study adds weight to the increasing recognition that taking into account women's perceptions is crucial to improve the delivery care experiences of women [36-38]. The results of our study, particularly the themes concern-ing patient-provider relationships, are congruent with those seen in both developed and developing countries – that positive experiences have a profound influence on acceptance, uptake and use of services and affect demand, compliance, uptake and quality of care [18, 20, 23, 33, 39-43].

The means to address the factors relating to good delivery care practices are therefore to ensure a high level of aware-ness amongst practitioners. Sitzia and Wood describe several mechanisms by which patient views might be communicated to the health system from patient-provider discussions, patient advocates, patient comment-boxes in hospitals, patient committees, complaints committees, focus groups, public meetings and surveys [20]. Additionally, training and supervisory interventions that encourage acquisition of interpersonal skills are highly recommended [44]. International organisations such as the World Health Organization (WHO), the International Federation of Gynecology and Obstetrics (FIGO) and the International Confederation of Midwives (ICM) have defined a minimum set of skills for providers [45-47] that go beyond clinical skills to include a wide range of inter-personal and attitudinal skills. These include general care and counselling of women, cultural sensitivity, appropriate communication skills, provision of psychological support and involving women, parents and families in provision of care.

The framework we use helps to highlight that interventions to correct the situation should not only be directed toward the health professional. Many of the expectations of women for good quality care lie beyond the capacity of the health professional to provide. The Indian government is committed to improving the quality of their pop-ulation and reproductive health programmes. There is acknowledgement that general health system improvements addressing the cost of care, availability of human resources, equipment or infrastructure – i.e. providing an "enabling environment" – are key to providing good delivery care. It should also be noted that other factors such as personal needs and social and familial influences may not be possible to improve as part of service provision.

The study was dependant on interviews, women's subjective accounts of the care they received. A broader sense of the issues could be obtained by observing interactions, and including perspectives of women who choose to deliver outside facilities and without a health professional. Provider's accounts of care are an even less examined area [23, 42, 48] although they have been stated as "a crucial component of any attempt to change institutional protocols" [19]. We would therefore recommend that providers' perspectives and motivations are investigated in conjunction with descriptions of user-views, as two parts of a whole, in order to identify effective mechanisms by which needs of the users can be responded to, to ultimately increase quality of care.

A final recommendation resulting from this study relates to the need for continuing research and documentation of women's perspectives. Even when birth outcomes are successful some of the accounts of care depict serious neglect and abuse. There is a need to share common responsibility for ensuring that research, policy and programming address these serious malpractices, sub-standard care and lack of "woman-friendliness" in maternity services.

8. Conclusion

The recommendations emerging from this study reinforce the importance of provider awareness regarding attitude, and the need for development of inter-personal communication skills into education and training, alongside supporting supervisory mechanisms. Provider perceptions are also an important area to investigate to facilitate change in clinical practices. Recommended interventions should be supplemented with broader health systems improvements, including an understanding of the 'demand-inducing' factors which influence women's decision making for their delivery care.

Our findings suggest that health professionals' attitudes towards patients is a critical element of care – as are a successful labour outcome and non-medical factors such as cost, perceived quality of care and proximity to services. These components of care were influential on women's expectations which in turn influence acceptability and uptake of services.

9. List of abbreviations

- ICM International Confederation of Midwives SAFE Skilled Attendance for Everyone
- TBA Traditional birth attendant
- WHO World Health Organization
- FGD Focus group discussion
- FIGO International Federation of Gynecology and Obstet-rics
- GNP Gross national product

10. Competing interests

The author (s) declare that they have no competing interests.

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