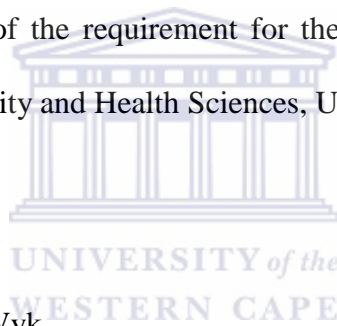


**DEVELOPMENT OF A PATIENT-CENTRED IN-SERVICE TRAINING
PROGRAMME FOR MIDWIVES TO INCREASE CLIENT SATISFACTION WITH
CHILD-BIRTH CARE IN KUMASI, GHANA.**

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A thesis submitted in fulfilment of the requirement for the degree of Philosophiae Doctor in
Nursing in the Faculty of Community and Health Sciences, University of the Western Cape



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20th December, 2016

ABSTRACT

Background: Satisfaction with the care mothers receive during child-birth is known to have a very strong influence on their future use of facility-based care during child-birth. Women and children continue to die from complications associated with pregnancy and child-birth and the majority of the causes that lead to mortality are related to labour and delivery. For this reason it is imperative for mothers to access facility-based child-birth care to receive skilled birth care. Mothers report dissatisfaction with facility-based child-birth care as one of the reasons for home births without skilled attendants. The presence of the skilled birth attendants is known to reduce maternal and neonatal mortality rates because of their ability to diagnose any early complications, and to intervene appropriately.

Aim: The aim of the current study was to develop an in-service training programme for midwives to provide patient-centred child-birth care that would increase client satisfaction with child-birth care.

Method and findings: The intervention research model by Rothman and Thomas (1994) – Design and development (D & D) – was used as the research framework. Only the first four of the six phases of the D & D model were applied in this study.

In the first phase, a situational analysis was done using a qualitative study. The expectations, experiences, and satisfaction with child-birth care of antenatal and postnatal mothers, were explored. The research was conducted in four health institutions within the Kumasi Metropolis. Between 12 and 15 participants were purposively sampled in each hospital. Data were collected by means of individual in-depth interviews using an interview guide and data were analysed using content analysis. The study found that mothers expected to receive respectful care and safe care. Mothers had encouraging experiences and discouraging experiences during their child-birth care. The discouraging experiences did not align with their expectations of care, leading to dissatisfaction with child-birth care.

In the second phase of the study an integrative literature review was conducted to identify evidence-based best practices to deal with client dissatisfaction with health care. The integrative literature review indicated that in-service training was commonly used as best-practice to improve health professionals' knowledge, skills and attitudes towards work and consequently to improve health outcomes for patients, including client satisfaction.

In the third phase of the study, the in-service training programme to enhance patient-centred care was developed using Chinn and Kramer (2005) guidelines for programme development and steps to programme development by Management Sciences for Health (2012).

The fourth phase entailed an assessment of feasibility and usability of the in-service training programme using 6 midwives in a district Hospital. The procedure was guided by the I-Tech Technical Implementation guide (2010). The outcomes of the assessment was used to refine and revise the developed in-service training programme.

Conclusion: This study sought to develop an intervention to increase client satisfaction with child-birth care service by engaging the following processes in phases:

- Assessing the expectations and experiences of mothers about child-birth care services.
- An integrative literature review for evidence-based best practice to tackle client dissatisfaction with health care.
- Designing a patient-centred care in-service training programme together with experts in the field of maternal and child health.
- As assessment of feasibility and usability of the in-service training programme by means of a pilot test to refine the programme.

Recommendations: It was recommended among others that, the study is carried out on a national scale to cover all administrative regions of Ghana. It is further recommended that the study findings and the programme developed form part of the continuous professional assessment course requirement for nurses and midwives.

KEYWORDS

Development

Patient-centred care

In-service training

Programme

Child-birth care service



DECLARATION

I declare that “*Development of a patient-centred in-service training programme for midwives to increase client satisfaction with child-birth care*” is my own work, that it has not been submitted for any degree or examination at any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

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ACKNOWLEDGEMENTS

First and foremost, I would like to thank God Almighty for his divine guidance, grace, provision and protection through this PhD journey.

This journey has been made possible through the support and guidance of a host of people to whom I owe my sincere gratitude. For as Isaac Newton (1976) stated “If I have seen further, it is only by standing on the shoulders of giants.”; to these giants, I am grateful.

To my supervisor, Professor Brian van Wyk for his constructive criticisms and guidance in ensuring that this study met the expected rigour of a Doctoral Thesis. Thank you for being available for consultation at all times, for keeping me on track and for funding support to a writing retreat to finish up. I really admire your style of supervision.

I acknowledge Dr Lucia Knight my co-supervisor for the promptness with which she gave feedback and her guidance and encouragement through the process. My sincere gratitude.

To lecturers from the School of Nursing and School of Public Health, thank you for your support through the process. Professor Oluyinka Adejumo, thank you for being my supervisor in the early stages of my PhD studies.

My appreciation also goes to my husband, Beloved Mensah Dzomeku for holding the fort in my absence and for his patience, and to my children Mawunyo, Elsie and Daisy for their patience, endurance and prayer support through this process. I love you all so much, you are a blessing.

I am also grateful to my parents, siblings and friends for their encouragement and support particularly in my absence. Lydia Danku (my sister) and Mr Augustine Apreku! You have been a blessing. God bless you. I am also grateful to Lesley Cushman for editing this thesis.

My special thanks go to the study participants and experts in maternal and child health in Ghana for their contribution to the success of the thesis. Your input is very much appreciated.

To my colleagues at the School of Nursing and School of Public Health of the University of the Western Cape (Dzibodi, Anita, Gladys, Sawan, Ferdinand, Emma, Priscilla, and Kufre): it was helpful meeting you on the journey. I say thank you for walking this important journey with me. I say ‘Bravo to you all for the encouragement!’

DEDICATION

This thesis is dedicated to:

My husband (Beloved Mensah Dzomeku), my children (Mawunyo, Elsie and Daisy) for their support throughout the process.

To my sister Faustine (who passed on the day I was flying to the Western Cape to present my proposal) may your gentle soul find rest with the Lord. To my other sister and brothers Lydia, Courage and Edem for holding the fort especially in those difficult times. Thank you for understanding.

To my parents Mr and Mrs Danku for the encouragement and prayer support.



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LIST OF ACRONYMS

BI	Behavioural Intentions
CS	Customer Satisfaction
DD	Design & Development
ECT	Expectation Confirmation Theory
GSS	Ghana Statistical Service
GMA	Ghana Medical Association
IR	Intervention Research
ICM	International Confederation of Midwives
KD	Knowledge Development
KU	Knowledge Utilization
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NDPC	National Development Planning Commission
RCM	Royal College of Midwives
SBA	Skilled Birth Attendant
SQ	Service Quality
WHO	World Health Organization



CHAPTER ONE

INTRODUCTION

1.0 Background of the Study

Mothers and babies are vulnerable to morbidity and mortality during child-birth. Even though maternal and neonatal mortality are preventable these days, more than 10% of women worldwide still die from child-birth related causes annually while 90% of these challenges are from developing countries (WHO, 2014). According to the National Institute of Population Studies, USA (2008), the leading causes of maternal mortality in developing countries are postpartum haemorrhage (27.2%) and puerperal sepsis (13.7%). Without extra care from health care givers, most of the newly born babies are likely to die from avoidable causes such as hypothermia (cold), hypoglycaemia (low blood sugar) or infections (Pearson, Larsson, Fauveau, & Standley (2007); WHO, 2007). It is estimated that, worldwide, 45% of deaths among children occur in the neonatal period (WHO, 2015; Murray et al., 2007). Of these deaths, approximately 41% occur in sub-Saharan Africa (SSA) (WHO, 2015). These deaths are predominantly caused by infectious diseases from birth, despite the fact that most of these diseases are now preventable and or treatable (WHO, 2015). Pearson, Larsson, Fauveau, & Standley (2007) observe that the health of newly-born babies and their survival is closely linked to the kind of care that the mother receives before, during and after the postnatal period. It is worrying that an increasing number of child mortalities continue to occur in the neonatal period. Liu (2012) reports that world-wide, 40.3% of similar deaths, which is about 3.027 million deaths, still occur in the neonatal period annually as a result of lack of access to health care. Yet, very little attention seems to be adequately paid by care-givers to the nature of services mothers continue to receive during pregnancy, child-birth, and in the postnatal period.

Improving the child-birth care service is therefore still a critical priority for most countries throughout the world, even though important inroads have already been made through local and global initiatives (Lanzo, 2001; Bhutta, Chopra, Axelson, Berman, Boerma, Bryce, . . . Cavagnero, (2010); Liu, 2012). Most of the child-birth complications that eventually lead to maternal and neonatal mortality occur during labour and are unpredictable. For this reason, all child-bearing women are now encouraged to have access to child-birth care from skilled care providers (Pearson et al., 2007; Ekwochi, Ndu, Di, Amadi, Okeke & Obuoha (2015). It is

estimated that about 30 million women become pregnant in Africa each year and of these, it is believed that about 250,000 representing 0.8% die from pregnancy-related causes in Africa. Approximately one-third of nearly one million still-births do occur during labour, while it is believed that approximately 280,000 representing 0.9% babies die of birth asphyxia soon after birth (Pearson et al., 2007; Ekwochi et al., 2015).

Worldwide, complications associated with pregnancy and child-birth represent the major cause of mortality and morbidity among women of child-bearing age, far exceeding other causes of morbidity and mortality like tuberculosis, suicide, sexually transmitted diseases and HIV and AIDS (WHO, 2014). However, despite the fact that most developed countries have made enormous progress in reducing the staggering death rates associated with pregnancy, labour and delivery, many women still continue to face very high risks of death and disability from complications (Ronsmans, Collin and Filippi, 2015; WHO, 2014). Ronsmans and Graham (2006) report, from a series of Lancet studies, that the high risks of women dying as a result of pregnancy or during their life-time is about 1 in 6 in the poorest parts of the world, compared to 1 in 30,000 in Sweden. Lanzo & Al (2001) also report that approximately 10% of women die each year worldwide during pregnancy and shortly after delivery. UNICEF and Partners (2013) estimate that 2.6 million infants die during their first month of birth. This is an unfortunate situation because maternal and neonatal mortality are largely preventable and yet there is lack of early and appropriate care, which constitute a severe violation of the reproductive rights for both women and children (Moyer, Dako-Gyeke and Adanu, 2013).

Notwithstanding the policies that are now in place to reduce the levels of maternal and neonatal mortality, the levels of infant mortality still remain persistently high in developing countries (WHO, 2014). As a response to some development problems to address indicators of health and population wellness, the international world has formulated the Millennium Development Goals (MDGs), which are now referred to as the new targets for the Sustainable Development Goals. These MDGs were set at the 2000 Millennium Summit with the express purpose of accelerating the global progress in development, including health (WHO, 2014). The fourth (of the eight) MDG seeks to reduce the mortality rate among children under the age of five by two thirds, and the fifth MDG seeks to reduce maternal mortality rates by three quarters by 2015. Thus, over the

period 1990-2015, maternal mortality rates have sharply dropped by 45% worldwide (WHO, 2014). However, the worldwide maternal mortality rate (the number of maternal deaths per 100,000 live births) has declined by only 2.6 % annually. This is far away from the annual maternal mortality decline of 5.5 % that was meant to be achieved by MDG-5 (WHO, 2014).

The WHO (2013) reported that Ghana's Maternal Mortality Rate (MMR) has been 524 per 100,000 live births in 2008, which consequently decreased to 350 per 100,000 live births in 2010. However, an increase was later observed in 2014 of 380 per 100,000 live births. It became evident at the end of 2014 that Ghana, and many other developing countries, would not achieve their MDGs 4 and 5 targets. Mensah-Bonsu (2011) found out that Ghana, lacked adequate health care centres, which resulted in most mothers seeking the services of traditional birth attendants. Also, those mothers who decided to use facility-based child-birth services had to travel long distances, on bad roads to access the health services, and this led to more mortalities in emergency conditions (Mensah-Bonsu, 2011). The same author points out poverty, as another factor contributing to maternal mortality, making most mothers unable to pay for their hospital bills and therefore, did not patronize the facility-based child-birth care until the introduction of a User-Free-Exemption policy which was implemented for all pregnant women in 2003. This replaced the cash-and-carry policy for health care (Mensah-Bonsu, 2011).

Another factor that is reported as being responsible for a lot of maternal mortalities in Ghana was the shortage of nursing staff, especially midwives, which has been attributed to "brain drain". The "brain drain" ensued when most nursing and midwifery specialists left the country to seek for better living conditions abroad as from 1998 onwards (Nyonator et al., 2001). The diminishing number of midwives resulted in a corresponding increase in maternal and neonatal mortality in Ghana, a situation which suggests that the presence and availability of midwives is significantly important in the general reduction of maternal mortality.

Further studies equally indicate that there is need for skilled health care at birth, emergency obstetric and new-born care centres (EmOC), together with additional interventions, such as antenatal steroids for pre-term labour. This could avert up to 34% of neonatal deaths. This means that of Africa's 1.16 million new-born deaths, 22.3% could be saved if over 90% of women and

new-born babies receive skilled child-birth care. Skilled birth care in Ghana is provided mostly by midwives. Thus, skilled birth attendance is proposed to be the main priority and key indicator to measure progress towards the achievement of the MDGs 4 and 5 and now the sustainable development goals (WHO, 2014; Records & Wilson, 2013). Skilled care at birth and immediately thereafter, saves the lives of many mothers and babies by preventing countless health complications (Parhurt et al., 2005). One of the reasons contributing to the failure of maternal health strategies to provide skilled care delivery systems is the failure in many countries to understand and address the factors that restrict access to good health care (Mumtaz et al., 2014). The UN Millennium Development Goals Project (2005) reiterates that reducing maternal mortality mostly depends on facility-based health care systems that function well in terms of the provision of prompt and adequate health services to all women.

There are reported barriers to accessing skilled birth services. These are the maltreatment by midwives, poor attitude of health workers towards mothers and poor quality of health care, all potentially preventing most women from seeking child-birth care services in facilities that are manned by skilled birth attendants (Moyer, 2013; Esena and Sappor, 2013; Crissman et al., 2013). Maltreatment of mothers by midwives during child-birth care is known to take various forms as reported by the literature on maternal and child health. Maltreatment includes physical abuse, such as beating the woman while in labour, threatening to beat her or actually slapping her during child-birth (Bowser, 2010). Other forms of maltreatment are non-consented health care, including the absence of informed consent for procedures during child-birth (Bowser, 2010). Mannava (2015) and Onasoga et al. (2012) confirm that the attitude of midwives towards women during child-birth is a major factor influencing women's choice and decision on where to give birth. Women's failure to seek skilled health care for birthing may sometimes lead to maternal mortality because of unforeseen complications that always arise during pregnancy and delivery (Adanu, 2013). Also reported is non-confidential care in the form of lack of privacy in facilities where women deliver and lack of privacy related to delicate client information (Bowser, 2010). The attitude of health care professionals is also known to be a deterrent to the total utilization of health care services by women. The way women are treated during delivery can sometimes drive them away from skilled health care centres where they are supposed to be treated with respect and dignity (Family Care International, 2003).

There are also other forms of poor health worker attitudes that lead to the abandonment of health care by midwives (Center for Reproductive Rights & Federation of Women Lawyers, 2007). There are times when some of the women are left alone during labour and birth as health providers sometimes fail to monitor women and intervene in life-threatening situations during delivery (Bowser, 2010). Additionally, some of the women give birth in health facilities without any assistance from health care givers, while others receive incomplete or rushed birth care treatment (McMahon et al., 2014). All these issues are relevant because they provide evidence that suggests that clients' perceptions of health care providers' attitudes and behaviours give greater influence on the use of skilled maternity care to women than the more widely recognized factors such as accessibility or cost (Moore et al., 2002; Di et al., 2002; Andaleeb, 2001). Whereas accessibility to child-birth services may be a major contributor here to mortality, many studies (Mosadeghrad, 2014; Moyer, Dako-Gyeke & Adanu, 2013; Esena & Sappor, 2014) have shown that accessibility to skilled health care provision is not the only factor influencing women's decisions about their continued use of skilled birth services. Satisfaction with child-birth services in Africa, and Ghana specifically, remain a very important issue. This has not yet been adequately studied (Lanzo et al., 2001; Bhutta et al., 2010; Liu, 2012; Pearson et al., 2007; Ekwochi et al., 2015). WHO (2015) defines quality health care as the extent to which health care services provision to individuals and general populations leads to improved desired health outcomes. In view of this, health care must always be seen to be safe, efficient, effective, timely and people-centred (WHO, 2015).

Due to the treatment women receive from skilled health care facilities in Africa, many women resort to home deliveries without skilled attendants (Okafor, Ugwu & Obi, 2015; McMahon et al., 2014; Bowser & Hill, 2010; Jewkes & Abrahams, 1998). There is increasing evidence now that suggests that disrespect of pregnant and child-bearing women is a deterrent factor to their use of skilled health care facilities, and are a threat to achieving the global strategy of increasing skilled care provision for achieving the MDGs 4 and 5 and now the sustainable development goals (Moyer et al., 2013; Bowser, 2010). A little over 20% of participants in a study in Columbia, on the reasons for not delivering in health care facilities have said that they receive better health care attention at home than in skilled health care facilities (Bajpai, Dholakia and Towle, 2013). These women, therefore, feel that they have no confidence in skilled health care

facilities because of the way they are treated by skilled health personnel (King, 2015). There have been other participants who also reported that there is lack of sympathy and empathy, neglect, rudeness and verbally abusive behaviour, lack of temperamental control, inadequate attention, and lack of privacy in skilled health care centres. These aspects all form barriers to effective use of skilled child-birth care in health facilities (Holmes and Goldstein, 2012). As Doherty (2010) would assert, satisfaction with the type of health services that women receive is important for them to avoid feeling vulnerable at the time they mostly need health care. All those involved in providing health care should be continually improving their standards to ensure a high quality of patient experience (Jamison et al., 2006).

Studies done in Ghana have reported the existence of barriers to the use of maternal health services, with some clients using facility-based delivery care only as a last resort (Banchani and Tenkorang, 2014; Dzomeku, 2011; National Health Policy, 2007). There is a need to study sources of dissatisfaction among child-bearing women, with a view to improving health care services. This is because the improvement of health care services will eventually raise the quality of maternal health care and increase the use of facility-based delivery locally and globally. This will, in turn, reduce the MMR (Moore et al., 2002; Di et al., 2002; Andaleeb, 2001). Thus, enhancement and protection of the human rights for mothers during child-birth is necessary to improve their satisfaction with health care.

It is noteworthy that even when the health system provides adequate and appropriate facilities, workforce, equipment and drugs, quality maternal reproductive health care for new-born, health care may still not be achieved fully as is intended (UN Human Rights Council, 2011). The WHO reiterates that health care interventions which address the management of various complications during child-birth, on their own, are not probably sufficient to reduce maternal and neonatal mortality (D'Souza, 2013). A reduction in maternal mortality was noted only in health care facilities that combined essential interventions with comprehensive emergency health care, which makes an overall improvement in the quality of health care for women (Jamison et al., 2006). Quality health care provision refers to the creation of the most ideal conditions of child-birth, especially in skilled health care centres for clients. This only becomes possible when clients are happy with the care they receive from the skilled care provider. Thus, when health care providers are highly motivated to do their work, it inadvertently results in a reduction in

maternal and neonatal mortality (Jamison et al., 2006). Other studies have observed that lack of motivation by health care providers may lead to apathy and engagement in other parallel income-generating activities for the personal benefit of health care givers (Banchani and Tenkorang, 2014; Sakyi, 2008). Furthermore, education of health-care professionals and the efficient regulation of health care practices are important in creating the health care environment that is positive on client satisfaction by health care providers (D'Souza et al., 2013). It helps to create good partnerships between health care providers and their beneficiary users, all leading to satisfactory health delivery to all clients (WHO, 2013).

Consideration should also be given to factors like infrastructural provision and human resource motivation to the enhancement of quality of health care and achievement of positive child-birth outcomes. It is imperative that attention should be made on the interactions between the midwives and their clients during health care provision (UN Human Rights Council, 2011; Moyer et al., 2013). This interaction between would-be-mothers and the midwives is a strong factor for the creation of mothers' satisfaction and subsequent use of skilled health care facilities. These reported interactions demonstrate that relationships remain one of the most important challenges towards the full achievement of maternal health goals (Yakong, Rush, Basset-Smith, Bottorff, & Robinson, 2010). The relationship between the expectations and actual experiences of clients in a health care encounter can lead to either their satisfaction or dissatisfaction with health care provision. Usually, patients are satisfied when their expectations are met positively during their experiences of health care provision (Levesque, Bogoch, Cooney and Johnston, 2000). Equally true, dissatisfaction may arise when experiences deviate significantly from expectations (Ogunfowokan and Mora, 2012). This is why it is important to provide highly satisfactory child-birth services that afford beneficiaries the best possible quality of life. This line of thinking leads to a patient-centred approach to health care provision (The Health Foundation, 2014).

In patient-centred health care, all health and social care professionals work collaboratively with the people they serve (The College of Family Midwives of Canada, 2009; The Health Foundation, 2014). The benefit of the patient-centred health care approach is to support health care providers to develop their knowledge, skills and confidence in order to effectively manage

services, while making informed decisions about their own health and health care services. It is coordinated and tailored to meet the needs of the individual care giver, as well as work within a framework of health institutions. Crucially, it eventually ensures that beneficiary people are always treated with dignity, compassion and respect (The Health Foundation, 2014). It also ensures that the patients are included in decision-making processes about their health care. It is a dynamic health provision system. This model of care with emphases on patient-centred approach to care is required in child-birth care settings.

This model is normally based on the creation of more harmonious relationships between clients and their service providers. It emphasises mutual respect and honesty of service providers and their clients. This would make child-birth care provision most attractive to many women who will most likely repeatedly utilize skilled birth care (UNFPA, 2014). This principle is enshrined in The White Ribbon Alliance (2011) *Respectful Maternity Care Charter*, which proposes that the notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality, to encompass full respect for women's basic human rights, autonomy, and dignity of women's feelings, choices and preferences.

Studies have emphasized that adopting the patient-centred health care strategy, rather than the 'business as usual' default model requires making fundamental changes on how health care services are provided and rendered, together with the specific roles of, not only those who provide the health care, but even from the patients too. The relationships that are generated by patients and the health care professionals are solid (The Health Foundation, 2014). Despite the challenges that can occur when making this health management shift, the patient-centred care approach does exist in a number of modest but growing number of health care services, often yielding positive outcomes. It only involves effort and being commitment to it (The College of Family Midwives of Canada, 2009; The Health Foundation, 2014). Thus, it is a health imperative to develop an in-service training programme to promote patient-centred care for all midwives in order to increase the chances that clients would receive satisfactory child-birth care services, especially in public health care centres in Kumasi, Ghana.

1.1 Problem Statement

Generally, research on maternal and neonatal mortality has focused on the association between socio-economic status, and levels and patterns of mortality in different populations. In a developing country like Ghana, correlations between mortality and socio-economic factors have been used to generate causal inferences about the mortality determinants (Kanmiki, et al., 2014). Similarly, income and education levels, for example, are two commonly measured correlates. These factors are assumed to be causal determinants in women's access to child-birth care health services (Mosley and Lincoln, 1984). Critical information such as mother's expectations, experiences, and consequent satisfaction with child-birth health care and the potential impact of these on use of skilled child-birth care is often a neglected research field in Ghana. Specific approaches such as the relationship between patient-centred care and the improvement of child-birth care services are evolving areas of health provision research. However, these are broad and general, and what constitutes mothers' satisfaction with child-birth care services remains largely vague and poorly accounted for (Luxford, Safran, & Delbanco, 2011).

The Government of Ghana, especially the Ministry of Health, have implemented several initiatives to increase the facility-based health delivery rate, including making antenatal care and delivery free of charge to patients (Population Council, 2006), and waiving enrolment fees for the National Health Insurance Scheme for pregnant women (GSS, 2009a). However, there is still a majority of pregnant women who deliver at home without skilled attendants during child-birth. This may be the case because the expectations of the pregnant women are not met during facility health care provision. Ockleford (2004) asserts that there are often mismatches between what women expect to receive from their maternity care and the nature of health care service provided.

While over 95% of women in Ghana attend antenatal services for care, supervised delivery is only 42% (Demographic and Health Survey, 2009; Ghana Statistic Service, 2009b). This has meant that most maternal and neonatal deaths occur at home, unattended by skilled health professionals, and more than two-thirds of babies born die in their first week of life. This

happens because there are still a number of impediments to health access and care during child-birth in Ghana. This is one of the main reasons why a more robust, efficient and effective, patient-centred approach to health care is essential.

The American Institute for Healthcare Enhancement (IHE) has a model for the enhancement of accessibility of health care that has been specifically adopted by many African countries in their effort to improve primary health care accessibility and acceptability (Greiner Knebel, 2003). It suggests that three strategies could be used for the general improvement of patient accessibility to health care. These are: making it possible for the system to predict and absorb demand, matching supply and demand and, re-designing the system by making it more efficient. In terms of the process, IHE suggests a “*plan, do, study, act*” cycle for testing change in the work setting by planning it, trying it, observing results and, acting on what is learned. Although it seems that these strategies may also be useful for improving client satisfaction in child-birth care services in Ghana, there is a general paucity and inadequacy of empirical data on how this could be implemented. A high level and analytical approach incorporating both social and medical science methodologies into a coherent programme is clearly needed to improve child-birth health care in Ghana.

A good understanding of client satisfaction with child-birth health care services at all levels is necessary for health care planners to design and prioritize appropriate interventions, particularly in-service training. This can substantially decrease maternal and neonatal morbidity and mortality. This, therefore, was the motivation for this study, to develop an in-service training programme to promote patient-centred care for midwives in order to increase client satisfaction with child-birth care services in public health centres in Kumasi, Ghana.

1.2 Aim of the study

The primary aim of this study was to develop an in-service training programme to up-skill midwives knowledge to deliver health care services that would increase client satisfaction in child-birth care services in public health centres in Kumasi, Ghana.

1.2.1 Objectives

The objectives of this study were:

- To explore the expectations that mothers have of child-birth care services in public health centres.
- To explore the experiences that mothers have with child-birth care services in public health centres.
- To explore and describe the service enhancements that mothers require for satisfactory child-birth care services delivery in public health centres and, to outline areas in which these enhancements are required.
- To develop a patient-centred care in-service training programme to increase patient satisfaction with child-birth care services in public health centres in Kumasi, Ghana.

1.2.2 Research Questions

The current study is guided by the following research questions:

- What expectations do mothers have of child-birth care services in public health centres?
- How do mothers experience child-birth care services in public health centres?
- What enhancement(s) do women require for a satisfactory child-birth care services in public health centres and, in which areas are these enhancement(s) required?
- What patient-centred care in-service training programme need(s) to be in place to increase patient satisfaction with child-birth care services in public health centres in Kumasi, Ghana?

1.3 Layout of the Dissertation

The ensuing chapters of this dissertation are structured to present the significant issues in a rational way. In Chapter Two, the literature review presented in three sections. In the first section, the review covers literature on the association between child-birth care and infant mortality, as well as interventions to improve child-birth care services. In the second section, literature on mothers' experiences with child-birth care is presented. This includes experiences of ill-treatment of patients at child-birth and traditional thinking on child-birth expectations. The third section has a discussion on the literature on theoretical assumptions for the current study.

In Chapter Three the research methodology is presented. This chapter introduces the research design, which is the intervention research design by Rothman and Thomas (1994). The chapter

contains details of the first four phases of the intervention research methodology and how these are applied in the study.

In Chapter Four, the findings and discussions of the first phase of the study are presented. This chapter reports on mothers' expectations, experiences and satisfaction with child-birth care during pregnancy, labour and puerperium (Phase I).

In Chapter Five, an integrative literature review is presented. This is intended to identify evidence-based best practices to the improvement of client satisfaction in child-birth care (Phase II).

In Chapter Six, the design and development of the intervention, which is a patient-centred care in-service training programme for midwives, is presented (Phase III).

In Chapter Seven, an assessment of the feasibility and usability of the in-service training programme is presented (Phase IV).

Chapter Eight contains the summary of the study's findings, conclusions and recommendations



CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

In this chapter is a review of the literature on child-birth care, presented in three sections. In the first section, the review covers literature on the trends in maternal and neonatal mortality, as well as interventions to improve child-birth care services. Also in this section is a discussion on issues that affect patient care such as communication with patients and respect for patients. In the second section, literature on mothers' expectations and experiences with child-birth care is presented. This includes experiences of ill-treatment of patients at child-birth and traditional thinking about child-birth which affects mothers' expectations and experiences with care. The third section presents the theoretical underpinnings of the current study.

2.1 Trends in maternal and neonatal mortality in developed and developing countries

Pregnancy and child-birth are expected to be happy times for parents and families however in some settings it brings with it morbidity and mortality for mothers and neonates. Whereas in the developed countries women could deliver at home and still have access to skilled care which is essential for the survival of mothers and babies, the same cannot be said of developing countries as mobility and mortalities occur mainly as a result of lack of access to skilled birth care (Bartlett, 2005; Kilpatrick, 2002). This makes the health risk associated with pregnancy and child-birth between the developed and developing countries vary greatly (The State of the world's children, 2009). All over the world efforts to reduce maternal mortality rates has been less successful than in other areas of human development; making child-birth the most serious health risk for women in developing countries (The State of the world's children, 2009). Averagely, 1,500 women die daily in sub-Saharan Africa from complications related to pregnancy or child-birth (Bartlett, 2005). Consequently, maternal mortality rate is possibly the major gap between the developed and developing worlds than any other areas of human development. For example, in the developing world, the life-time risk of a woman dying from risks associated with pregnancy and child-birth is more than 300 times greater than for a woman living in a developed country and no other mortality rate has this disparity (The State of the world's children, 2009).

Morbidities are often associated with child-birth in developing countries as millions of mothers who survive the obstetric cycle are left with life-long pregnancy related injuries, infections, diseases and disabilities. Nanda et al. (2005) reports that for every woman who dies from pregnancy or child-birth, an estimated 20 others may suffer pregnancy related illness or experience additional severe complications. It is however evident that 80% of morbidities and mortalities in child-birth could be prevented if mothers have access to essential maternity and basic health-care services (Bartlett et al., 2005 (Kilpatrick & Abott-Chapman, 2002).

With regards to the neonates, the World Health Organization (2004) reports that approximately 40% of deaths among children occur in their early neonatal period, that is the first seven days of their life and that these deaths are also preventable with timely and appropriate care. As in maternal mortality rates, 98% of neonatal mortalities occur in developing countries (Lawn et al., 2005; WHO, 2004). The gap in neonatal morbidity and mortality between the developed and developing world is also very great as the WHO report again that a child in the developing country has 14 times the risk of death than one in a developed country and that these deaths occur within the first 28 days of their life's (WHO, 2004). According to the WHO (2004) about 40% of neonatal deaths could be avoided with skilled care at birth as most of the babies die within their first 24 hours of life (Lawn et al., 2005). There is evidence that suggests an association between child-birth care and infant mortality. A more recent report by the WHO (2014) still reiterate that a child is in greater danger of dying in the neonatal period than in the childhood period and that safe child-birth and effective neonatal care are essential to prevent these deaths. Sharan (2004) and Haines, Sanders, Lehmann & Al (2007) observed that most mothers in sub-Saharan Africa experience poor access to adequate healthcare. It is estimated that 41% to 72% of new-born deaths can be avoided through adequate health care interventions (Haines et al., 2007).

Creating an environment that enhances the health of mothers and neonates and makes pregnancy and child-birth safer is essential (The State of the world's children, 2009). The health of mothers and newborns are complexly related and preventing mortalities need the same interventions to be applied for both mother and newborns (Bartlett, 2005). This is because reducing the mother's risk of mortality and morbidity directly improves the child's chances of survival. Furthermore,

complications the mother suffers during labour increases the risk of neonatal death (Bartlett, 2005). Hence, providing for a safe child-birth depends on the care and attention given to mothers and newborns, which include the availability of adequate health care facilities, equipment, medicines and emergency obstetric care when needed and skilled health personnel (The State of the world's children, 2009). For these interventions to be effective, they must be grounded within a framework that works at strengthening and integrating health systems with women's rights. A human rights approach to child-birth care will ensure that care is patient-centred (Miltner, Lambermon, Hamelink, & Meguid, 2016).

Similarly, Ghana recorded high maternal and neonatal mortality rates and 43% of all child-births have been noted to occur at home (Ghana Statistical Service, 2009). These babies who are delivered at home may have a greater risk of being exposed to unhealthy care practices, compared to babies delivered in health care facilities. This has made child-birth care inaccessible and available to mothers at the times they need them most. This situation calls for the existence of a sound understanding of child-birth care services at both household level as well as at health care planners level, where it is necessary to design and prioritize appropriate health services interventions that is accessible and affordable to mothers, in order to substantially improve mothers' child-birth experiences and satisfaction with child-birth care.

Accessibility of child-birth care services is affected by; the availability of human and material resources and the affordability of the health services. Affordability involves calculation of the cost of health care services while acceptability of health care services refers to staff's interpersonal skills to render agreed services, including building trust between the service provider and the services recipients. Where the users do not trust the health care providers, they are normally reluctant to continue to use their health care services (Bart et al., 2011; Piferffer and Mwaipopo, 2013; Mannava et al., 2015). The attitudes and behaviour of health care providers tends to affect the patients' trust of their health care services providers and, consequently, their own satisfaction or otherwise with those health care services. This, in turn, ultimately affects their health-seeking behaviour (Mannava, Durrant, Fisher, Chersich, & Luchters, 2015). Therefore this study seeks to explore the expectations and experiences of mothers about child-

birth care and to determine what constitute satisfaction with care among mothers. This will then serve as a basis for providing patient-centred care services to mothers during child-birth care.

2.2 Interventions to improve maternal and child-birth care services

A number of intervention programs have been designed, piloted and demonstrated in developing countries to improve child-birth care. In a bid to reduce infant and maternal mortality and morbidity and to enhance the quality of child-birth health care services, the '*continuum of care*' has become a rallying call for Ghana and many other countries in order to decrease the annual maternal deaths that are in the region by half a million, four million neonatal deaths and six million maternal deaths (De Graft-Johnson, Kerber & Tinker 2006; WHO 2005). Key government health care interventions that were put in place included human resources capacity development for maternal health services as well as measures to improve communication with patients and respect for patients.

2.2.1 The Continuum of health care

Continuum of health care is a concept encompassing a health care system that guides and monitors patients over a long period of time using a wide-range of health care services covering all levels and intensity of care. The continuum of care covers a set of strategic principles of health care that are based on experiences from health care systems and delivery over a period. The continuum of health care assesses delivery of health care services over a period of time from birth to the end of life (Kerber, 2007). The continuum of health care assesses the quality of care patients receive in the facilities and has recently been highlighted as a core principle of programmes for maternal, new-born, and child-birth services that is aimed at reducing maternal and neonatal mortality (Tinker, Hoope-Bender, Azfar et al., 2005). Within the continuum, all women are expected to have access to reproductive health choices and care during pregnancy and child-birth so that all babies can be expected to grow, thrive and survive well (Kerber, 2007). The continuum of health care is the basis of all health care in many developed countries, where government –funds all health care systems which enjoy near-universal coverage of health care (Save the Children, 2006; Padmanathan, 2003). In many low-income countries, which have shortages in human and financial resources and therefore, have inadequate health care system infrastructure. In this case health care is neither continuous nor integrated, although some countries, like Sri Lanka, have managed to decrease maternal, neonatal, and child-birth mortality

by bringing all health care closer to individual families. An effective continuum is especially important for maternal survival, since timely linkages to referral-level obstetric health care is necessary for the decrease of maternal and neonatal mortality. Monitoring implementation of the continuum of health care for mothers, neonates and children is carefully tracked in order to see whether the performance of health care systems is what it is supposed to be, since a functional continuum depends on public health planning and strengthening of health care systems. The continuum of health care for mothers, neonates and children therefore provides a meaningful framework whereby single evidence-based interventions can be combined and conveyed in packages in accordance with local needs and capacity (Save the Children, 2006; Padmanathan, 2003).

Countries ranked as the ten best for maternal health have all successfully implemented a functional continuum of care for maternal and child health (Sines, Tinker and Ruben, 2006). In the United States of America the continuum of care has been successfully implemented. These include actions to improve the health of women and children that are integrated and delivered in convenient, cost-effective packages to communities and families (Sines, Tinker and Ruben, 2006; WHO. World Health Report, 2005). Integrating different models of care, strengthening health systems to improve health outcomes for mothers and children among others. The continuum of care is considered useful in Africa as it is capable of helping to reduce maternal and neonatal mortality rates (de Graft-Johnson et al., 2005). The continuum of care has two approaches which aim at bridging the gap in care around the time of birth when the risk of death is highest for the mother and baby and bridging the gap in care at the place where it is most needed (de Graft-Johnson et al 2005). This approach has successfully been used in the USA by connecting essential maternal, new-born and child health packages throughout adolescence, pregnancy and child-birth. Also by providing skilled care at birth and immediately after which has helped to reduce the risk of death for mothers and babies. To bridge the gap in care at the place where it is needed by strengthening the links between the clients and the health facilities (de Graft-Johnson et al., 2005; Sines, Tinker and Ruben, 2006). This is considered to be useful in Africa where most of the maternal and neonatal mortalities occur around the time of birth. In Africa, effort has been made to enhance primary health care, emergency health services, reproductive health care among others in the bid to improve health care. There is however the

need to improve the skills of health workers and strengthen health system supports to improve the quality of care provision and to successfully apply the continuum of care approach to improve care (Sines, Tinker and Ruben, 2006; WHO. World Health Report, 2005).

2.2.2 Capacity development of human resources for maternal and child-birth care services

Several approaches have been made to reduce maternal and infant mortality in Africa by enhancing accessibility to primary health care, emergency health services, reproductive health care and family planning (Murphy, Goma, Mackenzie et al., 2014). The greatest challenge to the realisation of all these objectives was the availability and equitable deployment of adequate numbers of trained human resources in order to realize health accessibility for all since Africa has a history of human resource crises (WHO, 2005). This resource mobilization must benefit women in child-birth challenges. It is a fact that thirty-six countries on the continent have less than the WHO's minimum recommended number of human resources in order for them to provide basic and adequate health care services. Health personnel in Africa is mostly inappropriately distributed in these countries, with the majority of them being found working in urban areas. Thus, on average, less than one doctor, nurse and midwife per 1,000 populations is allocated per region to deal with all health issues (Joint Learning Initiatives, 2004). Consequently, it is estimated that one million additional health personnel is required in Africa in order to meet the minimum recommended number of 2.3 doctors, nurses and midwives per 1,000 people of the populations (Joint Learning Initiatives, 2004). Efforts have been made over the years, with assistance from the WHO regional Committee for Africa, to expand the continent's health workforce which has led to an increase in the human resource number between 2005 and 2010. All of these efforts require stakeholder consultations in the designing, implementation and evaluation of health care policies in order to ensure that skilled human resource planning in health care and health care systems reforms become responsive to contextual factors in different countries (Murphy, et al., 2014).

In Nigeria, there has been a comprehensive health care policy which was adopted as a way to strengthen its commitment to improve the health care system as the first level of referral. Midwives were trained in life saving health skills, especially in emergency obstetric conditions.

This has resulted in reductions in maternal and infant mortality (Kwast, 1996). At the same time, South Africa has initiated two strategies for the deployment, recruitment and retention of skilled manpower in less developed areas of South Africa. In 2004 South Africa used the Rural Allowance Policy to address critical mal-distribution of skilled staff. This policy made health care by skilled manpower much more accessible in rural areas of South Africa. The second strategy that South Africa used was the implementation of the Occupation-Specific Dispensation Incentive Strategy in 2007, a financial incentive scheme with the aim of retaining nurses/midwives in the public sector in rural health care facilities. This policy did not achieve its intended goals because of the preconditions that were not met (Ditlopo, Blaauw, Rispel, Thomas, & Bidwell, 2013; Lagarde, Blaauw and Cairns, 2012).

Malawi had a different experience to the South African situation. It committed itself to dual-focused health care policies in order to capacitate skilled human resources in health care provision, and thereby reducing maternal and infant mortality. Its Emergency Human Resources Program lent essential support to health care provision package, including the five main facets of: salary top-up, developing domestic training capacity, using international volunteer human resource as a stop-gap measure and improving monitoring and evaluation of health care provision (Palmer, 2006). These health improvement strategies in Malawi were almost similar to Zambia's approach to addressing skilled human resource shortages (Gow, George, Mutinta, Mwamba and Ingombe, 2011; Gow, George, Mwamba, Ingombe and Mutinta, 2012). These health policy experiences can be compared to the Ghanaian health situation.

In Ghana, a health worker retention strategy has been put into place as government human resource policy for obstetrics and gynaecology specialists. This led to the training of high calibre health staff between 1989 and 2006, a situation that has resulted in a reduction in maternal and infant mortality rates (Klufio, 2003). Other issues that affect health care provision is communication with patients and respect for patients within the health care system.

2.3 Communication with patients

Communicating with patients is critical to the success of patient-centred health care. Health care professionals are expected to communicate well and share complete and unbiased information

with patients and their families in ways that are affirming and useful (Institute for Patient-and Family-Centered Care, 2008). If communication during the health care process is effective, patients receive timely, complete and accurate information, which enhances their care and recovery (Blanchard, 2010). However, communication problems sometimes arise during the caring process. This is sometimes associated with poor health literacy on the part of the patient and the difficulty of communicating unpleasant information on the part of the health care providers (The Health Foundation, 2014). This notwithstanding, communication is very important to clients while they receive care.

Melese, Gebrehiwo, Bisetegna, & Habte (2014) in assessing client satisfaction in labour and delivery services at a maternity referral hospital in Ethiopia found out that provider communication with clients had the highest satisfaction ratings whereas inadequate communication about procedures were found to be sources of dissatisfaction. In conclusion they point to the need for provider communication and involvement of their clients during care provision. Similarly, in a study on attitudes and behaviours of maternity health care providers in interactions with clients, Mannava, (2015) identified poor communication as a factor negatively affecting care provision and client satisfaction. The authors suggested strengthening health systems to include communication and counselling skills for health workers to improve child-birth care. These studies point to the fact that there is much more to be done to improve communication between providers and clients to improve satisfaction with care provision.

2.4 Respect for patients

Respect for the patient is essential in patient-centred health care and health care practitioners are expected to listen to their patients and honour patients' perspectives about their health care (The Health Foundation, 2014; Blanchard, 2010). There are several aspects of patients' respect that health practitioners are expected to be mindful of.

2.4.1 Depersonalizing patients

During the process of health care, the capacity of health care professionals to respond to patients as individuals is at risk. For the midwives, there is a daily natural struggle concerning their ability to cope with different mothers who are in suffering or in pain, and are always tested for

their ability to remain sensitive to all these demands as individual people. The natural human defence mechanism in them when they are in such situations is to depersonalize people in distress, so that they can continue to cope as health care professionals (The Health Foundation, 2014). Further to this, Morad & Parry-Smith (2013) assert that most midwives dealing with emotionally difficult situations may employ different psychological defences in order to preserve their own identity. This creates health practices that tend to protect health care professionals rather than the patients. However, from the patient's perspective, the defensive behaviour of health care providers simply mean that the health providers see themselves as profoundly important, and personal issues are transformed into matters of routine, while patients become members of "this group of patients," or "this type of problem" (The Health Foundation, 2014). In this kind of situation, health care professionals need to depersonalize. Even though depersonalization is most commonly found in settings where patients are chronically ill, it means that all health care settings have the potential to depersonalize patients (Goodrich et al., 2009). This situation can result in continuous tension between mothers and the self-asserting midwives who distance themselves more and more from their clients in a variety of ways (Aranda and Jones, 2010). This leads to failure to involve mothers in health care decision-making and make health care providers maintain eye contact during conversations and examination of patients (Morad et al., 2013). This situation results in compromising mothers' dignity and their human rights and is not ideal for the effective provision of health care.

2.4.2 Informed consent

Normally, in order to engage patients in the decision-making processes, midwives need information about how people make decisions and the kind of influences that affect decision-making processes. According to the Ontario Medical Association (2010), midwives must obtain the patient's informed consent for treatment that is given voluntarily and is not obtained through misrepresentation or other fraudulent ways. Such treatment is said to be informed if the patient receives all the information about the nature of treatment, the expected benefits, the material risks and side-effects, alternative options, and the likely consequences of not having the treatment (Wanzer, Booth-Butterfield and Gruber, 2004). Moreover, the patient must receive responses to his or her requests for additional information about these health care matters. This is how mothers normally perceive health care. Their perceptions of the quality of health care they

receive is highly dependent on their interactions with their health care providers, which gives them a good understanding of their health care needs and participation in the whole health care processes (Wanzer, Booth-Butterfield and Gruber, 2004; Clark, 2003; Bowers, 2002). In this regard, lack of attention and involvement and any perceived unkind discourse is seen as leading to their dissatisfaction with health care delivery (Eghdampour et al., 2013).

Patient-centred health care has numerous benefits to patients as it leads to the patient's satisfaction with health care approaches and can produce a positive effect on the health care outcome. An evaluation of the relationship between patient-centred health care and the cost to it while in a hospital situation shows that hospital units that were more patient-centred have statistically and significantly better health care outcomes than those that were less patient-centred (Behhel, Myers and Smith (2000). This means that addressing patients' expectations about their health care needs affects their satisfaction with it (Rao, Weinberger and Kroenke (2009). In addition, meeting patients' expectations improves other symptoms leading the control of their diseases (Behhel, Myers and Smith, 2000).

2.5 Mothers' expectations and experiences with child-birth care

This section highlights the expectations and experiences mothers have with child-birth care and how these affect their overall satisfaction with care. It also shows the traditional thinking on child-birth expectations and how this affects the individual mother's satisfaction with child-birth care.

2.5.1 Mothers' expectations of child-birth care

During pregnancy, women develop thoughts about their child-birth which then informs their expectations of their child-birth and even how they respond in child-birth (Gibbins and Thomson, 2001). Therefore it is important to explore women's expectations in child-birth so as to help women develop realistic expectations of child-birth. Exploring women's expectations about child-birth is also important in identifying gaps in child-birth care so as to improve care during child-birth (Green and Renfrew, 2000). Every woman has expectations of child-birth which differs from woman to woman. These expectations according to Gibbins and Thomas (2001) also differs in how realistic they are. In a phenomenological study of women in England,

Gibbins and Thomas (2001) report that for some participants their expectations were of how they could manage the pain of labour, others were with complications of labour and for yet other participants, their expectations were with their own health and that of their babies. Other researchers have also reported women's expectations of loss of control and support during child-birth (Green and Renfrew, 2000). Green and Renfrew (2000) report that for many women, these expectations could lead to fear and anxiety about the unknown.

Similarly, Zhang and Lu (2014) conducted a study on child-birth expectations of women in their final stage of pregnancy while in their transition stage to parenthood. Five factors were identified by the expectant mothers regarding child-birth expectations, which ultimately affected their satisfaction with whole health care provision: the care-giving environment, spousal support, control and participation in the child-birth process, labour pains and general medical health support. The results suggest that it is of great value for maternal health professionals to create a safe and comfortable health care environment for all expectant mothers, in order to create a more satisfactory child-birth experience for women. This is also supported by Royal College of Midwives (2012), who hold that child-birth care must take place in an environment that promotes the woman's human rights. Studies have shown that expectation of child-birth are not exactly what women experiences in child-birth. For example, women may either experience more pain or less pain during child-birth than they actually expected, which makes experiences not exactly what women expect about their child-birth (Gibbins and Thomson, 2001). What all these previous studies have observed is vital for this study because expectations affect the perception of the experiences mothers will have in child-birth and experiences subsequently determine satisfaction with child-birth care. Expectations also helps women to make coping strategies ahead of their experiences, which is useful during child-birth (Gibbins and Thomas, 2001).

2.5.2 Mothers' experiences of disrespectful child-birth care

Mothers world-wide have different experiences of health care services during pregnancy and child-birth. A study in the US by Soet, Brack and Dilorio (2003) has shown the prevalence and predictors of women's experiences of psychological trauma during child-birth and here report that 34% of participants experienced traumatic birth. A further analysis of their results by

regression analysis showed other factors such as event characteristics in first stage of labour such as feeling of powerlessness, expectations and interaction with medical personnel as significant predictors of perceptions of the child-birth as traumatic. There are also reports that good experiences during child-birth have many implications for a woman's future well-being. The whole idea is to see all women getting the best health care services that can safe-guard their life experiences. This can only happen when health care delivery is patient-centred.

Health provider attitude has long been reported as a strong determinant of patient satisfaction, more so than the technical skills of providers (Turkson, 2009). McMahon et al. (2014) did a qualitative study of women's experiences of disrespectful maternity health care and abuse during child-birth in the Morogoro Region of Tanzania. They reported that women experienced various forms of abuse such as verbal and physical abuse, as well as feeling ignored and neglected. The authors reported that as a response to these forms of abuse, participants preferred to deliver at home or under traditional child-birth attendants, in order to avoid unpleasant experiences in the public health care facilities. The findings are supported by a qualitative study on health care users' and providers' accounts of the poor quality child-birth care by Mselle (2013). In this study the author reported that participants had unpleasant experiences for which reason women in the study settings preferred home births unattended by skilled birth attendants. In conclusion, the author encourages making facility birth a safer alternative to home birth by paying attention to the interaction between the midwife and her clients. McMahon, George, Chebet, Mosha, Mpenbeni & Winch (2014) further reiterate that women in labour lack essential support and end up experiencing unpleasant health care situations such as neglect, physical and verbal abuse. For these reasons, most women end up preferring to deliver at home. This background information will be vital to use in the study to assess women's expectation, experiences and satisfaction with available child-birth care provision in Ghana.

Abusive situations, such as medical treatment without informed consent, omission of information, over-riding one's refusal of treatment or misrepresentation of medical situations all require interventions to address them (Goldberg, 2009). Hodges (2009) explains that the issue of abuse in facility-based health care delivery is a systemic problem that is facilitated by lack of responsibility and a situation where care providers are not liable for the wrongs they commit. This has implications when considering the establishment of a satisfactory child-birth care delivery to clients. The health care of mothers and their babies will continue to suffer such

abuses, thereby preventing most women from accessing facility-based health care in the future if attention is paid to the process of care provision. This is the aim of this study's investigation.

In Ghana and most developing countries, it is generally known that pregnancy and child-birth are critical times for families, as they worry so much about the health and well-being of woman and their babies (WHO, 2013). Health care providers would want to avoid complications at child-birth, like haemorrhaging, sepsis, hypertensive disorders, unsafe abortion and prolonged or obstructed labour. All these are some of the leading causes of maternal mortality during labour. These consequently result in uncertainties among mothers and their families concerning the outcome of their pregnancy and child-birth. The uncertainties are as a result of high MMR in the country, where morbidity and mortality do not only concern expectant mothers and their newly-born babies, but also the whole family (WHO, 2013). There is need to investigate what mothers in Ghana expect and experience during child-birth care.

Oweis & Abushaikha (2004), from a study about Jordanian pregnant women's expectations in their first child-birth experiences, point out that women have had detailed experiences about their child-birth services and the roles of their support persons and health care personnel. This gives them an idea of the quality of medical interventions they received. They argue that health care providers should put more emphasis on child-birth preparations of mothers about the realities of labour in order to improve health care provision. Using a qualitative phenomenological approach Gibbins and Thomson (2001) found from their study in England that women's choices, expectations and experiences of child-birth care are important in their satisfaction to their care. When women take an active part in their labour they feel that they are 'in control' as an essential component of their child-birth experience. This is why Oweis and Abushaikha (2004) believe that women hold both positive and negative expectations of their child-birth experiences in the labour process. In a systematic review about labour pains and women's satisfaction with their experiences of child-birth care services. Similarly, Hodnett (2002) asserts that, pregnant women usually anticipate very painful labour processes. These are the desires that women have of child-birth care provision and satisfaction with care, these may be useful in exploring the Ghanaian women's expectations and experiences with child-birth care.

2.5.3 Traditional thinking about child-birth

Different communities have different ways of perceiving child-birth experiences and what the experiences generally mean to women. Kartchner and Callister (2003); Ip, Chein, & Chan (2003); Lu, (2012) note that child-birth expectations and perceptions among the Chinese is greatly influenced by family interaction. Chinese people value strong and cohesive bonds between family members during child-birth (Kartchner and Callister, 2003; Lu et al., 2012). They have different expectations of medical interventions in child-birth health care than women from other countries. Zhang and Lu (2014) suggest that Chinese women tend to fit into today's medical health care model in developed countries, a model that has many medical interventions in child-birth health care, while the Scottish women want a different model they see as 'natural' child-birth that conveys a sense of control and freedom from any medical interventions by the women. Ip, Chein, & Chan (2003) report that Chinese primiparas rely, ultimately, on medical interventions in facility-based institutions, rather than traditionally independent health care approaches. This explains the role of cultural influences in child-birth expectations among women and the medical choice that makes them happy to use.

For Ghana, there are no studies that have been done about the traditional expectations of child-birth experiences by child bearing women. However, Fischer (2000) talks about how personal and traditional beliefs that can affect women's satisfaction in child-birth care. His view is that most Ghanaian women are, without doubt, attracted to the traditional or even religious, health care services and are often said to be ignorant about their other medical help options. Thus this study investigates the experiences and expectations of Ghanaian women in child-birth care provision to determine their satisfaction with care.

In conclusion, the literature shows that the development in maternal and neonatal mortality rate is great and that the developing countries still have much to do to make pregnancy and child-birth safer for women. It also points to the fact that maternal and neonatal mortality rates remains the greatest divide between developed and developing countries than for any other health indicator. Further, the evidence also points out that efforts are made in various countries through interventions that improve maternal and neonatal care, however, there still need to be additional interventions particularly with patient-centred care approach to care. Mothers still experience disrespectful care during facility-based care which makes them prefer non-skilled child-birth

care to skilled child-birth care. A patient-centred approach to care would improve the experiences mothers have in child-birth leading to client satisfaction with care and facility use.

2.6 Theoretical frameworks

The preceding literature indicates that patient satisfaction is the end result of the interplay between women's expectations about their child-birth care and their actual experiences of it. As previously stated, mothers with positive expectations at the start of child-birth care might become dissatisfied if their expectations are not met. On the other hand, mothers with negative expectations, and a positive experience with child-birth health care leaves women much more satisfied with health care provision they receive (Bleich, Özaltın & Murray, 2007). This study draws on the *Expectation confirmation theory* and *Customer satisfaction theory* because of their link with client satisfaction with health care processes. In the next sections these two theories are discussed in turn.

2.6.1 Expectation confirmation theory

The Expectation Confirmation Theory (ECT), posits that satisfaction is determined by the interplay between prior client expectations and perceptions about service delivery (Jiang and Klein, 2009). It further states that, prior to any event, the individual has an expectation of what must happen and how it will happen. If that expectation is met positively, then the individual is satisfied. If that expectation is met negatively, then the individual becomes dissatisfied (Jiang and Klein, 2009). Based on this theory, mothers will return to use basic facility-based health care if they were satisfied with child-birth health care provided in a previous encounter.

2.6.2 Customer Satisfaction Theory

Customer Satisfaction Theory asserts that there exists a relationship between quality of service and customer satisfaction and behavioural intentions (Choy, Lam and Lee, 2012). Quality service refers to the overall delivery of outstanding service to customers in a way that satisfies the customer (Chakrabarty et al., 2007). According to Newman (2001), quality service is the gap between client expectations and perceptions and the actual service delivered. *Customer satisfaction* therefore, refers to the gratification of a customer's feelings after receiving a certain service. All customer judgements or evaluation are usually based on their prior expectations and

perceptions. *Behavioural intention* refers to the decisions that the customer makes about use of a certain service following her evaluation of the service received. According to these authors quality service leads to customer satisfaction and, consequently, better behavioural intentions for facility-based use or non-facility-based use for child-birth health care services.

The premise of the current study is as follows: that the relationship between mothers' expectations of their child-birth health care experiences and their actual child-birth health care experiences leads to either their satisfaction or their dissatisfaction with child-birth health care services. Therefore, the first underlying assumption of the study is that if mothers are satisfied with the quality of child-birth health care services, they are more likely to re-use facility-based child-birth health care services again in future and, or may also recommend its use to others. The second assumption follows from the first, and is that if the quality of child-birth health care service does not meet mothers' satisfaction, then, they might not re-use facility-based child-birth health care services again in the future and, might not recommend their use to others.

In Figure 2.1, the theoretical framework for child-birth health care services is presented. It illustrates that mothers' values inform their expectations about child-birth health care provision and that those expectations about child-birth health care provisions also reflect their own values. Mothers' expectations of child-birth health care services further influence the nature of their experiences of child-birth health care, which in turn leads to their satisfaction if expectations are met, or dissatisfaction if their expectations are not met. Further, whether the client is satisfied or dissatisfied will also influence their decisions about whether they can use facility-based health care services in the future. A satisfied health care client is most likely to continue to use facility-based child-birth health care services. At a facility-based health care unit, a client receives skilled child-birth health care services that contribute towards the reduction of maternal and neonatal mortality rates. On the other hand, a dissatisfied mother is likely not to use facility-based child-birth health care services again in the future. In the latter case, she will most likely receive unskilled child-birth health care, and this might contribute to higher maternal and neonatal mortality rates.

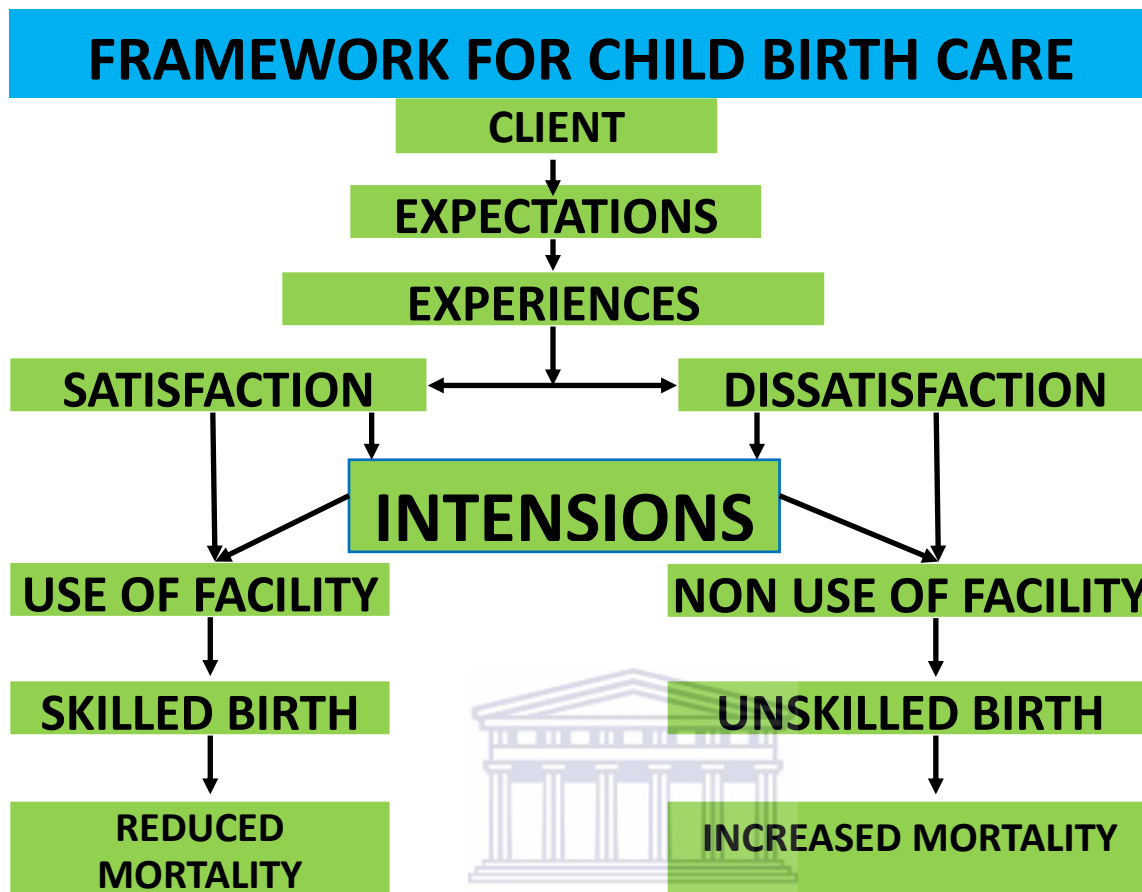


Figure 2.1 A Framework for child-birth care services

2.7 Chapter Summary

The literature review in this chapter has established that an association exists between child-birth health care service and national and international maternal and infant mortality rates, and that an improved child-birth health care service is likely to lead to some reduction in maternal and infant mortality rates. Intervention programmes by health care providers may be put in place to improve service provision and this may reduce maternal and neonatal mortality rates, particularly in developing countries where the maternal mortality rates are still considered high. It has also been noted that child-birth health care provision in developing countries is faced with many challenges with human and material resources and their distribution across any country. It has also been noted that skilled child-birth health care provision faces challenges of interpersonal relationships between patients and their health care providers which often leads to patient dissatisfaction with health care services. There is, therefore, great need for interventions that can

address the relationships between the skilled health care providers and their clients in order to increase clients' satisfaction with child-birth health care provision and, further reduce national and international maternal and neonatal mortality rates.

In the next chapter, the methodology for the study is discussed.



CHAPTER THREE

METHODOLOGY

3.0 Introduction

The intervention research framework by Rothman and Thomas (1994) was used to guide and conduct the study. This chapter provides detailed information on the activities undertaken in the study, in line with the selected research framework, the phases of the study and ethics considerations that guided the implementation of the study.

3.1 Study settings

Ghana has ten administrative regions, each with a regional capital. The Ashanti region is one of these administrative regions and its capital is Kumasi (see Figure 3.1). There are 530 health care facilities in this region; of which 325 are public health institutions. The Kumasi metropolis has 20 public health care facilities that provide child-birth health care services. Four of these facilities were chosen for the current study.

The first health care facility was established in 1997 to provide basic health care services to the people of the community and its environs. The facility is headed by a Physician's Assistant.¹ The facility provides general out-patient services, and reproductive and child-birth care services, which include family planning, antenatal care, delivery and postnatal care. The health care facility has the following health care professionals: 1 Physician's Assistant, 15 general nurses, 4 community health care nurses and 4 midwives. The facility has a bed complement of 12.

The second health care facility was established in 1994 to provide basic health care services to the people of the community and its environs. The community is located near the Kwame Nkrumah University of Science and Technology (KNUST), Kumasi. The health care centre is currently headed by a midwife. The health care centre also provides general out-patient services and, reproductive and child-birth health care services which include family planning, antenatal care, delivery and postnatal care. The health centre has the following health care professionals: 2 midwives, 5 general nurses and 7 community health care nurses. The facility has a bed capacity of 4.

¹ *Physician's Assistants are nurses who have had additional education and are permitted to prescribe. They assist physicians in their duties.*

The third health facility was established in 1980 to provide basic health care services to the people in the community and its environs. The hospital is currently upgraded to the status of a regional hospital and is headed by a Medical Director. This regional hospital provides the following services: general out-patient health care, reproductive and child-birth health care services which include family planning, antenatal care, delivery and postnatal health care, HIV Testing and Counselling (HTC), Prevention of Mother-To-Child Transmission of HIV (PMTCT), sickle cell screening for infants, in-patient services, Child Welfare Clinics (CWC), laboratory services, dental services, eye care services, anti-retroviral therapy, physiotherapy, tuberculosis screening and treatment, a Mother-Baby Unit (MBU) and a herbal clinic. The hospital has the following health professionals: 19 medical officers, 14 physician's assistants, 51 midwives and 93 nurses. It has a bed complement of 50.

The fourth health facility is a teaching hospital that was established in 1954 as a referral point hospital for all district health care centres in the Ashanti region and its surrounding regions. It is the second-largest teaching hospital in Ghana. Currently it receives referral cases from the Ashanti region, the Brong Ahafo region, the Western region and the three Northern regions. It is headed by a Chief Executive Officer. It provides the following services: general out-patient health care, reproductive and child health services which include family planning, antenatal care, delivery and postnatal care, HIV Testing and Counselling (HTC), prevention of mother-to-child transmission of HIV (PMTCT), sickle cell screening for infants, in-patient services, child welfare clinics (CWC), laboratory services, dental services, eye care services, anti-retroviral therapy, physiotherapy, tuberculosis screening and treatment, a mother-baby unit (MBU), orthopaedic services, a burns unit, and many other services. Its child-birth health care Directorate has the following health professionals: 20 Obstetrics and Gynaecology consultants and specialists, 30 medical officers, 62 midwives and 103 nurses. It has a bed complement of 1100.

The four health care facilities in Ghana were chosen because they are within the metropolis and the choice was based on their key characteristics in terms of health care delivery systems. The teaching hospital was particularly chosen because it is the only health care teaching hospital within the Ashanti region. One teaching hospital was chosen because it is the Ashanti regional hospital in addition to two clinics because of their rural setting, which offers a comparison of health care provision between urban and rural settings.

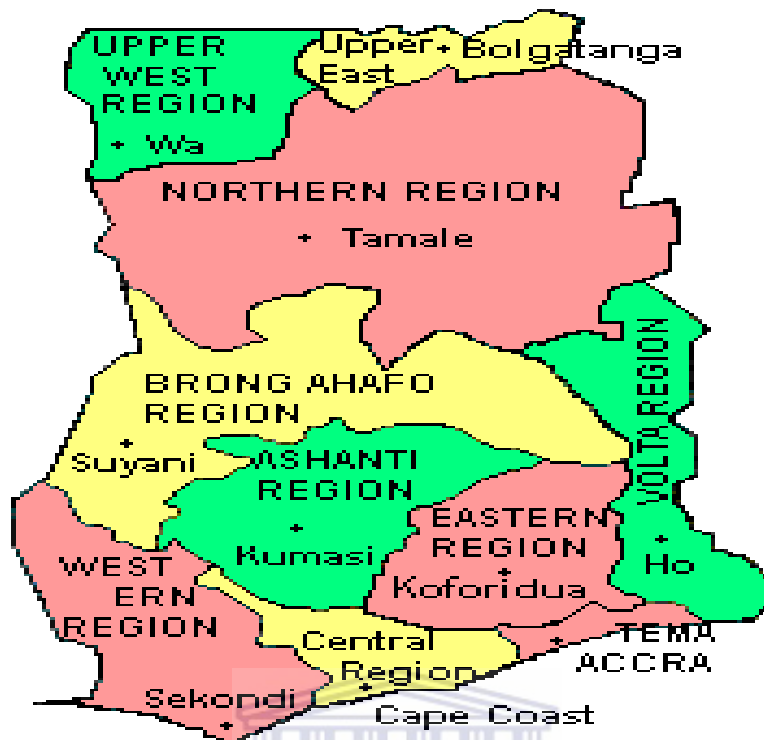


Figure 3.1 Map of Ghana showing the ten Administrative Regions

3.2 Methodological Framework: Intervention Research

The purpose of intervention research is to conduct research that will yield “results that can be put to practical use by practitioners, administrators and policy makers” (Rothman & Thomas, 1994: 3). This selected methodological framework was considered suitable to meet the aim and objectives of the current study, which was to develop an in-service training programme to promote patient-centred care for midwives that would increase client satisfaction with child-birth health care provision.

This framework for intervention research utilizes three integrated components, also referred to as facets of intervention research namely: Knowledge Development, Knowledge Utilization and Design and Development as shown in Figure 3.1. These three components can also be used independently. In this study, the Design and Development component was used. The Design and Development method is a problem-solving process for seeking effective interventions and tools to deal with given human and social difficulties (Rothman & Thomas, 1994). Design and Development research has many different approaches to it that seek to construct a systematic

methodology for evolving human service interventions (Rothman & Thomas 1994). For example, it offers steps of interconnected activities that are intended to guide researchers and practitioners to develop innovative interventions for effecting change in problematic situations relating to human interactive services. It has its own objectives, methods and results and can be used as an independent research method (Rothman & Thomas, 1994). The outcome of the Design and Development research could be the assessment and intervention methods, service programs and policies. Design and Development is the research approach that is used in this current study because it is a process that is systematic, deliberate, and immersed in research procedures while focusing primarily on developing an intervention. This makes Rothman & Thomas (1994: 12) to refer to Design and Development as having “a mission-oriented, problem-solving cast”. Additionally, the Design and Development research approach has inter-connected activities and phases which serve as a guide to the development of an in-service training programme to promote patient-centred care for midwives.

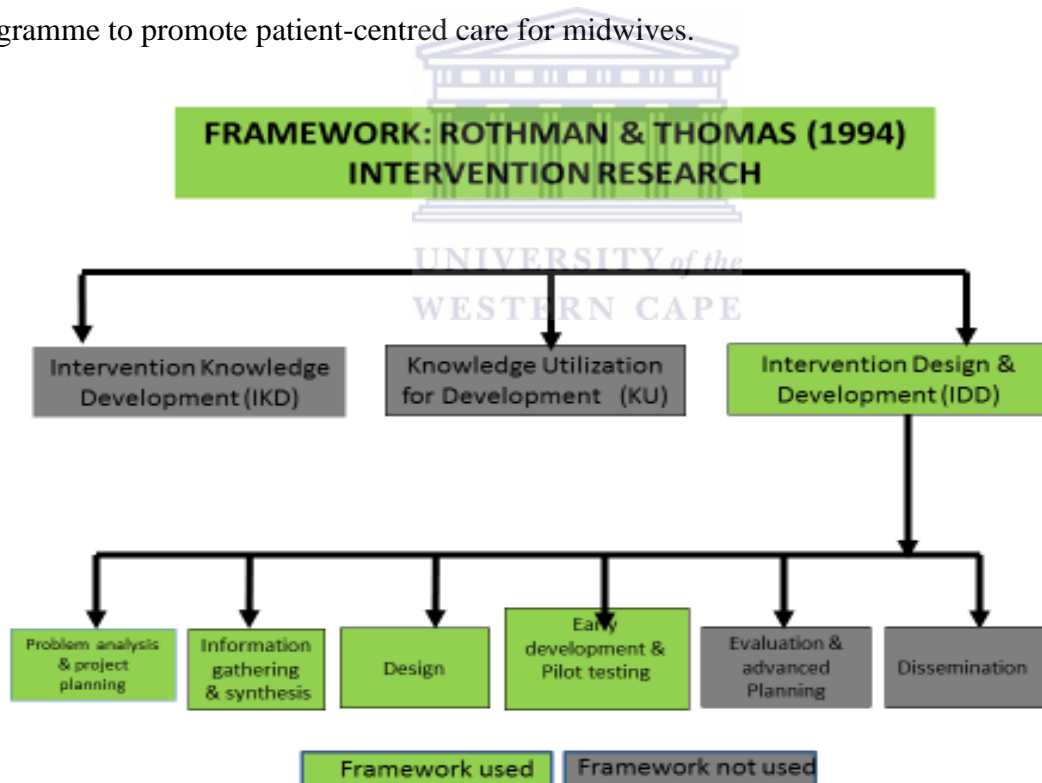


Figure 3.2 Intervention Research Framework (Rothman and Thomas, 1994)

There are six phases of the Design and Development research approach, as is shown in Figure 3.2. However, only the first four phases were applied in the current study to develop an in-service training programme to promote patient-centred care for midwives to increase client satisfaction with child-birth care services. The first four phases are used in this study because they address the aims of the study which is to develop a patient-centred care in-service training programme for midwives to provide client centred care services. The phases are:

- i. Problem analysis and project planning
- ii. Information gathering and synthesis
- iii. Design
- iv. Early development and pilot testing
- v. *Evaluation and advanced development*
- vi. *Dissemination*

3.2.1 Phase I: Problem analysis and project planning

This phase is addressed in the first three objectives of the study.

- a. To explore mothers' expectations of child-birth care in public health centres in Ghana.
- b. To explore mothers' experiences of child-birth care in public health centres in Ghana.
- c. To explore and describe the service delivery improvements that mothers' recommend for satisfactory child-birth care in public health centres.

The specific activities of this phase were:

- *Identifying and involving clients*
- *Gaining entry and cooperation*
- *Identifying the concerns of the population*
- *Analysing identified concerns*
- *Setting goals and objectives*

The implementation of each of these activities is described in turn.

Table 3.1 Objectives of phase I and activities within the phase

Objectives of the study	Specific activities within this phase
<ul style="list-style-type: none">• To explore mothers' expectations of child-birth care in public health centres in Ghana.• To explore mothers' experiences of child-birth care in public health centres in Ghana.• To explore and describe the service delivery improvements that mothers' recommend.	<ul style="list-style-type: none">• <i>Identifying and involving clients</i>• <i>Gaining entry and cooperation</i>• <i>Identifying the concerns of the population</i>• <i>Analysing identified concerns</i>• <i>Setting goals and objectives</i>

Identifying and involving clients

The midwifery clients receiving health care services at antenatal and postnatal clinics in the four public health institutions within Kumasi constituted the study population. Purposive and convenience sampling strategy was used. Only those participants who were present on the days for data collection and met the study inclusion criteria were involved after their consent was sought. This sampling was done solely by the researcher and her two research assistants without the involvement of staff of the various facilities. A minimum of 12 and a maximum of 15 individual interviews were conducted in each of the four hospitals this gave a total of 56 participants for the study.

Gaining entry and cooperation

The researcher did not have challenges of gaining entry into the settings of the study because the settings were familiar to her as she had practised in these facilities in the past. The researcher is affiliated to the College of Health Sciences, Kwame Nkrumah University of Science and Technology, Kumasi, where she has interacted with many managers and midwifery practitioners in the various hospitals on follow-up visits for student clinical placement and experience, so this process was executed well by the researcher. This kind of familiarization, according to de Vos (2005), enhances gaining access to the research setting. The research ethics application guideline by the various health facilities were followed and obtained from the Director of Health Services

for the Kumasi Metropolis. The process took three months to be completed. The Hospital administrator introduced the research team to the matrons'² in-charge of the various midwifery facilities and also disclosed the intension of the study. The matrons then introduced the research team to her other colleagues and the antenatal and postnatal clients.

Identifying concerns of the population (mothers)

Being an exploratory qualitative research design to explore the expectations and experiences of mothers and their satisfaction with child-birth. Individual in-depth interviews with childbearing mothers about their care during pregnancy, labour and puerperium was paramount. This served to gain an impression of their expectations, experiences and satisfaction with their child-birth care.

The researchers used offices in the Nursing and Midwifery Training School (NMTC) for the interviews and for the recording of data in one of the hospitals as the NMTC is on the hospital premises. In the other three facilities, the interviews were held in staff offices, far away from the maternity blocks where it was busy and the chances of being disrupted many. This was to ensure the confidentiality of participants and to allow the participants to relax during the interviews. The interviews lasted approximately 45 minutes each. Two research assistants were involved in the data collection after they had received training from this researcher on interviewing skills.

An interview guide, with probing questions, was used to explore mothers' expectations, experiences and satisfaction with child-birth care provisions (Appendix 1). The in-depth individual interviews were recorded with the consent of participants. Recording of these interviews were necessary to ensure that information was well captured in order to safeguard its validity. In addition, field dairies of all verbal and non-verbal cues and gestures that gave meaning to the data was also kept. Four interviews were conducted daily at two-week intervals. This allowed for adequate time for listening to the tapes several times, transcribing and reading through the text. This process of simultaneous transcription allowed an opportunity for further exploration during the next set of interviews. Data collection, thus, ran for six weeks in each facility and was done from December, 2014 to April, 2015. Data collection ceased in each setting

² A matron is the midwife in-charge of a health facility

once there was enough data (data saturation) to answer the study's research questions but, no new information was being elicited (Field and Morse 1999).

A language expert from the Department of Languages, KNUST, Kumasi, was consulted to translate and transcribe into English some of the data that was recorded in a local language ("Twi"). Through back translation, this was again translated into "Twi" by another language expert to ensure that the meaning of the responses was not lost.

Analysing identified concerns

Transcripts were labelled with the first few letters of the name of the health facility from which the participant was contacted, and a serial number of participant. For an example, the fourth participant from one facility was identified as 'Apat 4' whereas the tenth participant from another facility was identified as 'Ksouth 10'. The researcher read through the transcripts several times in order for her to have a sense of the data so collected and to also organise the data.

Content analysis was done in order to identify trends and patterns that re-appear in the transcribed interviews. This is because this study is designed to describe the expectations and experiences of mothers during child-birth care (Miles and Huberman, 1994). This involved consideration of the literal words in the text being analysed, including the manner in which these words were uttered. In this way, content analysis provided a method for highlighting the exact words from the text that appear to capture key thoughts or concepts by each participant (Field and Morse, 1999). This procedure offered the researcher an opportunity to learn about how participants viewed child-birth health care service. During the content analysis, themes and sub-themes were identified while making sense of the data.

Setting Goals and Objectives

Setting goals and objectives is the fifth activity of Phase I of Rothman and Thomas (1994) Design and Development methodology. From the analysis, it emerged that client satisfaction with child-birth care would increase by providing patient-centred health care. The focus of this current study is to develop an intervention to enhance midwives' abilities and competencies to provide a patient-centred approach to child-birth care. The content of this training programme was based on the outcome of Phase I of this study.

Rigour

In qualitative research, rigour, according to Marshall and Rossman (2011), attempts to answer the following questions:

- How credible are the particular findings of the study?
- How transferable and applicable are these findings to other settings or groups of problems?
- How can we be reasonably sure that the findings are reflective of the subject and the inquiry itself?

Lincoln, & Guba (1985) refer to these questions as establishing the “truth value” of qualitative research study which replaces reliability and validity in quantitative research. The researcher was guided by validation methods suggested by Mugenda and Mugenda (2003); Green and Thorogood (2004) and Creswell (2007). These are:

- *Triangulation*: Data were collected from different sources to provide reliable evidence and throw light on the issue of expectations, experiences and patient satisfaction with child-birth health care services. In this study, four different settings were used for data collection and data were collected from both antenatal and postnatal clients to allow for collection of different perspectives. Collection of data from the different sources allowed for data source triangulation.
- *Credibility*: The researcher made sure that participants were accurately identified. Peer de-briefing and member check were also done by engaging colleague researchers and participants in the research process. Colleagues checked the research questions and transcripts as an on-going process during data collection and made inputs into probing questions that were subsequently asked participants. Whereas transcripts were read to participants to check the accuracy of information recorded. These were to ensure the credibility of data obtained.
- *Transferability*: The researcher has provided detailed description of the research setting and methods to enable associating the study to settings with similar locations if the situations are comparable.
- *Dependability*: The researcher provided detailed information on each step of the study to enable an external researcher to repeat the inquiry and achieve similar results. This ensures that findings are consistent and could be repeated.

- *Confirmability*: This was done through audit trails, thus; the data collection protocol was developed to keep an account of the data collection and analysis processes. Pilot testing was also done to ascertain clarity and acceptability of the research elements. The researcher gave the findings and data to a colleague researcher to confirm that the findings could be said to be supported by the data. This, together with the researcher's own checking ensured that the research findings were acceptable.

3.2.2 Phase II: Information Gathering and Synthesis

Phase II is aimed at identifying the evidence of the facility-based best practices in health care in, health personnel training models. Case studies in maternal and child-birth health care provision, as well as interventions that have been implemented or shown to address the problem of client dissatisfaction with child-birth health care provision through an integrated literature review. An integrative literature review is a form of literature review that summarizes empirical or theoretical literature, in order to provide a broad understanding of a particular phenomenon or health care problem (Broome 1993). It also presents a varied perspective on a phenomenon of concern and has been advocated as important to nursing science and nursing practice research (Evans and Pearson, 2001; Estabrooks, 1998). The steps to be followed in an integrated literature review are:

- i. Reviewing existing information sources;
- ii. Studying natural examples; and
- iii. Identifying functional elements of successful models (Rothman and Thomas 1994: 32).

3.2.3 Reviewing existing information sources and studying natural examples through integrative literature review

Literature was reviewed on interventions to improve health care and maternity care, to identify strengths and limitations of existing modules that can be helpful in addressing client dissatisfaction with child-birth health care provision. According to Thomas (1984), there is the possibility of identifying already existing and relevant interventions during the information search. Thus, through integrative literature review, strengths and limitations of existing guidelines or programmes were identified.

Both primary and secondary sources of information were used as advocated by Thomas (1984) and Strydom and Delport (2011). The use of more than one source of data was seen as relevant

to the integrative design procedure, and aided the researcher in certifying and double-checking findings. The integrative literature review was done with the assistance of a colleague with the necessary knowledge and skills for this study.

Methodology for information gathering and synthesis

Search strategy

The search strategy for the review covered articles published in databases such as: Academic Search Complete, Health Source: Nursing/Academic Edition, CINAHL and Google Scholar. The period for this review focused on publications from 1996 to 2016. This allowed for inclusion of both older and more recent articles.

The following search terms were used and with the help of Medical Subjects Heading (MeSH), other terminologies were identified for the search:

1. ("midwifery" OR "nurse midwives" OR "midwives" OR "midwife" OR "skilled birth attendant" OR "nurse") AND
2. ("training" OR "guideline" OR "intervention" OR "program" OR "programs" OR "in-service" OR "education" OR "curriculum" OR "learning") AND
3. ("patient-centred care" OR "patient-focused care" OR "soft skills" OR "patient satisfaction" OR client satisfaction")

Exclusion criteria for the search were interventions provided by Traditional Birth Attendants (TBAs) or Community Health Workers (CHWs) and to patients.

Data extraction

Data were extracted using a standardised format in the form of a table which enhanced the synthesis and analysis of the data. The narrative synthesis approach given by Popay et al. (2006) and Iwelunmor et al. (2015) was adopted by first developing a preliminary synthesis, exploring relationships in the data, assessing the robustness of the synthesis and developing sub-review questions. During the preliminary synthesis, descriptive characteristics of the retrieved articles were extracted in a table to produce a textual summary from the articles. The researcher was guided by the following questions to identify salient features that are necessary for the development of the intervention.

- What training programmes or guidelines have been put in place to improve care provision to clients?
- What evidence suggests that these programmes were successful?
- What techniques were used in the delivery of the training programmes?
- Who were the participants attending these programmes?
- How feasible are the intervention programmes?

Data synthesis

Data were analysed using the systematic synthesis method as given by Popay et al. (2006) and Tarraco (2005) and, also by exploring the relationships in the data. After the first step of extracting the data, the researcher reviewed again the extracted data to check for disparities and erroneous and/ or inconsistent data. This was followed up by exploring relationships between and within the data through the use of sub-questions for the review in order to identify relevant issues on interventions needed to improve on the client health care and/ or health outcomes. These reviews were then fused together as evidence that could be applied to improve maternal client satisfaction with child-birth health care provision.

This process of interrogating the literature resulted in identifying functional elements of successful models, so as to avoid repeating the mistakes of the past. This step concluded Phase II of Design and Development research methodology.

3.2.4 Rigour in data collection and analysis process

Rigour was ensured by evaluating the quality of the articles using a checklist adopted from JBI- Qualitative Assessment and Review (QARI) critical appraisal (Appendix 2). On the basis of the criteria, each reviewed paper received a quality grade of ‘yes’, ‘no’ or ‘unclear’ on a ten-item score. The score is calculated out of ten and any score between 8 and 10 is considered good in quality and, therefore, good for their inclusion in the study. This was done with a colleague and any disagreement in this grading process resulted in consulting a third colleague for resolution.

3.2.5 Phase III: Design

This is the third phase of Design and Development research methodology in order to develop an in-service training programme to promote patient-centred care for midwives. This phase was

expected to yield positive ideas for the development of the interventions (Rothman and Thomas, 1994). It is also referred to as a stage for focused planning (Rothman and Thomas, 1994). The activity in this phase specifies the procedural elements of the in-service training programme to promote patient-centred care.

Specifying the Procedural Elements of the in-service training programme to promote patient-centred care

The focus of this operational activity is to develop a guide for the interventions needed in health care service provision. In this study, the steps that were followed in the procedure of designing a programme, as is said by Chinn and Kramer (1991). It outlines the steps to be followed in integrated theory and knowledge development in nursing and Management Sciences for Health (2012) for designing a programme. These authors advise that in designing a programme, information should be provided on the purpose of the programme, the definition of concepts, the structure of the programme, and its underlying assumptions. This was duly carried out in the design phase of the study.

Themes that emerged after analysing participants' data in Phase I were used as the basis for the modules. Four draft modules were developed by the researcher. Thereafter, 4 experts in the field of maternal and child-birth health care were invited for a 2-day workshop to make input into the programme. The experts were made up of 2 midwifery tutors who are the trainers of midwives, and they hold Master of Science degrees in midwifery and 2 retired principal midwifery clinicians who have had 30 years and 35 years of experience in midwifery clinical practice. They hold Bachelor's degrees in midwifery.. The aims and objectives of the study were discussed with the experts, including the results of the first two phases. Experts, together with the researcher, were engaged in a brainstorming exercise on the topics to be included in the training programme, based on the themes from Phase I of the study. Also discussed were the structure of the training modules, duration of the training, teaching methodology, setting of the training and facilitators for the programme. The researcher then developed the content and adopted some content from already existing sources based on the feedback from the expert consultations.

3.2.6 Phase IV: Pilot testing and early development

The fourth phase of the Design and Development research methodology was aimed to pilot testing the draft patient-centred health care in-service training programme to determine whether it could be implemented and to examine its viability and utility as a health practice tool. Rothman and Thomas, (1994), say this results in the refinement and detailing of the interventions needed, leading to subsequent outcome evaluations of a more crystallized health practice vehicle. Important operational activities that were used in this phase were:

- Developing a proto-type or preliminary intervention
- Conducting a pilot test
- Applying design criteria to the preliminary intervention concept.

Developing a prototype or preliminary intervention

Rothman and Thomas (1994: 36) assert that in this stage of the design process, preliminary procedures are selected and specified to develop the proto-type intervention strategy of use of pilot testing. The researcher also needed to establish and select a mode of delivery which was either by workshopping, telephone consultation, peer-mediated instructions or other ways of communicating the intervention to intended users. The programme was assessed through a 3-day in-service training workshop for midwives using the I-Tech Technical Implementation guide (2010) for evaluating a training programme.

Conducting a pilot test

Pilot tests are designed to determine whether the intervention will work: “to see if the beast can fly” (Rothman and Thomas, 1994: 36). Pilot studies are implemented in settings that are convenient for the researcher, and somewhat similar to ones in which the intervention will be used. In the current study, the proto-type was delivered through a 3-day in-service training programme for midwives in Juabeng Hospital, which has similar human and material resources and client characteristics as the settings in which the initial phases of study was done.

The assessment of feasibility and usability of the patient-centred care in-training programme was done using feedback from three key groups: the recipients, the facilitators and an observer. Recipients’ evaluation was drawn from daily as well as end-of-programme evaluations and pre-

and post-test. This was done using a pre- and post-test questionnaire. Results of the pre- and post-test were analysed using a paired student's t-testing technique to assess the difference between pre- and post-test scores of the training modules. The facilitator and observer assessment were also done by means of an assessment tool that was developed using I-Tech Technical Implementation guide (2010). Results from the assessment by the facilitator and observer were also summarised and reported.

Role of the observer

An observer was recruited to be present at all the training sessions. The observer, according to the I-Tech Technical Implementation guide (2010), should be someone who participated in the designing of the training programme. For this assessment, one of the experts who was involved with the designing phase of the programme was recruited as an observer. The observer performed an important function during the workshop since she was not directly involved in facilitating the workshop. It was, therefore, easier for her to monitor elements in the assessment, such as use of the materials by trainers and participants, the interaction between participants and trainers and participants' level of engagement. The observer was also tasked with capturing all stories, cases and examples that were used by trainers and to provide general and comprehensive feedback on each session. The observer noted whether an activity did not work out well with a particular group of participants or whether the facilitator skipped any specific activity or session. The observer noted the activities which took more time than anticipated, or the ones that led to some interesting discussions on certain topics that were important to the learning objectives of the training programme. If participants appeared confused at certain times during the training session, the observer would note this, together with the points at which the confusion occurred. The observer also participated in daily de-briefing meetings with the facilitators in order to review the success and challenges of each day's sessions. Lastly, the observer summarised all the activities in her detailed comments at the end of each day, which was then fed back into the training programme.

Study population and sampling

Recipients of this pilot programme were midwives in a District Hospital within Kumasi. The total population of midwives at the Hospital was fifteen. Of this number, 3 were on annual leave,

1 on sick leave and 5 were on night shifts at the time of the assessment. Of the 6 remaining, their consent was sought for their involvement in the training programme. The researcher approached 3 participants who were available in the ward and made telephonic contact with the other 3 who were not on duty, and they all agreed to participate in the study. Thus, 6 participants were involved in the assessment. Prior to this, a formal letter from the hospital administration was sent to the unit to inform the midwives about the study and to seek their consent to participate in the study. Purposive sampling was used to choose participants for the assessment, based on the judgement of the researcher, because the midwives had typical attributes of the population that serve the purpose of the study (Strydom, 2011).

The involvement of midwives ensured credibility of the in-service training program (Lincoln and Guba, 1985) because the design concept was ‘tested’ on the intended users, and its effectiveness in achieving the desired goal meant that the patient-centred in-service training guidelines would be useful in similar settings. The inclusion criterion for the assessment was any midwife working in the maternity department of the Juabeng District Hospital at the time of the study.

Setting and duration of the assessment

The in-service training programme to promote patient-centred care was pilot-tested at a District Hospital over a period of three days. This setting was chosen because it is similar to the ones in which the intervention was applied and was also accessible to, and therefore convenient, to the researcher (Rothman and Thomas, (1994).

Applying design criteria to the preliminary intervention concept

According to Rothman and Thomas, (1994: 37) the design process is informed by common guidelines and values for the intervention research. Relevant questions that guided this stage were:

- Is the intervention effective?
- Is it replicable by typical end-users?
- Is it simple to use?
- Is it practical?
- Is the intervention adaptable to various contexts?
- Is it compatible with local customs and values?

3.3 Ethics considerations

In this study, the following ethics principles, as proposed by Marshall and Rossman (1995) and Miles and Huberman (1994), were followed:

Honesty - the researcher endeavoured to be honest in all scientific communications with the relevant people in the study. There were also ethical consideration in the reporting of data, the results, the methods and procedures. There was no fabrication, falsification or misrepresentation of data. Integrity - the researcher acted with a sense of sincerity when carrying out this study. There was consistency of thought and action by the researcher. Carefulness - the researcher avoided careless errors and negligence. There was careful and critical consideration of the research process and accurate records of research activities. Openness - there was sharing of data, results, ideas, tools and resources among peers for their input and the researcher was open to new ideas and criticism from all who participated in the research.

Informed Consent – participants’ consent was sought before they were involved in the study at all levels of this research. They were told exactly what they were being asked to do before their involvement in the study. An information sheet was given to participants who could read and write. The information in the sheet was interpreted for the illiterate and semi-literate participants. This went through a process of translation into Twi language and back translation by language experts into English. The research assistants therefore read these translated information to participants in Twi. The information sheet provided detailed information on the study and the level of involvement of participants, what the study was about, and what the information was to be used for. They were also assured of anonymity and confidentiality of all information given. Participants’ consent was sought for all recording of the interviews both audio and written and it was explained to them that this was being done to ensure that data was captured accurately. Participants also signed consent forms for both the written and audio recordings. Please see appendix pages 210-213 for information sheet and consent form. No pressure on individuals to participate - participants were allowed to freely participate in the study. No incentives were given for participation in the study. Participants were approached directly and not through the midwives on the unit. Interviews were conducted after they had already received care for the day. Respect for individuals’ autonomy - participants were allowed the freedom to decide what to do and what not to do. Even when they had consented to participate in the study by signing the

consent form, they were made aware that they were still free to withdraw from the study at any time without giving reasons for it. They were also told that they had the right to request that the data they have given be removed from the study.

Anonymity and confidentiality - there was nothing to identify any one participant's information with the person herself. No names were taken during the individual interviews. The consent forms had participants' names but could not be linked to the data provided. To ensure confidentiality, the data that were collected were well-protected and only the researcher had access to it. Audio-tapes from the individual interviews were transcribed and saved with a code that only the researcher had access to. Further, the data was used for its intended purpose, and the information had remained protected from disclosure outside the research setting.

Beneficence – measures were taken to avoid harm to participants. An arrangement was made with a clinical psychologist of KATH for his attention in case a participant had emotional trauma from narrating an unpleasant experience. Although, the study did not have any direct and immediate benefit for the participants, it was explained to them that findings from the study will inform the development of an intervention that will improve child-birth care and that, they may benefit from the service in future child-birth.

Avoidance of harm to participants - participants were protected from harm and arrangements were made for any participant who could be traumatized by recounting of unpleasant experiences of the past to be seen by the counsellor at KATH, Kumasi.

Permission for the conduct of this research was sought from the Higher Degrees Committee of the Faculty of Community and Health Sciences (CHS) at the University of the Western Cape, and also from the ethics committees of Komfo Anokye Teaching Hospital and the Kwame Nkrumah University of Science and Technology, Kumasi, Ghana. All approvals were given.

3.4 Summary of chapter

Conducting this research required specific methods to guide the research process scientifically. The Intervention Research: Design and Development approach by Rothman and Thomas (1994) was used to provide the framework for the study. In this chapter the rationale for choosing this methodology and the phases that were followed has been discussed. The underlying assumptions and intellectual structure upon which this study was built is that, mothers' satisfaction with a previous facility-based child-birth care provision is paramount to their subsequent use of facility-

based care and consequent recommendation of same to others. The study further asserts that satisfaction with care is the result of an interplay of expectations and experiences with care. Therefore assessing the expectations and experiences of mothers' towards child-birth care is important in determining their satisfaction with care and in improving care provision.

Whereas there are six phases of Design and Development, only the first four phases were used in this study because that assisted in meeting the objectives for the study. Phase I comprised problem identification and analysis, Phase II information gathering on functional elements, Phase III entailed designing and developing the patient-centred care in-service training programme in order to increase client satisfaction with health care provision during child-birth health care. The developed intervention was based on the results from Phase I and Phase II of the study. Phase IV was the assessment of feasibility and usability of the training programme. The chapter also discussed the recruitment of study participants and data collection methods for each phase and concluded with ethical considerations for the study.



CHAPTER FOUR
FINDINGS AND DISCUSSIONS OF PHASE I
MOTHERS' EXPECTATIONS, EXPERIENCES AND SATISFACTION WITH CARE
DURING PREGNANCY, LABOUR AND PUERPERIUM

4.0 Introduction

This chapter reveals the findings on the ways in which care was understood and experienced by mothers during child-birth care in public health centres in Kumasi, Ghana. The chapter reports on objectives 1 to 3 of the study, which sought to: explore the expectations mothers have with child-birth care in public health centres, explore the experiences mothers have with child-birth care in public health centres, and explore and describe the service improvement mothers require for satisfactory child-birth care in public health centres, and also to outline areas in which these improvements were required. The themes that emerged relating to participants' expectations of child-birth care include women's desire for respectful and safe care; whereas their experiences with care include both encouraging and discouraging experiences. The following sections give details of these themes and sub-themes.

4.1 Description of participants' characteristics

Participants were between the ages of 17 and 43 years. Almost half of the participants were between 20 and 30 years (48%), 44.6% were between 31 and 40 years. Only 3.6% were younger than 20 and there was one participant who would not disclose her age.

Table 4.1 below describes participants' characteristics. A total of fifty-six mothers were involved in the study, made up of 15 from facility A, 12 from facility B, 14 from facility C and 15 from facility D.

Table 4.1 Description of participant's characteristics

	Facility A	Facility B	Facility C	Facility D	Total	Percentages
Age (years)						
< 20	0	1	1	0	2	3.6
21-30	4	6	7	10	27	48
31-40	10	4	6	5	25	44.6
41-50	0	1	0	0	1	1.8
Unknown	1	0	0	0	1	1.8
Formal Education						
Basic	0	1	0	0	1	1.8
Junior High School (JHS)	4	5	5	4	18	32
Senior High School (SHS)	3	4	1	5	13	23
Tertiary	5	0	0	4	9	16
None	3	2	8	2	15	26.8
Employment status						
Formal	6	0	0	4	10	17.9
Informal	8	8	2	9	27	48
Unemployed	1	4	12	2	19	33.9

One participant had only basic education, while 32% had Junior Secondary School (JHS) education, 23% had Senior High School (SHS) education, 16% had tertiary education and 27% had no formal education. This implies that most participants may not have regular incomes and may be engaged in menial jobs as they are not likely to have a formal employment. The implication is that, mothers' will have to work daily to earn a living, therefore attending antenatal clinic will mean loss of revenue.

Just under half of the participants were employed in the informal sector (48%), 40% were unemployed and 18% were employed in the formal sector. This suggests that the majority of the

study participants did not have stable employment. This may lead to an inconsistent income which also has a potential effect on their livelihood and the health of mothers and their families.

Table 4.2 Themes on expectations of participants about child-birth

Themes	Sub-themes
1. Expected respectful care	• Courteous and dignified care
	• Adequate communication and involvement
2. Need for safe care provision	• Request for consistent care givers
	• Lack of adequate resources for provision of care
	• Expected positive birth outcomes

4.2 Expectations of participants about their child-birth care

In table 4.2, two main themes emerged from analysing the transcripts of participants about expectations of child-birth care that influence their satisfaction or dissatisfaction with care; these were a desire for both respectful and safe care. Respectful care had 3 sub-themes of courteous, dignified care, adequate communication, and involvement. Safe care had 3 sub-themes such as familiarity with caregivers, adequate resources, and positive birth outcome. The respective themes and their sub-themes are described in the sections below.

4.2.1 Expected Respectful care

Participants in this study expect that midwives will treat them with respect to enhance their satisfaction with care. Mothers made inferences about the attitudes of midwives towards them and their response to meeting their needs as key elements of respectful care. A participant noted that she expects the midwives to be polite and pay attention to their care needs. She said:

I expect that my caregivers will be polite towards me, call me by name and give me and my baby all the attention and care we may need. They should say please and thank you to us, just as we say to them will be great. [Woman from Ksouth, aged 33]

Another participant mentioned that respectful care was necessary particularly when midwives interact with her because of her status in the community. She exclaimed:

Eii! Because they know me as Nana (Queen mother) they are really nice to me. They address me well. I anticipate that the same courtesies will be accorded me always....yes! they should use please, sorry if they go wrong. [Woman from KATH aged 28]

Yet another participant indicated her expectations about respectful care and admonished midwives to:

...spend more time with each mother and not brush over our complaints. They should be caring and polite. [Woman from Ksouth aged 28]

As a sign of respect, mothers also expect midwives to treat them as adults and recognise their own opinions. They also expect midwives to show an interest in them and their welfare:

I expect the midwife to show interest in me and my baby. She should understand me and talk to me well because I am also a responsible person. [Woman from Ksouth Aged 33].

It appears that hitting, shouting at, and ignoring mothers makes them feel like they are little children, feeling rather stupid and taken for granted. These forms of disrespect frighten mothers. This is evident in the quotation below:

I am afraid the midwives will not be nice to me, will hit, or shout at me during the birth. [Woman from Ayed aged 35].

Mothers in this study said they also expected that they were going to be treated as unique individuals, a sign in itself of great respect towards them. They expected that they would be called by their names and to be addressed by their unique identifiers as a sign of respect and care. This may be particularly important to mothers because the antenatal care is organized as group care, with mothers of varying status present at the same time. This is reflected in what the participant said that:

At the clinic you don't know who is who, sometimes the midwives belittle you before very small, small girls [Woman from KATH aged 42].

Mothers' responses in these quotes (above) show that they have expectations about their child-birth care and also have knowledge about disrespectful attitudes of midwives.

Courteous and dignified care expected

Courteous and dignified care is an aspect of respectful care. Participants in this study expected midwives to be considerate and show good manners towards them during child-birth care. To most mothers in this study, when midwives' are courtesy and provide dignified care to them, it meant that the midwives were professional in their approach to work and therefore saw mothers as the very reason why they were at their work-places. Thus their view is that midwives should not be in a hurry to dismiss them during care provision. Midwives taking due care to address the needs of mothers are therefore seen as being respectful and caring by mothers. At the same time, courteousness is also seen as taking due care and not hurrying over to complete their care. One of the mothers has this to say:

She (meaning the midwife) had all the time for me to answer my questions, even though we were many. She was calm and cool about her work. She is what a midwife should be.

[Woman from Ksouth 7 aged 31].

For most participants in this study, their expectations were that midwives should treat them as friends, and always greet them and/or respond well to their greetings, giving back friendly smiles that make them feel welcome at the facility. Said one of the mothers:

The midwives should be nice to me, also friendly, patient and treat me like I am one on them. They should be patient and respond to our greetings. They should show interest in me and ask about my health and wellbeing. [Woman from Apat aged 25].

In the Ghanaian culture, as is the case with others, visitors are received warmly with a smile and a handshake all signifying acceptance at the place so visited. This seem to be what participants in this study also expected, that midwives would show them welcoming gestures just as our culture in Ghana demands (Nukunya 2003). Where courteousness is not possible, participants' anticipations were of fear towards the whole care process.

I had always been praying to be received nicely when I arrive at the facility, which is

nice. It is what you expect when you go to someone's house. [Woman from Ayid aged 29].

Participants were apprehensive about the reception they would receive during the care process. A mother reports that the reasons for her fear are firstly, anxiety about the process of birth and secondly, about the form of assistance she will receive from the midwives. It seems the fear of mothers originates from their inability to predict how the whole process of birth will go for them and what form of assistance they might receive from midwives during the actual process of care. This can be seen in the quote below:

My greatest fears and worries had always been whether I will receive the required attention and care while in labour, something that would make the burden lighter. It was the uncertainty of where I would lie after the delivery. [Woman from Ksouth aged 31].

Key to dignified care for participants are issues of neglect of the woman's body. The childbearing woman expects her body (womanhood) to be protected and respected as much as possible:

They (midwife) should not just come to me and start asking me to part my legs for vaginal examination without any explanation and permission. It will not make me feel good at all. [Woman from KATH 2 aged 32].

Most of these mothers expect their consent to be sought before any procedure is carried out on them. This they say, makes them feel in control of their child-birth process. It makes them feel that their bodies and their own selves are being respected. Women seem to think that failure to receive the necessary information is tantamount to failing to receive dignified care. Any touching of part of their body without their consent is seen as constituting being disrespectful to their womanhood. An example of this is performing vaginal examinations without adequately informing and involving the mother. It makes women feel helpless, vulnerable and degraded during care and is seen as an abuse of their privacy. One can detect this in the quote below:

I don't expect the midwife to walk up to my bed with a tray and expect me to know that she is going to perform vaginal examination. [Woman from Ksouth aged 42].

Participants expect their body and particularly their genitalia to be treated with dignity and not to be made to feel that they are at the mercy of the midwives.

Adequate communication and involvement

Adequate communication refers to the ability to disseminate valuable messages to a patient while involvement refers to the ability to include the patient to become part of the care process. Communication and involvement were the second sub-theme under the theme on women's desire for respectful care. Through communication and involvement mothers expect to be informed of what is going on with them during child-birth. They also expect their opinion to be sought, this may give them the opportunity to make choices. A mother drew conclusions about her expectations in this quote:

I am expecting to be treated well, to be spoken to before decisions are made, to be able to dialogue with the midwife before decisions are made. [Woman from Apat aged 30].

This way the mother feels to have been communicated to effectively in the whole child-birth process, and end up being part of the process of child-birth care. Mothers do not want to feel that they are being controlled in labour: they may desire to know the reasons for actions that they have to embark upon in labour. Understanding the issues and processes also makes them feel in control of their care, and that they are not being dictated to:

If I can be told the reasons behind the 'dos' and 'don'ts', then I will understand and can easily comply. But it seems like commands when you are told for example to lie on your side, remain in bed, not walk around. Only taking orders...Hmm. [Woman from KATH aged 40].

Involving the mother in her care and communicating with her about the outcome of procedures and/or on decisions about her care is paramount in her compliance with care and her consequent satisfaction with care, as reported by this mother:

If the midwife will involve me in my care during labour by explaining things to me and giving me information, I will be very satisfied with my care. [Woman from KSouth aged 26].

What is common in all these expressions is the inherent need to be made aware of their progress and that of their babies in order for mothers to participate in any decision making.

4.2.2 Need for safe care provision

Safe care to participants in this study involves the avoidance of harm to the patient in the process of care provision. Safe care was identified as the second theme in participants' expectations of care. Sub-themes such as consistent caregivers, adequate resources and positive birth outcomes emerged. Most respondents seem to think that there is need for safe care provision in child-birth. This is evident in the views below where this participant made inferences about the skilfulness of the midwives which she expects to benefit from:

As for their job they know it very well, and they know what to do to help you. It is only the disrespect that is so much and that makes me feel afraid but I will deliver in the hospital, that way I will be safe. [Mother from Apat aged 37].

Receiving safe care eliminates fears and uncertainties associated with care and makes mothers feel secure with the care they receive. This also shows a link between respectful care and safe care. There is mention of fearfulness which can be related to unsafe care. Participants makes expressions on the need to eliminate fears and uncertainties which makes them feel the care they receive is unsafe. This is shown in the quote below:

In terms of delivery or conducting of delivery, they know what to do, they are good. I expect they would help me deliver safely too. [Woman from Ksouth aged 40].

By *they are good* the participant means that the midwife is skilful. Mothers have a great deal of confidence and trust in the services that are provided by the midwives during child-birth care, there is anxiety about how safe the whole process will be. This is borne out by the fact that if there are any complications resulting from unskilled child-birth care, mothers are brought to the facilities to be attended to by the midwives. Participants in this study therefore appreciate the knowledge and skills of the midwives:

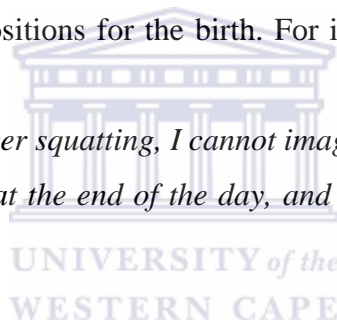
The reason why I came to deliver in this facility this time, hmmm, this is the first time I am having a baby in the hospital. On the last occasion, I almost died and the baby was

not coming, and so I was brought to the hospital. The midwife just set up an infusion on me and that was all so I prefer to come to the facility now. [Woman from Ksouth aged 28].

Women seem to compare facility-based care provision to unskilled care, in which case they seem to trust the skills of facility-based care personnel. They agree that it may be better to seek help from the more skilful than to go for unskilled care. Thus, the results suggest that when unskilled care fails, women eventually are brought to health facilities, sometimes when the health situations are bad and their lives are endangered.

Participants also mentioned birthing positions as important to their safe delivery, birth outcomes and satisfaction with child-birth care. Mothers' expectation is commonly that they will be allowed to choose their desired positions for the birth. For instance, one participant had this to say:

I should be allowed to deliver squatting, I cannot imagine lying down to deliver. My baby and I should be fine at the end of the day, and then I will be happy. Woman from Ksouth aged 31.



Request for consistent caregivers

Mothers in this study expect to have consistent caregivers or a caregiver they are familiar with during the child-birth care process; this makes them feel safe with the care they receive. This is because mothers seem to think that such midwives would ensure their safety. Participants' impression is that a caregiver gets to know them during antenatal clinic and therefore they both become familiar with each other better. This women feel increases the chances of the midwives' commitment to provide safe care. They also feel that their health status and that of their babies would be known to this midwife who will also carry them through the birth of the baby.

This is what a participant had to say:

I was praying to see a familiar face that is a midwife whom I am accustomed to, or one that I have met during my antenatal care earlier. The midwife I met when I came here in labour was not someone I had met before. I was so disappointed when I first met her

because I do not know her and how safe she can deliver my baby. But she did well, because she was patient and kind to me. [Woman from Ayid aged 30].

A mother reported that having a familiar midwife may boost mothers' confidence and general expectations about their general child-birth care. This would further contribute to her satisfaction with child-birth experience. It also seems that having someone familiar to the mothers gives them an opportunity to discuss their fears and anxieties ahead of their child-birth. To mothers in this study, it seems familiarity guarantees them safer care. This can be seen in the example below:

One thing that I have always wished for is that I will be given one midwife that takes care of me throughout my pregnancy and delivery. [Woman from KSouth aged 26].

Lack of adequate resources for provision of care

All participants in the study commented on the physical and other resources when they received health care and were anticipating to have better resources. Some of these resources can be linked to safe health care. When resources in the facilities are over-stretched and/or are in a poor conditions, this consequently has the potential of reducing the safety of child-birth care. Mothers outnumber the available beds, chairs, laboratory services and even the midwives in the antenatal clinics and wards, and in the postnatal clinics and wards which creates challenges for safety care. A participant had this to say:

The antenatal clinic and labour ward is always crowded, so that sometimes we do not even have chairs to sit on. We stand for a long time waiting for our turn. You can see that the midwives are fully stretched. That is what happened at the antenatal clinic where I was before. I am now expecting that it will not be the same when I go to deliver. I expect to have adequate facilities for my care this time around. [Woman from Ksouth aged 29].

Mothers made observations that, it was most common to find two mothers use the same bed and babies of different mothers using the same baby cots, because the mothers and babies outnumber the available physical resources in these facilities. This is what a participant said in anticipation:

All I look forward to is to have enough space and privacy in the facility. I do not want to share a bed with another woman. [Woman from KATH aged 36].

Mothers also wish that they would have access to basic services such as water during child-birth. Even though taps are supposed to run all the time in the facilities, felt that sometimes mothers have to find their own water. Yet another participant said:

In the hospital where I had my first baby, the taps were not running especially after I delivered. My mum had to bring me water from home before I had a bath. I did not like that at all. Water should always be available in the hospital. [Woman from Ksouth aged 29]

Furthermore, when discussing resources desirable to mothers during child-birth, some mothers mentioned their aspiration to have private spaces during child-birth. Clearly, many facets of the physical environment at these facilities seem to have an influence on a mother's child-birth care expectations. One mother spoke about the birthing suite in this way:

I expect to have my baby in the same room that I am admitted to. During my previous delivery in another hospital, I almost lost my baby because I had to walk into a different room to deliver when the baby was almost out. The midwife said I should come quickly and not push out the baby. It was so uncomfortable. At a point, I laid on the floor and pushed out the baby. My baby would have fallen if I did not lie on the floor. This was all because of lack of space to deliver. [Woman from Ayid aged 27].

The availability of adequate resources for child-birth care provision cannot be underestimated as it is important for the provision of safe care. Participants anticipate adequate resources for their care and that of their babies to ensure safety:


I expected that in the hospital, everything to save life would be available. If my baby does not cry immediately at birth, I expect that the baby can receive immediate help to save his/her life. I would be disappointed if there was no oxygen. [Woman from Apat aged 32].

Participants in this study also consider time spent in the facilities with the midwives as important in achieving safe and adequate care. The results show that most women wanted to spend less

time in the health facilities. The period spent in facilities depends on the kind of help women receive, which is linked to the resources at the health facilities. This is seen in the views below:

Hmm.....I desire that when I go to the clinic I come back early to go to work. I am a dressmaker, and if I do not go to work, no income comes to me. But going for antenatal care is a day's affair. If I leave home at dawn, I should come back by nightfall. [Woman from Ksouth aged 35].

Participants also had concern with the midwife-to-mother ratios. They seem to be worried that midwife-to-mother ratio is still large. Mothers expect to receive consistent maternity care, which will facilitate personal relationships with their midwives and also reduce their waiting times in the hospital during group care. Mother's expectations are that they should be able to receive individual antenatal care which will make them have personal relationships with their midwives and reduce their waiting times in the hospital as happens with group care. This does not seem to be what is happening in most of these institutions.



Expected Positive birth outcomes

Another sub-theme under safe care was positive birth outcome. Participants in this study consider having a safe vaginal birth, alive and healthy baby and healthy mother as positive birth outcomes. On the other hand, having a caesarean birth irrespective of the fact that the mother and baby are healthy is considered as a negative birth outcome. This is evident in the following comments:

I am expecting to deliver safely, have my baby alive and be in good health. I know that there are some women who get complications in delivery which can threaten their own lives or the life of their babies. [Woman from KATH Aged 38].

From the mothers' perspective a good outcome in labour is to have a natural birth. This sentiment shows that most mothers wish to experience a positive birth outcome.

I am expecting to have a good birth outcome, yes, to deliver by myself. Woman from Apat aged 29.

In summary, participants anticipate that the healthcare system can offer them a consistent and familiar caregiver with whom they can identify throughout their obstetric cycle. Participants wish to see the same care provider during antenatal care, labour and the puerperium.

It seems participants' anticipations of the healthcare system are to have a consistent and familiar care-giver whom they can identify with throughout their obstetric cycle. They prefer to see the same care provider during their antenatal care, labour and the puerperium. From the study, most mothers prefer to have mature midwives rather than the younger midwives.

Table 4.3 Themes on experiences of mothers in child-birth care

Themes	Sub-themes
1. Encouraging experiences	• Experiences of empathy
	• Experiences of continuous labour support and attention
	• Experiences of skilful care
2. Discouraging experiences	• Experiences of disrespectful care
	• Experiences of inadequate communication and involvement
	• Experiences of inadequate resources
	• Experiences of inconsistent caregivers

4.3 Experiences of mothers in child-birth care

Table 4.3 shows themes and sub-themes from the analysis of data on the experiences of participants about their care during child-birth. Two dominant themes emerged with various sub-themes, regarding the enhancement of satisfaction or dissatisfaction with care. The themes were encouraging and discouraging experiences. The sub-themes for encouraging experiences were empathetic support, continuous labour support and attention and skilled care. These experiences are aligned to the general expectations of mothers care and are similar but based on different perceptions of the childbearing processes. With regards to discouraging experiences, the sub-themes were disrespectful care, inadequate communication and involvement in care decisions,

inadequate resources and maintaining the same care-givers. Each of these issues will be presented together with their sub-themes.

4.3.1 Encouraging experiences

Participants reported having positive health care experiences. They showed that they were satisfied with their antenatal, labour and puerperal care. These are experiences that mothers were happy to have and which made them satisfied with their health care. The experiences include midwives showing empathy, continuous labour support and attention and receiving skilled care provision from midwives.

Experiences of empathy

Empathy is the process through which one attempts to project oneself into another person's life and image of a situation from his or her point of view (Hodnett 2002). Mothers considered empathy from midwives during child-birth as a strongly positive experience. They considered the ability of midwives to understand their own life experiences as constituting empathy. This includes when a midwife understood that they were in severe pain during labour and showed concern. One of the women said:

They were really caring and friendly. Sometimes it seemed to me like they were also in pain whenever I was having pain. They had time for us throughout the pregnancy.
[Woman from Ayid aged 30].

One of the mothers reported that empathy plays an important role in her child-birth care and makes her feel that she is not in the child-birth process all by herself. One of the women said:

I really appreciate the way they speak to me. They understood what was happening to me. I felt comforted about their care. [Woman from Apat aged 29].

The midwives' demonstration of empathy to mothers also reflects their caring nature and gives the mother a sense of belonging, as is demonstrated in the quote below:

My experience was super. The midwife was always with me during labour and showing concern. [Woman from Ksouth aged 33].

Other gestures that enriched the participants' experiences were kindness and compassion from the midwives. This is evident in the quote below:

I thank God for the midwife I met whilst I was in labour. She was very kind to me and to my husband too. She took us around the ward and told my husband what to do to help me go through the child-birth process well. [KATH Aged 32].

In contrast to all the above findings, there were some participants who did not find these gestures as positive health care experiences. These mothers thought that they did not experience positive relationships from the midwives, and said their main concern was just to deliver their babies and go back home. One of these women said:

For me, they did not treat me well, but I do not care about whether the midwife treats me well or not. Ah.... I came to deliver my baby. That is all. [Woman from KATH 28].

Another participant was also concerned about how she experienced the labour pains and her ability to cope well with it. This participant also understood that there was no way anybody, even the midwife, could help reduce the labour pains. She saw herself as the centre of everything and she just focused on herself alone. She said:

I did not even look out for things like how was being treated. All I was thinking of is About was the pain I was experiencing and how I would get over it. They do not mind you anyway. [Woman from Ksouth Aged 29].

It seems these mothers were preoccupied with whether or not they were able to go through their labour process successfully. They may have had the realization that, whatever the situation, they were the ones who were going through the process and, therefore, needed to focus on themselves rather than other people like the midwives.

Experiences of continuous labour support and attention

Continuous labour support and attention entails midwives being with the mothers throughout their labour period whilst providing them with health care and any other necessary health assistance. It enhances the mother's ability to cope with the labour process. It increases the chances of mothers having a spontaneous vaginal child-birth. Continuous labour support and attention was one of the sub-themes that emerged from the analysis of participant's experiences with health care. Most mothers seemed to suggest that they expected to have their midwives with them throughout the labour process. In the Ghanaian public health facility, family support in the form of having spouses and relatives around you is considered important. However, these cannot be accommodated in the labour ward or within the facility. This is the case because the wards only have limited space that separates each mother with curtains. Under these circumstances, the midwife is therefore the only source of support for mothers during child-birth. Thus, having a midwife with them throughout their delivery process gives mothers a feeling of security and hope that things will go well. It reduces anxiety and fear in them (Padmanathan 2003). This is evident in the example below:

I came here and met three midwives on duty. They actually supported me. They stood by me until the baby was delivered. One of them even held my hands during delivery and encouraged me throughout the process. They remained with me and responded well to all my numerous requests and questions. They never neglected me and I really appreciated them for that. [Woman from Ksouth Aged 29].

Supportive care during labour involves a lot of emotional and comforting measures, information and advocacy:

Immediately after I arrived at the out patients department whilst in labour, a team of workers in the hospital assisted me into the labour ward. They were actually very kind to me. The midwife then took over by examining me and making me feel relaxed throughout labour. [Woman from KATH Aged 28].

These views show that participants experienced a continuum of health care, where every medical team member did his or her part well, and collectively, that enhanced the mother's health care experiences in child-birth care.

Experiences of skilful care

Generally speaking, all midwives, throughout their training, receive important skills that are useful for the management of reproductive health care issues, including the management of normal pregnancy, labour and the puerperium. As part of the midwives skills, they are able to detect abnormality, manage and/or refer to the relevant departments or personnel. Most participants in the study acknowledged the skills of their midwives, as can be seen in the following quote:

In terms of delivery or conducting of the delivery process, they (midwives) do just what they have to do. The baby was not coming out well and that was why I was brought here. With the midwives efforts, everything went well. I did not have any surgery. [Woman from KATH Aged 40].

It seems most mothers showed how much they trusted their midwives for them to receive safe health care. Participants were very confident of what their midwives did and with their abilities to help them through their child-birth in order for them to have a safe delivery. One of the participants said:

When the midwife examines you and tells you something about your baby, be sure that is exactly what is the case is. After examining me, she said I will deliver in the next 5 hours and this is what happened. [Woman from Ksouth Aged 22].

Another participant spoke about her experience with the skills of the midwife during her child-birth care. She said:

The midwife is very skilful, I usually have difficult labour when I deliver at home, but the way she went about it, they have been trained. I will not stay at home anymore; I will rather come early to the hospital. [Woman from Apat aged 34].

Yet another participant in this study recounts encouraging experiences with her care in the puerperium:

I gave birth to twins. After the first twin, I was so exhausted. They encouraged me to help myself so that they can support me and honestly they did well. They gave me an

intravenous infusion and monitored me until the second twin came out. They afterwards monitored my blood pressure until I was completely stable. They cleaned me up and sent me to a neatly prepared bed to rest and breastfeed them. [Woman from Ksouth aged 26].

Participants in this study talk about their need for skilful care throughout the child-birth period and in the puerperium, including for the care of their baby. There were some participants in this study who were first-time mothers and did not have the knowledge and skills to take care of their babies. They therefore depended heavily on the midwives for their support and clearly appreciated it. Another participant had this to say:

I was welcomed well here and was helped a lot to experience labour. I was also given a cold drink after the delivery and helped to breastfeed my baby and to bath him [Woman from KATH aged 30].

The need for information and support is also acknowledged during the puerperium. Mothers feel they need to know what to do in order to take good care of themselves and their babies. It is deduced from these quotes that participants wish to be compliant with their postnatal clinic schedules and are happy if these were made known to them. This was done well by the midwives. Another participant said:

When I came to the hospital, I was examined and told that everything was alright with me. After delivery, I was also told when to report back with my baby for the examination and Immunization programme. [Woman from Apat Aged 37].

Participants also spoke about the need for getting essential information that assisted them with their health care and that of their babies during the puerperium. This is seen in the quote below:

After delivery, I was told to attend 2 weeks and 6 weeks post-natal clinic sessions with my baby. I did that and found the midwives very good in whatever they did. They told me everything I needed to know. [Woman from Apat Aged 28].

4.3.2 Discouraging experiences

The second theme that emerged from the analysis of participants' experiences with child-birth care was that of discouraging experiences. This theme had four sub-themes: disrespectful care, inadequate communication and involvement, inadequate resources and inconsistent care. These discouraging experiences align very closely with mothers' expectations and left participants less than satisfied with the type of care they received during child-birth.

Experiences of disrespectful care

There were some mothers in the study who reported that they experienced one form of disrespectful care or another. This suggests that the problem of disrespectful care is a common occurrence in health facilities. The disrespect took the form of disregard or impoliteness by the midwives. It means that midwives are not always good to their patients, as there are times when their services are questioned by the clients. One participant said:

The midwife was very rude to me and did not even mind me. [Woman from KATH Aged 40].

This often led to participants changing their usual health facilities or places of child-birth. Another participant said:

It is not like I only heard of it (bad attitudes) but I have actually experienced it before; the shouting, hitting and the verbal abuse. I have experienced all of them. I remember an unfortunate incident that happened during my first child birth. I got to the hospital in the morning just, when the night duty nurses were about to hand over to the morning staff that were not present at the time I arrived. One of the nurses told me to wait for the morning duty staff, in spite of the strong contractions and labour pains I was going through. She was very heartless. I pleaded with her but it yielded nothing. I decided to push out the baby right at the nurses' station and later when they got to know that indeed the baby was almost out, they rushed me to the delivery bed. It is very appalling and dehumanizing. [Woman from KATH Aged 32].

This shows that many women are not happy with the service delivery of nursing staff. Another participant who felt dissatisfied with the nature of communication and attitudes of the midwives to their clients during the child-birth process said:

I was shouted at whilst in labour and was hit on my thigh.....because the midwife said I was not pushing out the baby hard enough, and yet I was. She spoke to me as if I was her little girl. [Woman from Ksouth Aged 33].

Participants reported that the midwives, in an attempt to ensure that they comply with their directives and have a good outcome of birth, use various strategies, such as threatening, hitting, shouting and the like. A mother in this study reiterates what the midwives had told them earlier:

The midwife had told us at the antenatal clinic that if we fail to push in labour we will be beaten. She also showed us a whip she alleged was the one from the labour ward. I did not like that at all, are we children? [Woman from Ayid aged 34].

Thus, some participants reported that the midwives, in an attempt to ensure that they complied with directives and to have a good outcome of birth, use various strategies on their clients, such as threatening, hitting, shouting at them and the like. Mothers said that this happened as midwives sought to encourage them to push the baby out, particularly in the second stage of labour when the midwives realise that any further delay in delivering the baby could be detrimental to the baby and its mother. However, some mothers are not happy about it.

Although the intention of the midwives in these doings can be understood to be well-intentioned for mothers in order for them to have good outcomes of child-birth, mothers did not appreciate it as they think there are better ways of ensuring cooperation of the mothers. This is depicted in the following quote:

...Eh! Is that how you can communicate with adults in order for them to comply you're your orders? As for these people, I do not understand how they think when they do these things. [Woman from KSouth 6].

Thus, participants gave their own accounts of their experiences that made them discouraged with health care, such as non-courteous treatment.

Experiences of inadequate communication and involvement

Participants reported that generally there is a lack of effective communication and involvement of mothers in decisions made by the midwives during their child-birth care. Mothers considered effective communication with them or their families a cornerstone for providing satisfactory child-birth care because it makes the mothers understand and appreciate whatever is happening to them. Ineffective communication such as taking decisions without the involvement of mothers leads to dissatisfaction with care. A participant said:

The midwives did not even engage me in any discussions over my child-birth process. They never told or asked me about anything. [Woman from KATH aged 28]

Yet another participant expressed her dissatisfaction with ineffective and inappropriate communication from her caregivers; she also had some advice:

They should learn to communicate their findings to mothers after carrying out a procedure on both baby and mother. The midwife just handed the weighing card to me without telling me anything. They should be able to tell me whether my baby is gaining or losing weight or stunted. [Woman from Apat aged 30].

This is why inadequate communication and lack of involvement of mothers during child-birth care are seen as discouraging experiences.

Experiences of inadequate resources

Participants also reported that there were inadequate resource materials, including human resources. This left them feeling rather dissatisfied with the health care provisions they received. With regards to human resources, most of them report that it seemed that there were fewer midwives on duty to take care of a great number of mothers. One mother said:

...While in labour, we mothers were so many for only 3 midwives. They could not effectively attend to all of us. [Woman from KATH Aged 42].

Most mothers also thought that there was poor or inadequate material resources in the health facilities for their child-birth care. They said that material resources available were not enough to take care of them and their babies because of the overwhelming numbers of clients. A mother participant said:

At the facility, the majority of us stood while waiting for our turns. Only a few chairs were available. Even when everything is done and you have your prescription, you will still queue at the pharmacy. Ah, it is a nightmare to think that you will be going to the clinic. We are too many at the antenatal clinic for the midwives, so that we queue for everything, such as waiting to see the midwife, blood pressure checking, urine testing, laboratory testing and collecting medication at the pharmacy. [Woman from KATH Aged 38].

Experiences of inconsistent caregivers

Participants also gave accounts of the kind of care they received from the different midwives they worked with during their child-birth care, which left them less satisfied with the healthcare they received. Participants spoke about their unhappiness at meeting new midwives on each visit they made to the health care facilities, and wished they could have the same midwives who they could identify with. This is how they saw this:

None of those midwives who took care of us during the antenatal care were at the labour ward when we went for labour, getting different sets of midwives to take care of us and our newly born babies. If I had the choice, I would have a midwife I know already in my antenatal care unit when delivering my baby. [Woman from KATH Aged 40].

In summary, it seems child-birth care services in public health centres in the Kumasi metropolis is constrained by many factors, with material and human resources being the worst of them. Thus, health staff is unable to keep up with the large numbers of clients who visit these centres. Additionally, clients seem to have varied expectations of their care providers. They need facility-based child-birth that are manned by skilled birth care providers. This increases the safety of facility-based health care delivery and ultimately contributes towards a reduction in both maternal and infant mortality rates in the country.

4.4 Discussion of findings

This section presents a discussion of the results of the qualitative research on the ways in which health care provision is understood and experienced by mothers during child-birth care in public health centres in Kumasi, Ghana. The discussion places emphasis on how the findings relate to the wider literature. It seeks to draw attention to points of symmetry and asymmetry between the current study and other research findings.

4.4.1 Expectations and experiences of mothers

Expectations and experiences of mothers are discussed together in this section because from the results it was evident that clients' expectations were influenced by their previous experiences or the experiences of others, and therefore are reflections of their experiences. Results from the analysis of this study reveal that mothers' expectation of child-birth care was to receive respectful care which was courteous and dignifying and to be involved in their care. With regard to mothers' experiences with child-birth, they were encouraging if mothers perceived empathy, continuous labour support and skilful care. The care participants received was also dissatisfying if the mothers perceive disrespect, did not receive adequate communication and involvement, did not have adequate resources, and had inconsistent caregivers Moyer et al (2013).

4.4.1.1 Expected Respectful care

In the context of this study, mothers' expectations of care relate to receiving respectful care during child-birth, which then led to satisfaction with care. Similarly, a study from Bangladesh reports that the most fundamental forecaster for client satisfaction with service was provider attitude or behaviour, especially showing respect and politeness. This was found to be more important to clients than the technical skills of providers (Turkson, 2009). From inferences participants in this study made, respectful child-birth care was as important to them as the technical skills of providers.

There were concerns in this study about midwives addressing mothers by name to show them respect. The literature supports this finding and suggests that addressing clients by name helps maintain their uniqueness and identity, which goes a long way to improving their satisfaction with the care relationship (Morad, Parry-Smith and McSherry, 2013). This study also reported mothers' desire for attention and for midwives to use kind words when addressing them, which is similar to observations by Eghdampour, et al., (2013) who found that a lack of attention to mothers' can be seen in the comments and suggestions made by midwives, such as not speaking kindly and politely, which lead to dissatisfaction with care among mothers. The study therefore reported that most mothers expect the caregivers to be polite and empathetic towards them. Bower (2002) reports from an explorative qualitative study of mothers' experiences in labour the need for calm and supportive professionals who are kind to their patients and meet their emotional and physical needs. This helps to make the child-birth experience satisfactory to mothers.

This study, however, identified that there was an inadequate midwife-to-mother ratio, and this tended to affect mothers' expectations and satisfaction levels with child-birth care provision. It has therefore noted that inadequate numbers of midwives to-mother ratios in the facilities leads to a situation where mothers do not receive adequate attention from midwives during care. This was supported by ICM (2014); Twigg et al., . (2010); Flynn and McKeown, (2009), that the number of patients allocated to a nurse or midwife on a shift was directly related to patient safety, mortality and satisfaction with health care provision to patients. In addition, the internationally recommended midwife-to-child-birth ratio was one midwife for every 29.5 births (1:29.5) even though this was not realised in many countries, especially in Africa (Flynn and McKeown, 2009).

Expected courteous and dignified care

The study identified the truth that mothers expect to receive courteous and dignified child-birth care from the care givers. This means that mothers' expectation was that their interactions with their care providers will be cordial, that their views will be sought and they will receive satisfactory responses to their queries. The literature reports that seeing clients as individuals and being reasonable with them during care provision equates to dignity (Magill-Cuerden, 2007).

This was supported by Morad, Parry-Smith and McSherry (2013), and RCN (2008) that meeting the physical, emotional and spiritual needs of clients also constitutes dignity in care. The literature again reports that midwifery clients require emotional, information, physical and advocacy support particularly during labour (MIDIRS, 2008). These forms of support build their confidence in their ability to go through the process of labour and also to manage the pain (Mander, 1998).

Mothers' in this study reported experiencing various forms of belittlement by midwives. Aranda and Jones (2010), in a critical exploration using a feminist perspective and theories of recognition, showed that some of the reason why women in maternity settings are at risk of failing to receive dignified care was because in many cultures, pregnant women are belittled due to their age and gender. The risk was heightened because of the assumptions that the women themselves are to be blamed if there were problems, mainly if these lead to the death of the baby. In the context of this study the reasons for abuse were contrary to those in the Aranda and Jones (2010) study. In this study the reasons why the mothers are belittled, hit, or threatened by the midwives during child-birth was that the midwives felt that they were accountable for whatever happens to the mothers and babies during labour. The midwives therefore employ measures to ensure compliance of mothers during labour.

The study also reported empathy shown by midwives as important in the satisfaction of mothers. This was supported in a study by Moloney and Gair (2015), which showed that midwives' empathy during women's child-birth experiences plays a key role in creating a positive birth and mothering experience. Other studies explain that midwives, dealing with emotionally difficult situations, may result in them employing different psychological defences in order to preserve their own identity (Morad, Parry-Smith and McSherry, 2013). This was supported by Aranda and Jones (2010), who assert that as a result of a constant tension between recognising the other people's views and asserting the self-image, professionals end up distancing themselves from clients in a variety of different ways. This includes failure to include women directly in decision-making processes and refusing to make and maintain eye contact during conversation or examination (Morad, Parry-Smith and McSherry, 2013). All these may be employed by the midwives as their self-protection response when faced with difficult situations. The end result of all these are the diminishing a woman's individuality, thereby compromising their dignity and self-respect.

Adequate communication and involvement

The study identified that most mothers did not receive adequate communication about their child-birth care processes and were not involved in the decisions about care provision. This was in spite of the fact that informed consent was necessary before procedures are carried out on them, particularly when the procedures involve invasion of their privacy. These findings are congruent with those by Muliira, Seshan and Ramasubramaniam (2013), which hold that performing vaginal examinations (VE) for example can be embarrassing, cause discomfort or pain. According to Hassan et al., . (2012) women dislike VEs because they are embarrassing and can be performed with little accompanying information and the technique was often done as a ritual and in an intimidating manner. Further, Stewart (2005) and Ying Lai and Levy (2002) explain that mothers' genital exposure that was associated with VEs can lead to some form of humiliation, which may further lead to a feeling of helplessness and vulnerability, dehumanization and the feeling that one's privacy has been violated. These can be overcome through the use of effective communication and involvement of mothers in key decisions during the process of child-birth care.

Respect for a mother's wishes, and her involvement in key decision-making about her child-birth care are essential elements of her own care during pregnancy and labour (Royal College of Midwives, 2012). Thus the involvement of the mother in her child-birth care needs effective communication with her on the outcome of procedures and/or on decisions key about her care in order to make her care satisfactory. In the study, most mothers desire to have better physical and emotional labour outcomes and to be involved in the decision-making processes during labour (Hodnett, et al., 2010). The Royal College of Midwives (2012) assert that showing concern and giving enough information to clients were important to a mother's birth experiences and to her subsequent emotional and psychological well-being.

According to the Joint Commission on Accreditation of Healthcare Organizations (2005), there was a link between a healthcare team member's communication skills and a patient's ability to follow and abide by those recommendations. Therefore the health care provider's ability to

explain, listen and empathize can have a significant effect on patients' compliance. According to Hallam et al., (2016), childbearing women require individualized care, centred in kindness, respect and dignity throughout their maternity experiences. The emotional needs of the labouring woman relate also to the need for information about the progress of her labour. This study identified a communication gap between midwives and mothers, which affected mothers' expectations, experiences and satisfaction with care.

Request for consistent caregivers

In the context of this study, mothers expected to have the same midwives taking care of them throughout their maternal health care continuum. It was noted that having a familiar care-giver strengthened the relationship between mothers and midwives and made it possible to plan successfully for the future. This was also supported by RCM (2012) when they indicate that child-birth mothers wish to have predictability of the health care-givers during their pregnancy and child-birth care, and that there was a need to maintain client/midwife relationships. This finding echoes the results of Eghdampour et al., . (2013) and Goberna-Tricasa et al., . (2011) who reported that having different care-givers during midwifery care provision can lead to the dissatisfaction of mothers. The relationship with a midwife who monitors child-birth develops into greater proximity and mutual trust between the client and the health care provider (Goberna-Tricasa et al., . 2011). Thus, most women prefer to have a trusting relationship with their care-givers during the labour process because they feel vulnerable during pregnancy and child-birth processes and end up wishing to be comforted by a familiar person (Cook, 2005). This implies that there was a need to reorganize child-birth health care (focused antenatal care), so that midwives and mothers bond with each other throughout the obstetric cycle and develop this trusting relationship over that period of time. This requires planning and change of nursing and midwifery care from the current task orientation to patient-centred care focus.

The practice of focused antenatal care during antenatal care was ideal rather than the traditional group antenatal care because in this model the patient-health provider relationship was established and interaction between the client and provider becomes cordial. One vital component of this process was the promotion of the interpersonal and communication skills of the health carers (Goberna-Tricasa et al., 2011). The Royal College of Midwives (2012) advocates that all women in labour should receive a one-to-one patient/midwifery support in established labour. This

position was also supported by Royal College of Obstetricians and Gynaecologists (2007). However, it may remain a pipe dream in many African countries because of the manpower challenges.

Lack of adequate resources for provision of care

The study showed that most mothers received health care in facilities with limited material and manpower resources which makes mothers rather unsatisfied with their child-birth care. Mother's desire to have private spaces during child-birth care was explicitly shown. The Royal College of Midwives (2012) reiterates that child-birth care must take place in an environment that protects and promotes women's privacy and dignity, respecting their human rights. Clearly, many facets of the physical environment influence mothers' child-birth experiences. It was imperative that the ward and outpatient environment was designed in such a way that conversations and health care procedures does take place in privacy (Morad, Parry-Smith and McSherry, 2013). This was not currently what is happening.

The impact of the health care environment on the health and recovery of patients cannot be under-estimated. Other studies have shown the connections between the environmental design of health care facilities and the outcomes that are important for patients, families, health care staff and healthcare organizations (Ulrich, Young and Brockbank, 2008).

Goberna-Tricasa et al., . (2013) and Williams (2006) also found that mothers' awareness of technologies used in child-birth care tends to produce two opposing effects in them. On the one hand, they feel satisfied with health care technologies meant to assist them and therefore view it as a source of security, especially the knowledge that they are in a hospital environment with modern technological facilities was a very comforting thing if complications to their delivery emerge. On the other hand, some mothers are terrified by these technologies. The study found many mothers who were happy about technological resources in health facilities because they guaranteed safety of both mothers and their babies.

Experiences of skilful care

The skills of midwives were identified as good, and acknowledged by mothers in this study because they guaranteed safe delivery. Mothers report that midwives are able to intervene in difficult labours and assist them to deliver safely. Mothers appreciate the midwives' skills particularly when they have been in labour with the unskilled birth attendant without progress. This was supported by the National Institute of Clinical Excellence (2007) and Eghdampour et al., . (2013) who say that most clients are satisfied with the physical support and skills of midwives when in labour. It agrees with observations by Moyer et al., . (2014) who indicate that dissatisfaction with facility-based child-birth care normally originates from the lack of or inadequacy of skilful care. This was seen as one of the major contributing factors to high morbidity and mortality rates in Africa. Most women in this study therefore perceived the quality of facility-based child-birth care to be generally poor and believe that there are times when they may choose to avoid it.

Discouraging experiences

The study reported that some mothers experienced disrespectful child-birth care which left them dissatisfied with their child-birth care. Respect of the health care environment, according to Beach et al., . (2007), was the realization of the unqualified worth of patients as human beings when seeking health care. That respect involves regarding the autonomy of the person to agree or not to agree with health care that was provided to them. Moyer et al., . (2013), in their study on midwifery clients in rural Ghana, also indicated that maltreatment of health clients was spontaneously described as unsatisfactory by many participants. This suggests that the problem of experiencing disrespectful health care provision was not an unusual occurrence. Similarly, many participants in this study reported that they experienced some form of disrespect or another whilst in health facilities. Moyer et al., . (2013) therefore concluded that this may discourage some women from seeking facility-based delivery services. This study's findings seem to show that majority of mothers changed their usual health facilities when they experience problems of health care delivery. Use of unskilled child-birth care was then seen as endangering the lives of both mothers and their babies, leading to maternal and neonatal mortality (Moyer et al., , 2013).

Inadequate communication and involvement

Participants in this study reported that there was lack of effective communication and involvement with clients in decision making and their care which led to client dissatisfaction with child-birth care services. Communicating effectively with patients and families was a cornerstone for providing health care (Planetree 2008). The manner in which a health care provider communicates key information to a patient was seen as very important in encouraging patients to cooperate with health care providers. Effective communication facilitates patients' better understanding of health issues by the client and eventual acceptance of the health services being provided. Ineffective communication therefore, can lead to patient anxiety, vulnerability and powerlessness (Planetree, 2008). This was also evident in the study.

Rudman, El-Khoury and Waldenstrom (2007) and Eghdampour et al., . (2013) in assessing reasons for mothers' dissatisfaction with labour and delivery care, report that lack of information, lack of explanations about procedures and disrespect of clients are all undesirable issues in the provision of care. Findings from the current study also align with those of Brown and Lumley (2007) in Australia, who reported that inadequate information during labour care leads to dissatisfaction.

Positions used for the child-birth

This study also identified the most common delivery position that was used in facility-based health care that many mothers view as a source of dissatisfaction. Most mothers in this study prefer to deliver in other positions other than the lithotomy position which was the only position that is used in these facilities. Other studies have shown the advantages of using the other positions of delivery over the lithotomy position. It was believed that it affords women a natural environment for child-birth, where the child-birth canal opens by at least 30 percent more than other delivery positions and that there was also less pain associated with the process (Donsante, & Shorten, 2002). A gap was identified by the study of the use of more effective delivery positions during child-birth.

4.5 Service improvements required

It was evident from most participants' narratives that when their positive expectations are met during child-birth care, they ended up becoming much more satisfied with the services rendered to them. If a negative expectation was disconfirmed, they ended up satisfied with the health care services. On the other hand, if clients' positive expectations were not met, patients ended up dissatisfied with the health care delivery system. This findings is supported by the expectation confirmation theory (Jiang and Klein, 2009). Thus, participants' desire to receive respectful and safe care during child-birth care needed health care providers to communicate much more effectively with the patients and to involve the patients in key decision making in the health care process. Most mothers, therefore, expected to receive health care provision using adequate human and material resources. This is congruent with recommendations of the Royal College of Nurses (2013) that adequate human and material resources are essential for health care provision. Participants' dissatisfaction with the health care services they receive was normally associated with non-courteous treatment, disrespectful health care, ineffective communication and lack of patients' involvement in decision making, bad attitudes shown by health care-givers and poor or inadequate infrastructure and human resources, as was discussed in the earlier sections. It was therefore inferred from participants' descriptions of their expectations of child-birth care services and the kind of health care services they received that, in satisfactory child-birth care, most mothers' desire that their expectations be met positively by health services providers. The preceding section gave an outline of the areas in which participants desire an improvement in their child-birth health care provision.

4.5.1 An outline of areas of improvement in child-birth care provision

This outline was arrived at after synthesising the most dominant themes and sub-themes arising from the expectations and experiences of participants with child-birth care.

- Respectful care, which encompasses courteous and dignified care provision and adequate communication and patient involvement in decision making.
- Safe care provision, including having to maintain the same care-givers, availing adequate resources and yearning for positive child-birth outcomes.

- The use of varied delivery positions during child-birth.

4.6 Conclusion

Hitherto, the study has explored the expectations mothers in child-birth health care provision in public health centres, and described the health care services improvement for mothers in order to realise satisfactory child-birth health care provision in public health centres. It has outlined some of the areas in which these improvements are required. In this process observations have been presented, followed by discussions of the findings in which the following themes and sub-themes relating to mothers' expectations of child-birth health care provision has been detailed: safe health care, adequate communication and involvement of patients in decision making, adequate resources, positive child-birth outcome, empathy, continuous labour support and attention, skilful health care provision, disrespectful care and non-courteous treatment among others.

The cross-cutting factor among all these themes and sub-themes were effective communication. It was common knowledge that mothers are ignored, belittled, hit or teased by midwives in public health institutions. Hitting, shouting or ignoring mothers makes them feel that they are treated like little children, and therefore feel stupid and taken for granted. As has already been observed, mothers expect to be treated well, making them feel their self-worth and maintain their identity and dignity as women. They expect their body, and particularly their genitalia, to be handled with dignity, and not be at the mercy of the midwives. Touching their body parts without their consent constitutes disrespect to them and their womanhood. Thus, generally, most mothers indicated an inherent need to be made aware of their conditions and that of their babies in order for them to appreciate the services rendered on them and for them to participate fully in any decision making that affected them. It is no less important to say that effective communication in child-birth health care was an imperative to service providers as well as to the clients. It must be clear. Since the needs of each mother can sometimes differ from others, each mother needs to be engaged throughout the labour process in order to achieve effective mother participation in child-birth health care service. If mothers participate in key decisions about their own child-birth health care, they can eventually feel to be part of the whole process of child-birth health care and can be in better control of it.

The discussions indicate that these observations are not in isolation. Several other studies, reserving rights of study area variations, have, to some extent, attested to or alluded to the same observations. There is therefore, a link between respectful and dignified health care provision and safe health care provision. Respectful communication was dignifying and safe to mothers in the sense that it makes mothers understand the kind of health care processes that are offered to them and their nature of involvement in it. It also eliminates some fears and uncertainties that can be associated with health care provision and eventually strives to ensure the realization of safe health care provision. In the public health facilities themselves, resources are over-stretched and in poor condition as a result of high demand on them. Mothers out-number the available chairs and beds in the antenatal clinics and wards and in the postnatal clinics and wards. The situation was no different in the laboratories and pharmacies where mothers form long waiting queues to obtain these health services. Often, some participants have to stand for long periods while they await their turn for the services. Thus, participants reported positive experiences, for which they were satisfied with their health care services in the antenatal, labour and puerperal period. These are experiences that mothers were happy to have and which made them satisfied with the health care provision. Generally, mothers in this study referred to any interaction with midwives without their consent as being non-courteous treatment. They expected to receive health care services that are civil and cordial. Such health care service makes them feel disregarded, ignored and marginalized. It was evident from participants' narratives that when their positive expectations were met, they then become a lot more satisfied with the service. If a negative expectation was disconfirmed, they were satisfied. On the other hand, if clients' positive expectations were not met, they became dissatisfied with health care provision.

CHAPTER FIVE

INTEGRATIVE LITERATURE REVIEW OF INTERVENTIONS TO ADDRESS CLIENT DISSATISFACTION WITH MATERNAL HEALTH CARE

5.0 Introduction

In phase II of the current study an integrated literature review was conducted to review evidence based best practices to address client dissatisfaction with maternal health care, as observed in phase I. The current phase was the first step leading to the development of a patient-centred care in-service training programme for midwives to address client dissatisfaction with care. This chapter gives details of the functional elements that were identified from recognized best practice interventions that addressed client dissatisfaction with maternal health care.

5.1 Justification for study design

The rationale for conducting an integrative literature review is to summarize and critique the state of the science about a specific research topic, by analysing previous research studies and generating new perspectives on the topic (Torraco, 2005). The integrative literature search was useful in identifying how health professional's knowledge, skills and attitude had previously been upgraded to enhance patient care so as to learn from these interventions. The current literature review synthesises ways in which client dissatisfaction with maternal health/health care has been addressed; analysing the kinds of problems that were reported; and describing ways in which these were successfully addressed. The integrative literature review includes literature from all sources, and is not limited to randomized controlled trials (RCTs) as is the case with most systematic reviews but may include non-experimental research, such as case studies, observational studies, and meta-analyses (Whittemore and Knafl 2005). Thus, in the current review both qualitative and quantitative studies are included to allow for a broader examination of the problem (Bluestone et al., 2013; Tarraco, 2005).

5.2 Methodology

This integrative literature review was conducted using a literature search; details of the methodology are discussed next.

5.2.1 Search strategy

The search strategy for the review covered articles published in data bases such as: Academic search complete, Health Source: Nursing/Academic edition, CINAHL and Google Scholar. The period for this review focused from 1996 to 2016. The following search strategies were used and with the help of Medical subjects heading (MeSH) other terminologies were identified and included:

1. ("midwifery" OR "nurse midwives" OR "midwives" OR "midwife" OR "skilled birth attendant" OR "nurse") **AND**
2. ("Training" OR "guideline" OR "intervention" OR "program" OR "programs" OR "in-service" OR "education" OR "curriculum" OR "learning") **AND**
3. ("Patient-centred care" OR "patient-focused care" OR "soft skills" OR "patient satisfaction" OR client satisfaction").

5.2.2 Exclusion criteria

Exclusion criteria for the search was studies and interventions provided by Traditional Birth Attendants (TBAs) or Community Health Workers (CHWs) or to a community and to patients because these category of workers do not have the same work environment as the midwife. Studies that did not meet the aim of this current review were excluded.

5.2.3 Review question for data extraction

These review questions guided the data extraction process to ensure the collection of all relevant data, to minimise risk of error in transcription and to ensure precision in checking for information (Whittemore and Knafi, 2005). Therefore, the researcher was guided by the research questions put in place for evidence of interventions that may increase midwives' ability to provide client-centred care services to mothers during child-birth. These review questions guided the extraction of relevant data for the study as each question was applied to

every research article to identify relevant issues that address these questions. These relevant issues were then noted and extracted.

Review questions

- What training programmes or guidelines have been put in place to improve care provision to clients?
 - What evidence suggests that these programs were successful or what was the improvement in outcomes after these interventions??
 - What techniques were used in the delivery of the training programmes or guidelines?
 - Who were the participants attending these programmes?
- How feasible are these intervention programmes?

5.2.4 Data analysis

The approach given by Popay et al., (2006) in their guidance on the conducting of narrative synthesis in systematic reviews was adapted.

- i. Developing a preliminary synthesis
- ii. Data extraction and exploration of relationships in the data
- iii. Assessment of the robustness of the synthesis

Developing a preliminary synthesis

Preliminary synthesis of the available literature consisted of noting the descriptive characteristics of the retrieved articles in a table so as to produce a textual summary of the results. This enabled the exploration of relationships both within and between the studies reviewed as well as quality appraisal of the methodology used in the studies (Iwelunmor et al., 2015).

Developing preliminary synthesis began with determining inclusion and exclusion criteria for the study. Studies that were conducted between 1996 and 2016 were included. This was to allow for exploration of both old and new literature that improved client care by addressing health care professional's knowledge, skills or attitude. All studies included were reported in English.

Initially, all titles and abstracts were screened by the researcher and then a colleague to determine eligibility. The screening process was guided by the inclusion criteria for the study. Where there were any disagreements, a third person (colleague) was brought in to resolve it. During this process, some articles which did not meet the inclusion criteria were excluded; including book chapters, reports and dissertations.

5.2.5 Data extraction

After this first step of developing a preliminary synthesis, the researcher extracted data and reviewed again the extracted data for disparities, erroneous and or inconsistent data. This was followed by exploring relationships between and within data through the use of the sub-questions for the review to identify relevant issues on interventions to improve client care and or health outcomes. These reviews were then extracted as evidence that could be applied to improve maternal satisfaction with child-birth care in public health settings.

The researcher used a standard template to extract the following information from the articles please refer appendices 3-5 (Pages 177-183).

5.3 Description of table of robustness

The quality of the reviewed papers was assessed by the researcher and her colleagues using a checklist adapted from JBI-Qualitative Assessment and review (QARI) critical appraisal. On the basis of these criteria, each reviewed paper received a quality grade of yes, no or unclear. “Yes” attracts a score of 1 whereas “no” and “unclear” attracts 0. The criteria has ten assessment tools that include;

- i. if there were congruity between the stated philosophical perspectives and the research methodology
- ii. if there were congruity between the research methodology and the research questions or objectives

The article scores 2 if it explicitly had information on the assessment tool looked for and 1 if it did but was not clear. An article which did not have information of the tool assessed scored 0. The score is calculated out of 10 and any score between 8 and 10 is considered good in quality and therefore good for inclusion in the study. Any disagreement in this grading process resulted in consulting a third colleague for resolution. Based on these criteria, 4 articles were scored 9 whereas 8 articles were scored 8 indicating that the articles were of

good quality. Tables in Appendix 2 A and 2 B (pages 177-178) for criteria for robustness and assessment of robustness.

5.4 Results

Data-bases that were searched included Academic search complete, Health source, CINAHL, Google Scholar and Cochrane. From figure 5.1, it can be seen that 780 titles and abstracts were found to be potentially eligible. These articles were then screen by title and abstracts which led to the elimination of seven hundred and fifty-seven (757) articles and the retention of twenty-three (23) articles. Further screening of the 23 articles for duplication led to the elimination of 6 other articles. Seventeen articles were finally reviewed for full text and relevance which led to the elimination of five articles and the retention of twelve (12) articles which were eligible for the study. These articles were published between 1998 and 2015.

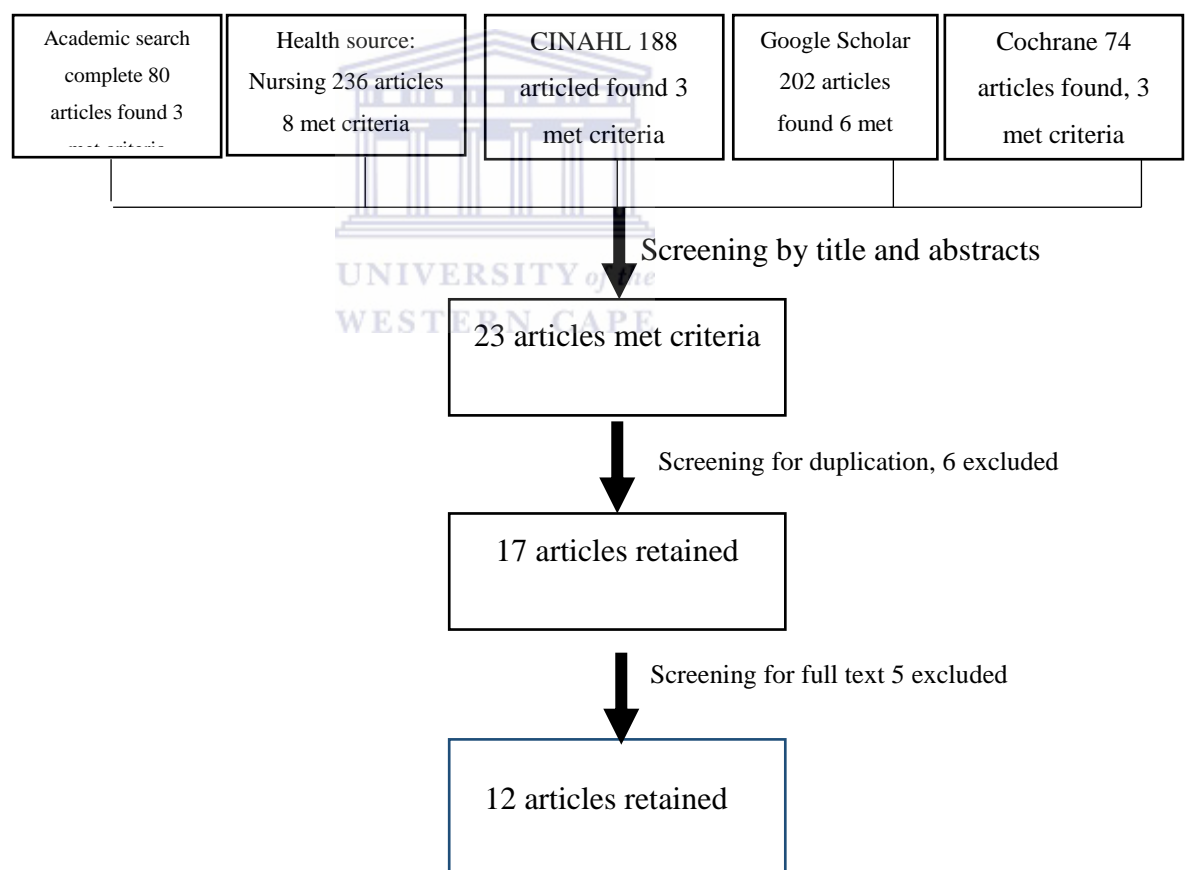


Figure 5:1 Diagram of data bases searched and flow chart of the screening process

5.4.1 Summary of study characteristics

From the articles included in this study, 4 used systematic reviews to identify randomised controlled trials (RCTs) that studied the effect of training on health professionals performance to improve care (Bluestone et al., 2013; Kerfoot et al., 2007; Rowe et al., 2002 and Coomarasamy and Khan 2004). Eight other articles used experimental and non-experimental studies and case studies while conducting training sessions among health professionals on various modules for knowledge, skills and communication training to improve health professionals' performance and patient care (Opiyo and English 2015; Norgaard et al., 2012; Majumdar et al., 2004; Ngongo et al., 2012 and Crofts et al., 2007).

Bluestone et al. (2013) in a study in the USA conducted a review on the effect of in-service training design and delivery with evidence from an integrative literature review. The authors conducted a search from multiple databases for systematic reviews, RCTs and programme evaluations published in peer reviewed journals from 2000 to 2011. Their research questions focused on the evidence supporting educational techniques, frequency, setting and media used to deliver instructions for continuing health professionals' education. From Nairobi, Kenya Opiyo and English (2015) studied how in-service training for health professionals can improve care in low-income countries. Their aim was to assess the effect of in-service training on the health professionals' treatment of patients in low-income countries. Methods used were Cochrane database search for systematic reviews. Randomized trials, non-randomized trials, controlled before and after studies and interrupted-time-series that compared the effect of in-service training versus usual care. From Taiwan, Lin et al. (2010) aimed to compare the effectiveness of learning in peer tutored problem-based learning and conventional teaching. They used an experimental design. Whereas Norgaard et al. (2012) from the United Kingdom studied how communication skills training increases self-efficacy of health care professionals. The objective was to investigate the impact of communication skills course on participants' self-efficacy with a focus on communication with both colleagues and patients. They used a training course implemented in a real-world context. From the USA and Canada, Kerfoot et al., . (2007) using RCT, participants were randomised to cohort groups 1 and 2. Cohort 1 received bolus education and were e-mailed a set of

materials only once. Cohort 2 received spaced education and received daily e-mails with repeated contents.

Coomarasamy and Khan (2004) in a systematic review, evaluated the effectiveness of standalone teaching and clinically integrated teaching among health professionals. Whereas Majumdar et al. (2004) studied the effect of culturally sensitive training on health care provider attitudes and patient outcomes. The objective was to determine the effectiveness of cultural sensitivity training on the knowledge and attitude of health care providers and to assess the satisfaction and health outcomes of patient groups with health care providers who received training. In this study, health workers were randomly assigned to experimental training and control groups. Their study was done in Birmingham, England. From the USA, Bruppacher et al. (2004) conducted their study to determine if simulation-based training or an interactive seminar for health professionals resulted in better care for the patients. A prospective, single-blinded, randomised controlled trial and training sessions with simulation and another with seminar were done.

Ngongo et al. (2012) with the objective to provide ongoing professional development to midwives while striving for excellence, used a 2 week intensive staff development including presentations and hands-on training on models to simulate obstetric emergencies. From the USA, Crofts et al. (2007) studied change in knowledge of midwives and obstetricians following obstetric emergency training. The objective was to explore the effect of obstetric emergency training on knowledge to assess if acquisition of knowledge is influenced by the training setting or teamwork training. Using a prospective randomised controlled trial conducted in 6 hospitals in the South West of England, participants who were midwives and obstetricians, were randomised to one of 4 obstetric emergency training intervention between 1 or 2 day simulation or hospital training course. Rowe et al. (2002) studied improving communication between health professionals and women in maternity care. The objective was to review trials of the effectiveness of interventions aimed at improving communication between health professionals and women in maternity care. Databases were searched, for controlled trials of intervention explicitly aimed at improving communication between health professionals and women in maternity care, their study was done in the UK. Findings from these studies are presented next.

5.4.2 Target Populations for the interventions

The population was mostly health professionals including nurses, midwives, doctors and anaesthetists (Opiyo and English, 2015; Crofts et al., 2007; Majumdar et al., 2004; Rowe et al., 2002). These studies were done in Nairobi, Kenya (Opiyo and English, 2015), the United States of America (Crofts et al., 2007), Canada (Majumdar et al., 2004) and in the United Kingdom (Rowe et al., 2002).

5.4.3 Interventions used to improve client satisfaction.

These interventions were aimed at addressing issues of staff communication with staff and with patients, attitudinal issues, skill acquisition and to determine the effects of attitudinal training for staff on patient care. In 4 of the articles reviewed the authors used RCTs, integrative literature search and literature reviews to assess for evidences as to how other health professionals' skills, knowledge, attitudes and communication towards clients were improved. The main intervention common to all 12 articles reviewed was the use of in-service training programmes to update knowledge, skills and attitudes of health professionals. Contents that were delivered centred on communication skills, culturally sensitive approach to care and improving health outcomes for patients. Educational techniques were the means or methods by which these contents were delivered; such as case studies, didactic/lecture, interactive teaching and learning approach, problem based learning and team based learning. The use of these various teaching and learning approaches enhanced the acquisition of the required knowledge, skills and attitude by the health care professionals although some of these approaches were found to be more successful than others.

Evidence from the RCTs suggests that *integration of in-service training programmes within the clinical setting* is useful in changing the behaviour of health professionals positively (Bluestone et al., 2013; Rowe et al., 2002; Kerfoot et al., 2007 and Coomarasamy and Khan, 2004). The use of in-service training has been successful in improving client-provider communication, provider-provider communication, knowledge, skills and attitude of health professionals towards patients and clinical behaviour in general (Opiyo and English, 2015; Crofts et al., 2007; Majumdar et al., 2004; Rowe et al., 2002).

Various *teaching techniques* were used in the interventions. Teaching technique refers to the means by which knowledge, skills, attitudes and behaviour was transferred by the instructor

to the learner (Bluestone et al., 2013). Eight articles were identified to focus on techniques. The findings of articles that focused on techniques is presented in Appendix 3. Educational methods that were used were lecture, interactive methods such as case studies/problem based learning, role play and simulation/demonstration.

Lecture

This is where knowledge content is presented and the facilitator determines content, organization and pace (Bluestone et al., 2013). The lecture method was used by Lin et al. (2010) and Reynolds et al. (2010) where lecture methods were found to be effective in the transfer of knowledge when compared with other methods. Reynolds et al. (2010) compared simulation-based training with didactic lecture and print visuals and found a significant increase in the mean post-test score and overall higher learner satisfaction with simulation-based training. Coomarasamy and Khan (2004) in a systematic review, compared classroom teaching with clinically integrated teaching for evidence-based medicine; they identified that classroom teaching improved knowledge but not as much skills, attitudes and behaviour; on the other hand, clinical teaching improved knowledge, skills, attitudes and behaviour.

Interactive methods

This is the use of varied teaching methods such as case study/problem based learning, simulation, demonstration, role play. These methods were used by Bluestone et al. (2013) and Lin et al. (2010) who found interactive teaching methods to be very useful in teaching knowledge, skills, attitude and behaviour. Interactive methods were also found to be useful in teaching the adult learner. These teaching and learning methods were found to be more successful with the adult learner because they are interactive. They were also useful when multiples of the methods were used together (Bluestone et al., 2013).

Case study/problem-based learning

This is an interactive teaching method which requires the use of created or actual cases that present materials and questions (Bluestone et al., 2013). These methods were used in training health professionals with positive outcomes (Nargaard et al., 2012; Bluestone et al., 2013).

Role play

This is also an interactive teaching method where roles are assigned to participants to depict a situation which is then discussed. This method was used by Bluestone et al. (2013) and found to be useful in the teaching of knowledge, skills, attitude and behaviour.

Simulation based training and demonstration

This is where the educational training takes place in settings that are set up to mimic the real situations. Simulation based training and interactive teaching was compared by Bruppacher (2010) it was found that both approaches were useful in the transfer of knowledge, skills, attitudes and behaviour.

Setting and frequency of the interventions

Setting is the place where the training took place. Two articles were identified that considered the place where the training took place. The findings are presented in Appendix 4 Opiyo and English (2015) in RCTs compared the effect of in-service emergency care training with usual care and found that the type of training did not make a difference, as there was improvement in health professional's treatment of patients. These intervention programmes were offered in settings such as the clinical settings and simulation laboratories and for durations between 1 and 3 days.

5.4.4 Outcomes of the interventions

The outcomes were the consequences of the training intervention and were changes in knowledge, skills, and attitudes which were affected positively and thereafter affected the clinical behaviour of health professionals. These were reported in the studied articles through post-test assessment of participants that received the various forms of interventions during the in-service training sessions. From the weight of the evidence across these studies reviewed, there was indication that in-service training could effectively address knowledge particularly if varied teaching methodologies are applied (Opiyo and English 2015; Norgaard et al., 2012; Majumdar et al., 2004; Ngongo et al., 2012 and Crofts et al., 2007).

5.4.5 Feasibility of these in-service training programmes

From the review, it is evident that in-service training programmes were feasible. The programmes did not bring about large budget cost if; participants were non-residential and so there were no accommodation cost, the programmes were held within the hospital premises and conference halls within the hospitals were used. The main costs incurred were for payment for facilitators and snacks and lunch for participants Majumdar et al., 2004; Ngongo

et al., 2012 and Crofts et al., 2007). On the other hand if participants are residential, the cost of accommodation and conference spaces adds up to the cost. The in-service training programmes are also organised in cohorts for the health professionals since all the staff cannot be taken off duty at the same time. However, the evidence strongly suggests that in-service training programmes are feasible for knowledge, skills and attitudes acquisition for health professionals to ultimately improve patient health outcomes (Norgaard et al., 2012; Kerfoot et al., 2007; Majumdar et al., 2004; Rowe et al., 2002).

5.5 Discussion of findings

From the review of articles identified for this study, there are similar discussions published about in-service education for health professionals as a format to improve knowledge, skills and attitudes with the aim of improving clinical behaviour and health outcomes for patients (Majumdar et al., . 2004; Nargaard et al., 2012; Bluestone et al., 2013). In-service training is a form of education and update given to people while they are in formal employment, and is a preferred choice of technique for health professionals because it does not take the professionals off duty for a long time as in a formal educational programme (Gott and Lesgold, 2000). Also in-service training programmes for health professionals enhances knowledge, skills and attitudes of health professionals to improve patient outcomes (Bluestone et al., 2013). In order to improve midwifery clients' satisfaction with child-birth care, in-service training programmes for midwives is considered expedient to change the clinical behaviour of midwives towards client care. The review found abundant evidence to support the use of in-service training which is frequently delivered in various modules useful for health professionals' improvement in client care (Norgaard et al., 2012; Kerfoot et al., . 2007; Majumdar et al., 2004; Rowe et al., 2002). The educational techniques that support positive transfer of knowledge, skill or attitudes (Bluestone et al., 2013; Norgaard et al., 2012; Kerfoot et al., . 2007; Majumdar et al., 2004; Rowe et al., 2002). These educational techniques are also supported by literature in education (Gott and Lesgold, 2000).

Furthermore, the review found that delivering modules such as communication skills and patient-centred care through the use of varied teaching and learning methods are helpful (Bluestone et al., 2013; Kerfoot et al. 2007). This is supported by some systematic reviews that centred on communication skills development and reported that the use of techniques that include behaviour modelling, practice and feedback, longer duration or more practice

opportunities were more efficient (Berkhof, 2011; Rabøl, Ostergaard and Mogensen, 2010) with simulations and feedback addresses attitudinal issues of health professionals.

For learning to occur, the learner must assume an active role in the teaching-learning process (Gott and Lesgold, 2000). Therefore teaching and learning that involves the learner actively enables learning. Additionally, the training methods that allow for immediate practice or application of knowledge after learning is useful in enhancing learning. This is supported by the adult learning principles (Norgaard et al., 2012; Brookfield, 1996).

5.6 Conclusions

In-service training is important in the improvement and safeguarding of competencies for optimal performance of health professionals to provide client-centred care service. Unfortunately, there were no interventions identified that aimed to improve patient-centred care for midwives. However, there is evidence of interventions for health professionals (which included midwives) and which aimed at improving clinical behaviour to improve client health outcomes. Thus, the use of multiple interactive educational techniques and application of adult learning principles can be helpful in the acquisition of attitudes and clinical behaviour.

Considering the nature of the competencies to be acquired by the learner and choosing the appropriate techniques to enhance its transfer is important in the success of designing and implementing in-service training programmes. Furthermore, it is useful to be conscious of and apply adult learning principles in the planning and implementation of the curriculum. From this review the following salient points are carried forward.

- i. Educational techniques that provide a passive transfer of information, such as lecture and reading should not be used alone as a teaching method but in combination with other methods that are interactive. Techniques that engage the learner in mental processing, for example, case studies, simulation and other interactive strategies should be used (Bluestone et al., 2013; Lin et al. (2010). This is also echoed by educational psychologists (Gott and Lesgold, 2000).
- ii. The use of simulation is a preferred educational technique, notably for psychomotor skill transfer (Crofts et al., 2007).
- iii. For the adult learners, self-directed learning was also found to be an effective strategy, but requires the use of interactive techniques that engage the learner. Self-

directed learning has the additional advantage of allowing learners to study at their own pace, select times convenient for them and tailor learning to their specific needs (Brookfield, 1996).

- iv. Adult learners want to be engaged in life-centred or problem-centred learning experiences and to perform tasks while learning. So the use of problem-based learning is recommended in teaching adults (Gott and Lesgold, 2000).
- v. Repetitive exposure of the desired competencies or behaviour is also supported in the literature. It is recommended to offer frequent in-service training programmes which then serves as reinforcement.
- vi. It is also important to direct the reinforcement programmes to important targets or information only to avoid what the educational psychologists refer to as cognitive overload (Gott and Lesgold, 2000).
- vii. The setting should be selected based on its conduciveness for the use of the educational techniques chosen. Additionally the setting should be similar to the work environment of the health professionals and should permit hands on practice for feedback.
- viii. The availability of appropriate staffing on the units, involvement of the staff in identifying the need for in-service training, having an explicit philosophy for the unit and continuous review and evaluation are important to ensure success and implementation of learning outcomes (Ngongo et al., 2012).

In-service training programmes can positively impact desired learning outcomes among midwives and further the provision of client-centred care services to clients, if effective teaching techniques are used.

CHAPTER SIX

DESIGN AND DEVELOPMENT OF AN IN-SERVICE TRAINING PROGRAMME ON PATIENT-CENTRED CARE FOR MIDWIVES

6.0 Introduction

In the first phase of the study it was found that mothers' experiences of child-birth care did not meet their expectations. Themes that emerged from the first phase of the study regarding women's expectations about child-birth care included;

1. Women's desire for respectful care with sub-themes of courteous care, dignified care, adequate communication, and involvement.
2. Women's desire for safe care which had sub-themes such as familiarity with caregivers, adequate resources, and positive birth outcome. With regards to women's experiences with child-birth care, themes that emerged were encouraging and discouraging experiences.

The sub-themes for encouraging experiences were empathy, continuous labour support and attention, and skilful care. With regard to discouraging experiences, the sub-themes were disrespectful care, inadequate communication and involvement with care, inadequate resources, and inconsistent caregivers.

In the second phase of the study, the integrative literature review, revealed that health professionals' knowledge, skills and attitudes could be upgraded to deliver improved care during in-service training programmes. Interactive educational techniques such as case studies, didactic/lectures with discussion, problem-based learning and role-play have been identified as best practice for in-service training modules (Bluestone et al., 2013; Ammentrop, Kofoed and Laulaund, 2010). In the current (third) phase, a patient-centred care, in-service training programme for midwives is designed and developed to build midwives' competencies to deliver patient-centred care that would enhance satisfaction with child-birth care.

The first section of this chapter describes the design of a patient-centred care in-service training programme; and the second section describes the outcome of the design process - the development of the in-service training programme to promote patient-centred care.

6.1 Description of the design process

The patient-centred care in-service training programme for midwives was designed using two sources: Chinn and Kramer's (1991) steps in integrated theory; and knowledge development in Nursing and Management Sciences for Health (2012): steps to programme development. These two steps were used because they offer a guide and an outline to the process of designing a programme which makes it clear and easy to follow and use. Chinn and Kramer's (1991) steps require that *the structure of the programme* should be described in terms of its **purpose**, **assumptions** and target **participants**. This is described in greater detail below. Management Sciences for Health (2012) further requires that details of the *dynamics of the programme* be provided in terms of subject areas, training topics and target groups to be involved. It further requires that the training objectives including teaching and learning methods, sequencing of topics, and orientation for facilitators, monitoring and evaluation be specified. These are discussed in great detail in this section.

6.1.1 Structure of the programme

Purpose

According to Maricel and Factoran (2009), in-service training programmes are implemented to improve the performance of professional staff by keeping them up-to-date with new knowledge, skills and attitudes, to release creative activities and to provide assistance to staff to meet expectations. The purpose of this in-service training programme is to build midwives' competencies (knowledge, skills and attitudes) to provide patient-centred care to mothers during child-birth care.

Assumptions

In the development of the patient-centred care in-service training programme for midwives, the researcher based her assumptions on the expectation confirmation theory (Jian & Klein, 2009), and customer satisfaction framework (Choy, Lam & Lee 2012). It follows from these theories that customer satisfaction/ dissatisfaction reside in people's ability to learn from their past experiences. This therefore leads to an increased possibility of embarking on similar activity if one perceives there to have been positive consequences as a result of this activity. These theories were deemed fit for the study based on their focus on determinants of satisfaction with service delivery (as discussed in the conceptual framework of the study). These assumptions are as follows:

- Patient values, expectations of and experiences with child-birth care determine their satisfaction with care.

- Patient satisfaction with child-birth care is a significant factor in determining the use of facility-based child-birth care services.
- The use of facility-based child-birth care reduces mortality in child-birth.
- Providing patient-centred care child-birth services will improve client satisfaction with care.
- Midwives (participants) will adopt an open and willing attitude for learning and change.
- Facilitators can facilitate the programme well using interactive teaching and learning methods which will enable midwives to provide patient-centred care.

Target participants

‘Participants’ refers to the target audience for the training programme. In the current study the participants are midwives and/or health professionals providing child-birth care services in health facilities such as nurses and doctors.

6.1.2 Dynamics of the programme

The dynamics of the programme includes the subject areas (modules) for the training, the training topics and target groups. It also encompasses details of the training objectives, teaching and learning methods, sequencing of topics, orientation for facilitators and monitoring and evaluation mechanisms.

In table 6.1 the subject areas (modules) are introduced. The four modules are; dignity and respect in patient care, communication skills, focused antenatal care and delivery positions. For each of these modules the training topics and their target groups are also specified. This is followed by detail of the training objectives, teaching and learning methods, sequencing of topics, orientation for facilitators and monitoring and evaluation mechanisms.

Table 6.1 Subject areas, training topics and target groups

Subject area	Training topics	Target groups
Dignity and respect in patient care	<ul style="list-style-type: none"> • Patients' rights • Patient-centred care concepts • Respectful patient care • Ethics and ethical issues in nursing and midwifery practice • Practical issues in patient care 	<ul style="list-style-type: none"> • Midwives/nurses/health professionals in child-birth care • Midwifery supervisors
Communication skills	<ul style="list-style-type: none"> • Communication • Forms of communication • Barriers to effective communication • Techniques for active listening • Importance of seeking patient consent 	<ul style="list-style-type: none"> • Midwives/nurses/health professionals in child-birth care • Midwifery supervisors
Focused antenatal care (FANC)	<ul style="list-style-type: none"> • Principles of FANC • Basic and specialised components of antenatal care • Schedules, objectives and procedures in FANC • Birth preparedness and complication readiness plan 	<ul style="list-style-type: none"> • Midwives/nurses/health professionals in child-birth care • Midwifery supervisors
Delivery positions	<ul style="list-style-type: none"> • Various child-birth positions • Advantages of the birthing positions • Education of mothers on the birthing positions • Conducting labour using the various birthing positions 	<ul style="list-style-type: none"> • Midwives/nurses/health professionals in child-birth care • Midwifery supervisors

Training objectives for this programme

On completion of this patient-centred care in-service training programme, participants (midwives) should be able to:

- i. Apply concepts of patient-centred care in their practice.
- ii. Provide patient-centred antenatal care.
- iii. Provide dignified and respectful patient care to mothers during child-birth.
- iv. Communicate effectively with mothers during child-birth care.
- v. Involve mothers in care provision and in decision-making during care.
- vi. Collaborate with mothers and their families during care.
- vii. Use varied positions during child-birth and allow mothers to choose desired birthing positions.
- viii. Provide patient-centred postnatal care.

Learning methods

It is noteworthy that no single teaching method can be considered better than any other. The facilitator/instructor's choice of a teaching method should be determined by the field of learning expected (Ibrahim, 2015). The choice of methods would be relevant to the stated objectives of a given content package, and/or guided by Bloom's Taxonomy of educational objectives (Krathwohl, 2002; Bloom et al., 1956). In determining the learning method, the facilitator is mindful of the fact that the adult learner (andragogy) learns better in an interactive teaching and learning environment. Below is a discussion of the teaching methods for the programme.

Interactive teaching methods

Interactive teaching methods allow the facilitator to connect with learners in a collaborative way (Ibrahim, 2015). The following teaching methods are discussed, namely brainstorming, case study, demonstration and discussion.

Brainstorming: This is a group technique that is useful in training situations. It enables the group to be more creative and involved in the group activity. In the group, members are encouraged to contribute any suggestions that come to mind on a subject. These are written down. Initially no criticisms are made of the views until the list is exhausted. The facilitators stimulate the brainstorming process by judging the usefulness of all the suggested answers and through the process expunge the unnecessary ones while keeping the useful ones.

Case study: In case study, a real situation is presented by the facilitator in a brief paper or presentation, this is then analysed by participants. The cases are usually taken from the professional field and are supported by visual materials, statistical data, charts and graphs, from descriptions of how the situation is viewed by different people, reports, data from the media and internet resources. The method sometimes results in ambiguity in the solution of the presented problem, which creates a challenge for discussion, reasoning of proposed solutions, and choosing the most appropriate solution. However, the result is not only knowledge gain, but professional skills and a well-formed personality and set of values (Yakovleva & Yakovlev, 2014). This method allows the students to familiarise themselves with the situation, its content and features, the main problems, and the factors and personalities that can intervene. Students can analyse the consequences of the decisions and select the optimal solution. For the teacher using this method there is the need to prepare the case, formulate the questions for the analysis and develop materials that students may need to solve the problem. The teacher also has some role to play during the classroom activities in discussing the case, where the teacher makes introductory and closing remarks (Yakovleva & Yakovlev, 2014).

Demonstration: During demonstration, the facilitator shows learners how and what should be done while performing a procedure. The facilitator also explains why, when and where an action is taken. This enhances the participant's ability to perform the action. Demonstration would be useful in teaching midwives positive ways of communication with mothers and also the more effective positions to use, to conduct delivery.

Discussion: Is a method that allows participants to learn from each other under the guidance of the facilitator. This is useful in combination with brainstorming to sample ideas on specific solutions to problems within a particular context.

In table 6:2 a comparison of some training methods is given, showing the advantages and disadvantages of the teaching methods, the content it is useful to deliver and the trainer's role in using these teaching methods. It is shown that lecture method of teaching has the advantage of enhancing the transfer of large volumes of information within a short time. It however has the disadvantage of making the learner a passive participant in the learning process and retention of information through this medium is minimal. Discussion method on the other hand enhances interaction among learners and stimulates interest in the learning process. One of its disadvantage however is that it takes time. Case study and role play on the

other hand is useful in changing attitudes and building analytical skills. It also involves the learner actively and enhances sharing of experiences among learners. However discussions that follow the case study and role play may cover a wide range of issues and not be focused. Group exercise is useful in developing team building or studying group dynamics. This teaching method involves participants actively, however it requires skills from the facilitator to manage the groups. Brainstorming is useful in retrieving the learners past learning and relies greatly on learners past experiences. It may however leave some learners passive and requires the skills of the facilitator to manage the group and ensure active participation of all learners. Demonstration is useful in showing the correct procedures and required standards in clinical practice.



Table 6.2 Comparison of some training methods (adapted from Human Resources Management)

Method	Useful for	Advantages	Disadvantages	Trainer's role
Lecture	<ul style="list-style-type: none"> • Passing on information and facts • Giving specific information related to occupation, job or task 	<ul style="list-style-type: none"> • Allows much material to be delivered in a short time • Handles a large number of participants • Permits lecturer to be in full control 	<ul style="list-style-type: none"> • Learner is passive • Little of what is said is remembered • Lecturer receives little feedback 	<ul style="list-style-type: none"> • Provide information • Answer questions
Discussion	<ul style="list-style-type: none"> • Stimulating interest and thought • Generating possible solutions to problems • Consolidating other types of learning • Developing consensus 	<ul style="list-style-type: none"> • Stimulates learners' interest • Involves learners actively • Allows sharing of learners' expectations with others 	<ul style="list-style-type: none"> • Time-consuming • Requires learners to have facts about the topic • Needs to be well controlled to have value • Can be dominated by a few active persons 	<ul style="list-style-type: none"> • Establish small groups early in the course • Help groups select moderators and rapporteur • Clearly specify tasks for each group and make sure individual participants have individual tasks • Assign time limits for each task and enforce them
Case study	<ul style="list-style-type: none"> • Solving problems • Changing attitudes • Building analytical skills 	<ul style="list-style-type: none"> • Involves learners actively • Allows sharing of learners' experiences with others • Stimulates ideas and discussions 	<ul style="list-style-type: none"> • Time-consuming to prepare • Not easy to validate • Discussion may focus on areas different from those intended by 	<ul style="list-style-type: none"> • Carefully prepare and read case and relevant material • Ask provocative questions to provide key issues for discussion • Guide discussion to achieve analysis, possible solutions and recommendations for

		of concrete subject	trainer	action
Role-play	<ul style="list-style-type: none"> • Developing interactive knowledge and modifying attitudes • Introducing humour and liveliness into training 	<ul style="list-style-type: none"> • Stimulates interest • Is fun • Is active • Uses participants' experiences 	<ul style="list-style-type: none"> • Time-consuming to prepare • Observers may be passive • Some key points may not be addressed • Those engaged in role-playing may learn more than observers • Serious issues may be trivialised/ treated with levity • Traumatic content may have damaging effects if participants are not properly debriefed 	<ul style="list-style-type: none"> • Choose a suitable story to illustrate key points • Debrief (discuss insights gained from role-playing)
Group exercise	<ul style="list-style-type: none"> • Team building • Developing interactive skills • Studying group dynamics 	<ul style="list-style-type: none"> • Facilitates high participation of motivated learners 	<ul style="list-style-type: none"> • Trainer's skills required to guide the exercise • Takes time for group to work in harmony 	<ul style="list-style-type: none"> • Prepare carefully to ensure that everything is organized
Brainstorming	<ul style="list-style-type: none"> • Stimulating creative thinking • Generating possible 	<ul style="list-style-type: none"> • Promotes active participation of learners 	<ul style="list-style-type: none"> • Time-consuming • Some learners may be passive 	<ul style="list-style-type: none"> • Record ideas • Rearrange into groups

	solutions <ul style="list-style-type: none"> • Consolidating past learning • Providing diversion 	<ul style="list-style-type: none"> • Uses learners' experiences and ideas 	<ul style="list-style-type: none"> • Requires high-level trainer skills 	<ul style="list-style-type: none"> • Lead discussion at the end
Demonstration	<ul style="list-style-type: none"> • Showing correct procedures and required standards 	<ul style="list-style-type: none"> • Stimulates a lot of interest • Can be used for large groups 	<ul style="list-style-type: none"> • Takes effort to produce • Good viewing by learners is difficult in a large group 	<ul style="list-style-type: none"> • Arrange for demonstration of materials in advance • Do demonstration alone to ensure that everything works • Observe participant demonstrations • Correct mistakes promptly • Encourage learners who are having difficulty following a particular topic slow learners



Sequencing topics

Sequencing of topics is important in any teaching and learning activity according to educationists. It involves the arrangement of topics in a logical order during training (Abbatt, 2004). In doing so it is important to bear in mind that most people prefer to learn in easy and progressive stages (Management Sciences for Health, 2012). Adult learners also prefer to start with an overview of the whole course before concentrating on particular aspects. The best method is to sequence topics to build on previously completed content and learning experiences. In addition, spiralling the content by revisiting the basic concepts repeatedly while building on them, is advisable. The trainer needs to be aware of training fatigue and not leave the most complex topic for the end of the course when learners are likely to be tired.

Orientation for facilitators

Trainers for this programme must be knowledgeable on the subject matter and be able to communicate at the level of the participants. The trainer should take into account the nature of the target group or audience and their level of knowledge and skills on the topic (Management Sciences for Health 2012; Abbatt, 2004). Trainers require four times the presentation time for preparation. This is to accommodate preparation time, during which trainers look for relevant information by consulting manuals and other resources that are relevant to the subject. The trainer then chooses appropriate learning methods and puts together a session plan. He/she takes time to prepare appropriate participants' guides and audio-visual aids well in advance of the training date.

The trainer should always go to the training venue ahead of the session to check the room, the seating arrangements and the audio-visual equipment. A friendly chat with participants before the session creates a comfortable environment (Management Sciences for Health, 2012). Personal introductions should take place at the beginning of the first presentation. This could be done by pairing participants to interview each other, and then each participant presents the other to the group or records the information on a wall chart for all participants to see (Abbatt, 2004).

The actual session should begin with the trainer presenting the objectives of the course or session and summarizing its main points. These main points are then expanded using the chosen learning methods. At the end of the session, the trainer should always summarize the discussion, making sure to allow time for questions and clarification. The trainer's style of

presentation should be one that will engage participants' attention and maintain eye contact with the group, making sure that his/her voice is clear and can be heard by everyone. When participant interest appears to be flagging, the trainer needs to be flexible and willing to change the schedule, perhaps by introducing a role-play method of teaching or arranging a practice oriented session, or by introducing an unscheduled break to allow participants to stretch or get refreshments (Management Sciences for Health 2012). A good story or joke can also help revive participants' interest.

Figure 6.1 illustrates an ideal seating arrangement for the training programme. Seating in circles allows each participant to be seen by the facilitator and other participants. It permits the facilitator's movement around the participants and is useful in keeping participants' attention on discussions within the group. It is suitable for group discussion in both small and large group sessions, as shown.



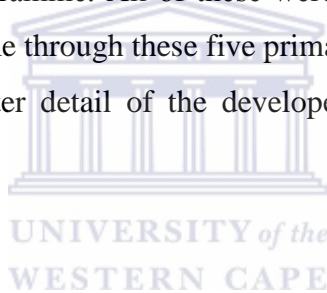
Figure 6.1 Seating arrangements adapted from McMahon et al. (1992)

Monitoring and evaluation

As with every educational programme, monitoring and evaluation are important to assess the performance and progress of participants and these are key roles of trainers. The assessment required in this programme is both formative and summative. Formative assessment is an on-going assessment during the training period which offers the opportunity for participants to improve. Summative assessment is a terminal assessment given at the end of a programme.

Formative assessment is, however, more important in this training programme, as the intent of the programme is not the awarding of marks or grades, but improvement in performance. The trainer can provide feedback and assistance that could make participants learn more quickly, as constructive criticism can be provided during the course. The trainer would also use the feedback from formative assessments to adjust the content and methods of the training to better meet participants' needs (Abbatt, 2004).

In summary, this first section of Chapter 6 focussed on designing a patient-centred care in-service training programme for midwives using the Rothman and Thomas (1994) development and design activities. It also discussed the structure of the in-service training programme, learning methods, and orientation for facilitators, among other aspects. According to Mo (2012), designing a programme is like mapping out a road trip or making a journey. A training design basically gives an outline of all the “what, where, who, when, and how” details of the training programme. All of these were addressed in this patient-centred care in-service training programme through these five primary components of training design. In the second part of this chapter detail of the developed patient-centred care in-service training programme is provided.



6.2 Description of the patient-centred care in-service training programme for midwives

6.2.1 Introduction

Four modules were developed for the training programme. Also in this section are the specific outcomes and assessment criteria and a plan of the programme. Detailed content of the programme is presented in Appendix 6.

6.2.2 Training Modules

There four modules in this training programme, namely:

- i. Dignity and respectful patient care
- ii. Communication in patient care
- iii. Focused antenatal care

iv. Birthing positions

Module I: Dignity and respectful patient care covers issues in patient-centred care, respectful patient care, ethics and ethical issues in nursing, and midwifery practice and practical issues in patient care.

Module II: Communication in patient care includes forms of communication, barriers to effective communication, techniques to active listening, and the importance of seeking patient consent.

Module III: Focused antenatal care (FANC) focuses on principles of FANC, other forms of antenatal care, basic and specialized components of antenatal care, birth preparedness, and a complication readiness plan.

Module IV: Effective birthing positions focuses on various child-birth positions, advantages of various birthing positions, and conducting labour in various birthing positions.

In table 6.3 each of the four modules are presented with their specific outcomes and assessment criteria. This serves as a guide to both facilitators and participants' in the use of this in-service training programme.

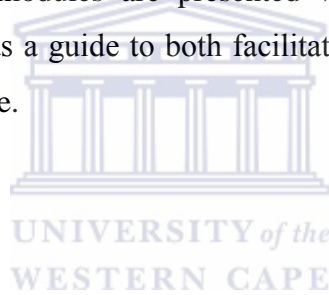


Table 6.3 Specific outcomes and assessment criteria for the modules

Specific outcomes	Assessment criteria
Provide dignity and respectful patient care to clients	<ul style="list-style-type: none"> • Define the term “patient-centred care” • Discuss patient-centred care concepts • Discuss the impact of patient-centred care on patient outcomes • Appreciate the perspectives of patients/maternity health consumers related to their interactions with the healthcare system, including health professionals. • Apply possible solutions to patient perspectives case scenarios through problem solving and role play. • Describe the personal characteristics and skills required in midwifery practice • Discuss ethical and legal issues in nursing/midwifery practice
Communicate effectively with mothers during child-birth	<ul style="list-style-type: none"> • Describe the process necessary for effective communication • Discuss the characteristics of effective communication • Identify barriers to effective communication • Demonstrate techniques to active listening • Use appropriate forms of communication with mothers • Appreciate the importance of non-verbal communication • Appreciate the importance of obtaining consent/permission
Practise antenatal care (focused antenatal care (FANC))	<ul style="list-style-type: none"> • Discuss the principles of FANC • Differentiate FANC from the traditional antenatal approach • Discuss basic and specialized components of FANC • Describe the schedule, objectives and procedures covered in each of the four FANC visits for women • Advise pregnant women on birth preparedness and complication readiness plan
Use effective birthing positions	<ul style="list-style-type: none"> • Identify various birthing positions • Discuss the advantages of these birthing positions • Teach mothers the birthing positions during antenatal sessions • Demonstrate the use of these effective birthing positions



In tables 6.4, 6.5, 6.6, and 6.7 below, a layout of the programme is presented. For each module sub-topics, performance objectives, teaching methods, teaching materials and outcome expectations are presented. It also gives out reading materials relevant to each module. This makes the curriculum user friendly to both facilitators and participants. It also provides additional sources of reference for use.

Table 6.4 provides an outline on dignified and respectful patient care has sub-topics that aims at addressing patient rights issues, ethics and ethical issues in nursing and midwifery care.

Table 6.5 offers an outline on communication in patient care. The aim of this module is to build midwives communication skills. The module covers forms of communication, barriers to effective communication and techniques to active listening.

Table 6.6 gives a framework on focused antenatal care. The aim of this module is to introduce a more patient focused antenatal care module, which saves time however enriching the antenatal experience of the client. The modules have topics on principles of FANC, its components and how to organize FANC clinics.

Table 6.7 provides a plan on effective birthing positions. The purpose is to expose midwives to various positions that enhances natural child-birth. Please see below details.

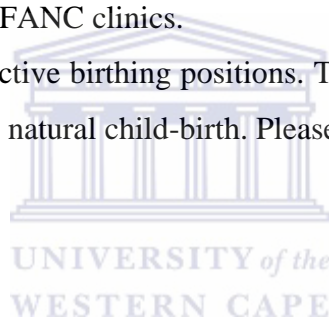


Table 6.4 Module 1: Dignified and respectful patient care

Module	Sub-topic	Performance objectives	Teaching methods	Teaching & reading materials	Expected Outcomes:
Dignity in patient care	Patients' rights	Discuss patients' rights	Discussion and brainstorming	Use of computer (PowerPoint presentations) Projector	To express the need to provide dignified and respectful patient care
	Patient-centred care concepts	Discuss patient centred-care concepts	Discussion and brainstorming	Hand outs Reading material:	
	Respectful patient care	Discuss respectful patient care	Discussion and brainstorming	<i>Chapter 4 of this thesis</i>	To discuss ethics and ethical issues in nursing/midwifery practice
	Ethics and ethical issues in nursing and midwifery practice	Explain ethics and ethical issues in nursing and midwifery practice	case study, role play, group exercise, Discussion and brainstorming	<i>Ashmore, R., & Banks, D. (2004). Student nurses' use of their interpersonal skills within clinical role-plays. Nurse Education Today, 24, 20-29</i> https://www.ncbi.nlm.nih.gov/pubmed/14690641	To explain legal issues in nursing/midwifery practice
	Practical issues in patient care	Discuss practical issues in patient care		<i>Fosbinder, D. (1994). Patient perceptions of nursing care: an emerging theory of interpersonal competence. Journal of Advanced Nursing, 20, 1085-1093</i> https://www.ncbi.nlm.nih.gov/pubmed/7860855 <i>Lachman V. D. (2012) Applying the Ethics of Care to Your Nursing Practice. Medsurg Nursing Vol. 21/No. 2</i> www.nursingworld.org.../EthicsStandards/ <i>Fry S.T. & Johnston M-J. (2008) Ethics in Practice: a guide to ethical decision making. Oxford: Blackwell</i>	

				www.wiley.com>...> Nursing & Midwifery >	
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Table 6.5 Module 2: Communication in patient care

Topic	Sub-topic	Performance objectives	Teaching methods	Teaching materials	Outcome expectations: the ability of midwives to:
Communication in patient care	Communication	Discuss communication	Discussion and brainstorming	Use of computer (PowerPoint presentations) Projector	Communicate effectively with mothers
	Forms of communication	Identify forms of communication	Case study group exercise, Role play and brainstorming	Hand outs Reading material: <i>Yorkshire and the Humber Medicines Management Training Scheme (2015)</i>	Explain procedures to mothers before carrying them out
	Barriers to effective communication	Explain characteristics of effective communication Identify barriers to effective communication	Demonstration	<i>Introduction to Communication Skills. Student Training Module; School of Healthcare, University of Leeds</i> https://medslearning.wordpress.com/what-we-do	Provide feedback to mothers on their care
	Techniques to active listening	Demonstrate active listening skills			
	Importance of seeking patient consent			<i>Chapman, Kimberly B. (2009). Improving Communication among Nurses, Patients, and Physicians. American Journal of Nursing, 109(11), 21-25</i> https://www.ncbi.nlm.nih.gov/pubmed/19826329	



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Table 6.6 Module 3: Focused antenatal care modules

Topic	Sub-topic	Performance objectives	Teaching methods	Teaching materials	Outcome expectations: the ability of midwives to:
Focused antenatal care (FANC)	Principles of FANC	Discuss the principles of FANC	Discussion, brainstorming and group exercise	Use of computer (PowerPoint presentations) Projector Hand outs Reading material: <i>The open University (The OU), Antenatal care module 13</i> www.open.edu>Home>Courses>Collections>Heat	Organise FANC sessions Utilise principles on FANC
	Other types of antenatal care (ANC) [traditional]	Differentiate between FANC and traditional ANC	Discussion, brainstorming and group exercise		
	Basic and specialised components of antenatal care	Explain basic and specialised components of antenatal care	Discussion, brainstorming and group exercise		
	Schedule, objectives and procedures in ANC	Describe schedule, objectives and procedures in ANC	Discussion and role play, and demonstration		
	Birth preparedness and complication readiness plan	Discuss birth preparedness and complication readiness plan			

Table 6.7 Module 4: Effective birthing positions

Topic	Sub-topic	Performance objectives	Teaching methods	Teaching materials	Outcome expectations: the ability of midwives to:
Birthing positions	Various child-birth positions	Identify various child-birth positions	Discussion and brainstorming	Use of computer (PowerPoint presentations)	Demonstrate the use of the various birthing positions to conduct labour
	Advantages of the birthing positions	Discuss advantages of the various birthing positions	Discussion and brainstorming	Projector Hand outs Birthing chair	
	Educate mothers on the birthing positions during ANC	Educate mothers on the birthing positions during ANC	Case study, role play and group exercise,	Reading material: <i>Centre for Spirituality & Healing; Effective Birthing Positions Mayo Memorial Building C592, 420 Delaware St. S.E.</i> https://www.takingcharge.csh.umn.edu/activities/effective-birthing-positions	
	Conducting labour using the various birthing positions	Demonstrate the use of the various birthing positions	Demonstration.		

CHAPTER SEVEN

ASSESSMENT OF FEASIBILITY AND USABILITY OF THE PATIENT-CENTRED CARE IN-SERVICE TRAINING PROGRAMME FOR MIDWIVES

7.0 Introduction

In the fourth and final phase of this study the feasibility and usability of the training programme to promote patient-centred care during child-birth was assessed. This chapter outlines the methodology used, to achieve this assessment. It also indicates the assessment process and its application to the developed programme. Rothman and Thomas (1994) referred to this process of assessment of feasibility and usability as developing a prototype or preliminary intervention.

7.1 Developing a prototype or preliminary interventions

At this stage a design for an in-service training program was developed to produce a format that can be evaluated under field conditions (Rothman and Thomas, 1994). The in-service training program was then implemented in a pilot test for feasibility and usability. Assessment of feasibility is the analysis of how effective a training programme could be while accounting for reasons that could affect its success, such as the contents of the programme and the materials for the training. The goal of feasibility studies are to place emphasis on potential problems that could occur during implementation of the programme (I-Tech Technical Implementation guide, 2008). Usability is a quality attribute that assesses whether a training programme is easy to apply and well-organized for use (I-Tech Technical Implementation guide, 2008).

7.1.1 Aim

The aim of assessment of feasibility and usability of the patient-centred care in-service training programme is to determine whether it could be implemented, and to otherwise examine its capability and effectiveness as a practice tool. This is intended to help in refining of the training programme. The assessment of feasibility and usability of a training programme is an important aspect of quality control in training and can help to ensure that the time and investment in training really pays off. The objectives for the assessment of the in-service training programme were:

- To determine the adequacy of the content of the patient-centred care in-service training programme for the achievement of desired skills, knowledge and attitudes.
- To ascertain the appropriateness of the training programme structure, duration and venue for the achievement of learning outcomes.
- To determine the appropriateness of the training methodology for the attainment of desired objectives.

7.1.2 Preparation for pilot implementation of the training programme

The I-Tech Technical Implementation guide (2008) was used for pilot testing and evaluating the training programme. This implementation guide requires that before any training programme is pilot tested, all stakeholders must be identified and prepared. The preparation ensures that everybody knows his/her role in the exercise. For this assessment, the stakeholders included the participants (who were midwives who received the training), the facilitator (who was the trainer) and an observer (who was not directly involved in the programme but took notes of the process and reported).

Participants

Participants (midwives) were not blinded but were informed that the training workshop was to assess the feasibility and usability of a patient-centred care training programme. They were told that they would be asked to provide extensive and honest feedback as part of the assessment process. It was also stressed that their feedback was critical to the improvement of the training programme. This was done to encourage participants to complete written evaluation forms in detail and participate actively in group discussions during the training experience. Participants were also given briefing with regard to specific evaluation activities that would be conducted. They were given enough information to enhance this activity.

Facilitators

Facilitator was likewise briefed in advance that this was a workshop to assess the feasibility and usability of a training programme. Facilitator was asked to follow the training programme as thoroughly as possible. The facilitator was provided with a copy of the training programme in advance to offer her the opportunity to review the assigned sessions.

Observer

The observer also received briefing on his role and was introduced to his assessment tool. He was also encouraged to observe every aspect of the programme and report.

7.1.3 Conducting the assessment (data collection)

During the implementation of the programme adult learning principles were observed by the facilitator and the patient-centred care in-service training programme was delivered as specified in the design phase. This was implemented from the 6th to the 8th of April, 2016. One primary advantage of in-service training programmes is that it does not take staff off their duty posts (Management Sciences for Health, 2012). The methods used for data collection are discussed in detail next.

Methods of data collection

Each of the three stakeholders assessed the following key areas of the programme; which were the *teaching methods*, *appropriateness of content* and *teaching materials*.

Recipients' Evaluation of the Workshop

According to the I-Tech Technical Implementation guide (2008) recipient feedback on the workshop is significant in assessing the feasibility and usability of the programme. Recipients' feedback included their subjective responses to the workshop such as:

What worked well?

What did they feel they learned?

What did they not understand?

How will they apply what they have learnt in the workshop, in their work setting?

Tool 1: Daily written evaluations

A daily evaluation was completed by participants at the end of each day of the workshop. These captured participants' reactions to the workshop sessions and activities while the information was still fresh in their minds. The daily evaluation form was brief and easy to complete, to avoid overburdening participants. Knowledge-related questions specific to the content covered daily were included to see if participants had absorbed some of the key themes for the day. According to the I-Tech Technical Implementation guide (2008) the data from the daily evaluation form does not need to be rigorously tallied and analysed; rather, the

trainers should scan the forms to determine general trends. For example, if a particular session seems to be getting markedly lower scores than other sessions, this would designate the need for further investigation to determine the reason.

The data evaluation forms were summarised daily and the results proved that the training programme was useful in improving participants' knowledge, skills and attitudes. Please see table 7.1 for results

Tool 2: Final written evaluation

Participants also completed a written evaluation at the end of the final day of the workshop. This evaluation allowed participants to reflect on the knowledge and skills acquired during the training within the context of the workshop as a whole. The final written evaluation also allowed participants to reflect on their key learning areas from the entire workshop, and assess how they will be able to use what they have learnt when they return to their work settings. **Results** show that participants were positive and enthusiastic about applying the knowledge, skills and attitudes they acquired to patient care. In addition, participant evaluation results were summarized and analysed to identify key themes and issues as flagged in recurring comments.

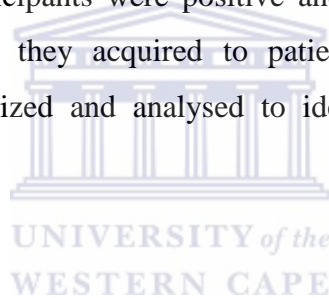


Table 7.1 Results from recipients' daily and final written assessment

Component	Summary of comment	Reasoning
What did recipients feel they learnt?	All recipients acknowledged that they had acquired knowledge, skills and attitudes to provide patient-centred care. Specifically knowledge, skills and attitudes towards communicating effectively during child-birth, using diverse positions during child-birth and in focused antenatal care.	Participants were able to demonstrate effective communication and positions used in labour effectively.
How will recipients apply what they have learnt?	Some recipients said they would offer more respectful care to mothers. Others said they would make an effort to communicate more effectively with mothers. Recipients also said they would initiate focused antenatal care in their services. All recipients said they would educate mothers on various positions in labour.	These measures would enhance the provision of patient-centred care services.
Daily/final written evaluation	More practice sessions are required especially in the modules of communication, and labour positions.	This would offer recipients more hands-on skills while they return demonstrate the skills.

Tool 3: Pre- and post-test

The purpose of the pre- and post-test was to provide an objective measure of changes in knowledge and/or skills resulting from the training, and thus can serve to provide valuable information about the feasibility and usability of the training programme (the I-Tech Technical Implementation guide, 2008). The pre- and post-test were scored and results were entered into a spread sheet by question; this enabled the researcher to see if there were particular content areas that were not well understood by participants.

Table 7.2 shows the results of pre-and post-test scores. This was done using a pair student's t-test technique. The paired student's t-test technique was used to assess the difference between pre-and post-test scores of the training modules. There were significant increases in participants' scores between the pre-test and the post-test which is an indication that the workshop achieved its objectives of improving knowledge, skills and attitudes and that the training programme was effective (I-Tech Technical Implementation guide, 2008).

Table 7.2 Results of pre- and post-test

Module	Pre-Score	Post-Score	P-value
Module 1: dignity and respectful patient care	5.17	7.67	0.004
Module 2: communication in patient care	5.67	8.33	0.002
Module 3: focused antenatal care	6.67	9.33	0.010
Module 4: birthing positions	5.00	8.67	0.001
Overall Mean Score	5.63	8.50	0.001

Facilitator's evaluation of training programme

The trainers' experiences using the training materials, her feedback on the thoroughness and appropriateness of the content, and her suggestions for activities and examples were received through a written report and incorporated into the programme. Table 7.3 gives a summary of the facilitator's report. This report pointed out that the training materials were adequate and the contents of the programme were appropriate. It was however suggested that some more

case scenarios should be introduced into the programme and also that the duration for the training should be increased beyond 3 days.

Table 7.3 Qualitative findings from facilitators' evaluation

Component	Summary of comment	Reasoning
Timing for delivery of modules	More practice sessions are required especially in the modules of communication and labour positions.	Increasing the time for the practice sessions will afford recipients further opportunities to demonstrate the required skills.
Training materials	More case scenarios will enrich the training programme.	To make the programme more practically oriented.

Observer evaluation of workshop

The observer reported on the assigned roles as stated earlier and this was noted and also considered in reviewing the programme. In table 7.4 key findings from the observer's report is presented. The observer indicated that the programme kept the participants busy during the training and there was no point that participants appeared confused. It was however indicated that the demonstration sessions of the programme needed more time as participants appeared to be rushed through these sessions.

Table 7.4 Qualitative findings from observation

Component	Summary of comment	Reasoning
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Demonstration	The programme maintained the attention of all recipients throughout the sessions and recipients interacted well during the process. Recipients did not appear to be confused at any point during the training. However, the demonstration session needs more time to be adequately done.	Allotted time was inadequate for all recipients to repeat and practise further their demonstration.
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7.2 Applying design criteria to the preliminary intervention concept

This is where the drafted patient-centred care in-service training programme were revised based on the findings from the assessment as discussed earlier. By so doing the training programme becomes feasible and usable to midwives and will hopefully improve client satisfaction with child-birth care (Shaw and Hunt, 2012). This was done by applying the comments and suggestions from each of the assessors (participants, facilitator and observer). Details are discussed in the next sessions.

7.2.1 Revising the Programme

All the feedback that was received from the three assessment areas during and after the training programme was used. This gave the researcher a good sense of what the data was saying. The next step was to revise the training programme based on the feedback.

Reviewing of a training programme may include adding, deleting, reordering content, simplifying the level of language used and reconsidering the span of time for the workshop (I-Tech Technical Implementation guide, 2008). For this programme, it became necessary to add case scenarios for the training, to increase the duration for the communication and demonstration units and reconsider the span of time for the training. A role play on respectful patient care was introduced into the programme to capture the undesired experiences of mothers during facility-based child-birth care. This was to highlight realities with facility-

based child-birth care. Again a case study on communication skills that depict the need for active listening during communication was introduced. Furthermore, additional time was allotted to the communication and demonstration unit under positions used during child-birth to 2 hours. Finally, the duration for the training programme was increased from 3 to 4 days to allow each of the 4 modules to run in a day.

All the participants stated that the training programme was effective, adaptable to other settings and compatible with local customs and values. The participants were full of praise for the programme, and acknowledged that they have been enlightened on certain patient-centred care issues they had taken for granted. All recipients, the observer and the facilitator indicated the need for more practice sessions in the training programme, and this was therefore considered in the revised training program.

It was determined that the content of the patient-centred care training programme was adequate for the achievement of desired skills, knowledge and attitudes. The teaching methods were considered or found to be appropriate, the structure of the programme was also adequate and the venue for the training was suitable for the acquisition of knowledge, skills and attitudes of recipients. The structure, the duration of training, and the venue for the training were all found to be appropriate in terms of its feasibility and usability. Also, the training methods were appropriate for the attainment of the desired objectives. However, the time allotted to various units within the modules was inadequate and there needed to be more case scenarios. This was done as per the feedback received, and the programme was adjusted appropriately.

7.3 Summary

In this phase of developing a patient-centred care in-service training program for midwives, the assessment of feasibility and usability of the training programme was done as specified by Rothman and Thomas (1994). Activities that were implemented included developing a preliminary prototype, conducting the assessment and applying design criteria to the preliminary intervention. These have been discussed in detail in the chapter. These processes helped to refine the patient-centred care training programme for midwives.

The process was made possible by implementing the programme on midwives in the Juabeng district hospital. Inputs were then made by stakeholders such as participants, facilitator and an observer which helped to enhance the programme. Multiple strategies were used to collect

data for this assessment. For participants, their assessment included taking a pre-and post-test assessment of knowledge, skills and attitudes. Participants also offered daily and end of programme evaluations. The facilitator assessed the programme by giving a report on the general impression on various aspects of the training programme such as the adequacy and applicability of content and teaching materials. The observer also gave his assessment on the general delivery of the programme using a check list. These inputs were useful for improving the programme.



CHAPTER EIGHT

CONCLUSIONS AND RECOMMENDATIONS

8.0 SUMMARY

This is the concluding chapter of the current study that aimed to develop a client-centred in-service training programme for midwives to enhance client satisfaction service provision during child-birth. The study used the first four phases of the Rothman and Thomas (1994) intervention research design and development approach.

This study set out to assess what mothers' expectations were with child-birth and how mothers experienced actual child-birth within health facilities in the Kumasi metropolis. This was necessary to determine their satisfaction with facility-based child-birth care, to provide satisfactory child-birth care with the hope of increasing facility-based child-birth.

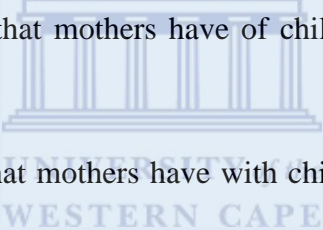
- 
- To explore the expectations that mothers have of child-birth care services in public health centres.
 - To explore the experiences that mothers have with child-birth care services in public health centres.
 - To explore and describe the service enhancements that mothers require for satisfactory child-birth care service delivery in public health centres and, to outline areas in which these enhancements are required.
 - To develop an intervention strategy to increase patient satisfaction with child-birth care

Diagram 8. 1 Objectives of the study

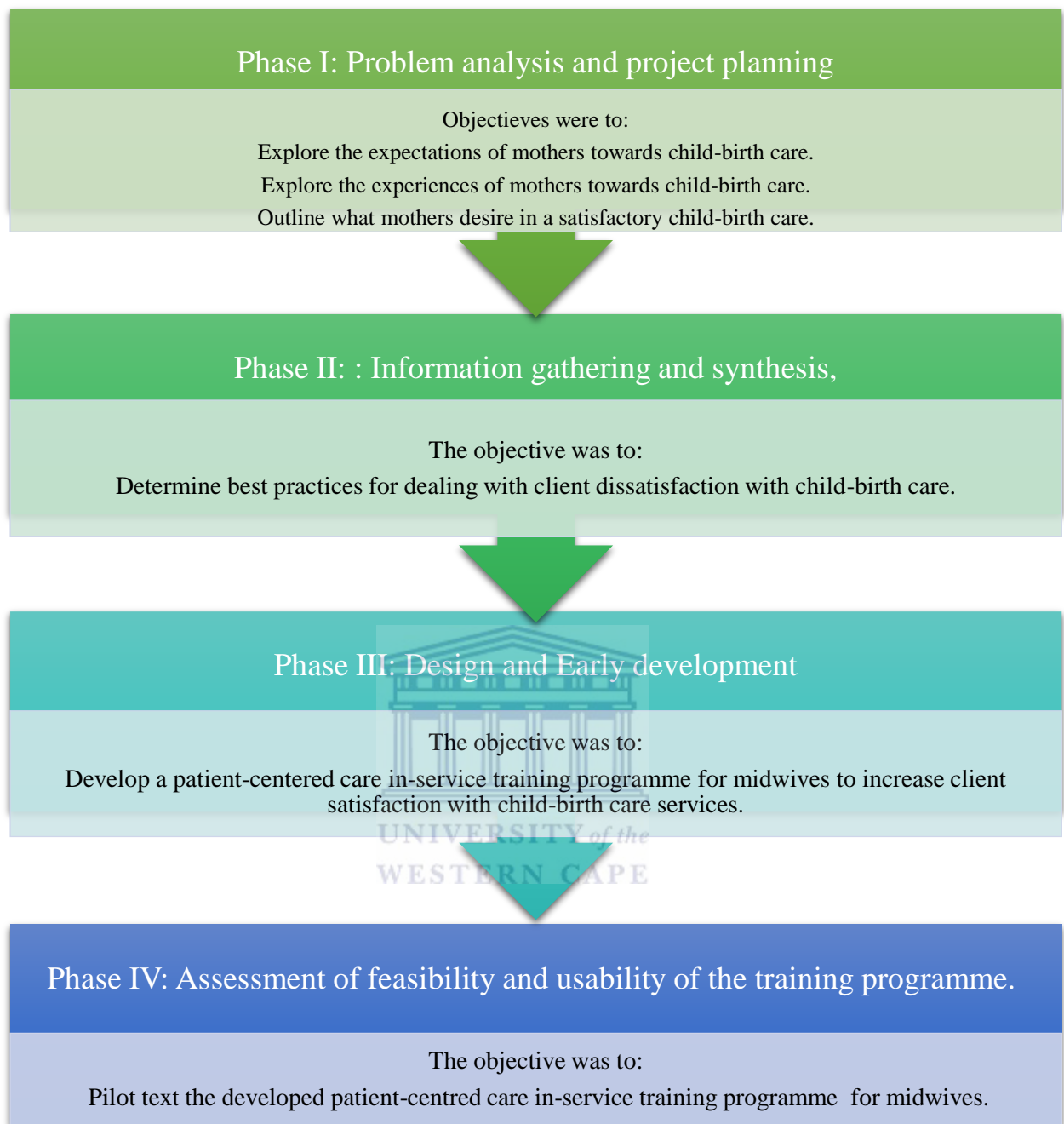


Diagram 8. 2 Phases and objectives of the phases

8.1 CONCLUSIONS

Chapters One and Two of this report were the introduction and literature review chapters. The literature was reviewed on trends in maternal and neonatal mortality, as well as interventions to improve child-birth care services. Further, a discussion on issues that affect patient care such as communication with patients and respect for patients were presented. The literature also covered mothers' expectations and experiences with child-birth care. This included mothers' experiences of maltreatment during child-birth care and traditional thinking about child-birth care which affects mothers' expectations and experiences with care. Finally, in this section the theoretical underpinnings of the current study were presented. The highlights of chapters one and two are evidence that supports high incidences of maternal and neonatal mortality particularly in developing countries and the failure to achieve the Millennium Development Goals (MDGs) 4 and 5 by 2015 and the introduction of the Sustainable Development Goals (SDGs). Again the chapter highlights intervention programmes and attempts made by various countries in an attempt to reduce maternal and neonatal mortality rates. The majority of these mortalities were observed to occur during and immediately after child-birth from causes that were preventable with skilled care at birth. The complications that lead to maternal and neonatal mortality could not be detected during antenatal care. Therefore even though over 95% of mothers seek antenatal care services during pregnancy, they still need to seek skilled birth services at child-birth. However, it was again noted that only 42% of mothers received skilled care at child-birth in Ghana. These were attributed to dissatisfaction with facility-based services where they receive skilled care, with mothers reporting abuse and maltreatment during facility-based care. Skilled care at birth was reported severally as important to reduce maternal and neonatal mortalities. It was also reported that even though multiple factors may influence the woman to use facility-based services, attitude of the care provider and the mothers' perception of the care she receives was the strongest determining factor for the use of skilled care services. The need therefore to deal with client dissatisfaction with skilled services was identified. Therefore, in Phase I of this current study mothers' expectations and experiences with child-birth was explored.

In Chapter Three the methodology of the study was discussed. This was Rothman and Thomas (1994) intervention research methodology, the study was done in 4 phases. Chapter Four discussed the findings of Phase I of Design and Development, the problem analysis and project planning phase. During this phase a situational analysis of midwifery clients'

expectations, experiences and satisfaction with child-birth was done using qualitative research methods. This answered the first three research questions.

Highlights of Phase I were the themes that emerged from the first phase of the study regarding women's expectations and experiences with child-birth care and included:

1. Women's desire to receive respectful care with sub-themes of courteous care, dignified care, adequate communication, and involvement.
2. Women's desire for safe care this had sub-themes such as familiarity with caregivers, adequate resources, and positive birth outcomes. With regards to women's experiences with child-birth care, themes that emerged were encouraging and discouraging experiences. The sub-themes for encouraging experiences were empathy, continuous labour support and attention, and skilful care. With regard to discouraging experiences, the sub-themes were disrespectful care, inadequate communication and involvement with care, inadequate resources, and inconsistent caregivers.

Findings from Phase I pointed to the need for midwives to provide patient-centred care services to clients. Therefore chapter five set out to identify ways in which client dissatisfaction with care have been addressed from the literature.

Chapter Five has the findings of Phase II of Design and Development, the information gathering and synthesis through an integrative literature review. The aim of this second phase of Design and Development was to identify functional elements of successful models and to learn from other studies ways by which health professionals' skills, knowledge and attitudes had been improved to bring about expected health outcomes. This served as a basis for evidence-based best practices, to avoid "reinventing the wheel" (Rothman and Thomas, 1994).

Highlights of this phase was the identification of in-service training programmes as useful in educating health professionals' on knowledge, skills and attitude change to improve care to patients. The need for consideration for adult learning principles during the training programme and the use of interactive teaching methodologies were also identified to be important to the success of in-service training programmes. Findings from the first and second phases of this study formed the basis for the development of an in-service training programme to promote patient-centred care for midwives in Phase III.

Chapter Six reported on Phase III, which was the Design and development of a patient centred in-service training programme for midwives. This phase followed the programme

development steps by Chinn and Kramer (1991), and Management Sciences for Health (2012).

Highlights of Phase III was a design and development of an in-service training programme to promote patient-centred care or client centred care for midwives to increase client satisfaction with child-birth care services. The programme has 4 modules as follows:

- v. Dignity and respectful patient care
- vi. Communication in patient care
- vii. Focused antenatal care
- viii. Birthing positions

Each of these modules had units and the teaching methods to use for various units were also specified. It also has role plays and case studies to make the teaching sessions interactive. Finally, the programme specifies facilitators' roles while implementing each unit.

Chapter Seven reported on Phase IV, which was the phase of assessment of feasibility and usability of the in-service training programme to promote patient-centred care. This followed the I-Tech Technical Implementation guide (2010) for programme assessment.

Highlights of this phase were the implementation of the developed patient-centered care in-service training programme on midwives in a district hospital and receiving feedback from participants, a facilitator and an observer. This feedback necessitated addition of a role play and a case study, the adjustment of the time allotted for demonstration sessions and increasing the minimum duration for the training programme. The three assessors attested to the fact that the programme was useful and the content was adequate for the improvement of knowledge, skills and attitudes of midwives. At the end of Phase IV the patient-centre care in-service training programme was refined for use.

In conclusion, the purpose, aims and objectives for conducting this research have been achieved, as the researcher was able to collect the appropriate data from participants to:

- Explore the expectations mothers have of in public health centres.
- Explore the experiences mothers have with child-birth care in public health centres.
- Explore and describe the service improvements mothers require for satisfactory child-birth care delivery in public health centres, and outline areas in which these improvements are required.

- Develop a client-centred in-service training programme for midwives, to increase patient satisfaction with child-birth care services in public health centres in Kumasi, Ghana.

The following final statements are made for improvement in child-birth care:

- There is a need for the nursing/midwifery training curricula to have explicitly developed courses on patient-centred care, customer satisfaction, effective communication skills, the use of diverse delivery positions in labour, and effective antenatal care modules.
- Courses to train trainers and instructors should be organised for nursing/midwifery tutors, preceptors and lecturers on patient-centred care modules, soft skills and how to teach these components in health care settings.
- Clinical nursing/midwifery staff in various hospitals should be trained in batches on patient-centred care modules and soft skills.
- There is the need to hold midwives accountable for their actions particularly their soft skills during care provision.

8.2 Usefulness of the theoretical frameworks

The study was conceived as a response to mothers' dissatisfaction with child-birth care services and its impact on facility-based child-birth care in Ghana. It capitalized on the strength of an expectation confirmation theory (ECT) by Jiang and Klein (2009) and a customer satisfaction framework proposed by Choy, Lam and Lee, (2012). These studies were used to highlight that mothers have expectations during child-birth which when met positively makes the mother more likely to use the facility in future. It is also used to highlight the fact that, if mothers expectations are not met, they are unlikely to use facility-based child-birth care in the future. Further, by indicating that client satisfaction is the sum of clients' expectations and experiences with care, the need to enhance mothers' child-birth care experience is emphasised using these theories. Finally, the theories highlight the need to help mothers' form realistic expectations about child-birth care since these are important determinants of their satisfaction with care and subsequent use of facilities

8.3 LIMITATIONS

The use of qualitative methods in the study hinders generalization of findings (Parahoo, 2007), as generalizing is not the focus or intention of qualitative studies. In addition, the subjective nature of qualitative research poses a limitation on the study. However, measures were put in place to minimize subjectivity in the process of analysis and reporting of the study results. This was done by adhering strictly to the study protocol. Again the researcher reflected on her own values and objectives and how these affect the entire study. The researcher was therefore conscious to keep her values away from interfering with the study objectives, by bracketing her own thoughts and assertions about child-birth care.

The quality of care, which is also an important aspect of the outcome of care, was not covered in the data collection. The focus of the study was purely mothers' expectations, experiences and satisfaction with child-birth care. Furthermore, the focus of this study is purely child-birth care satisfaction without consideration of other aspects of nursing care.

It is also acknowledged that the outcome of child-birth for mothers (having a live baby or still birth) could affect their overall satisfaction with care. To address this, however, mothers who did not have a good birth outcome were not included in the study. The study therefore did not purposively sample mothers who had had bad outcomes.

It is further recognized that, the use of six midwives for assessment of feasibility and usability of the patient-centred care in-service training programme developed was inadequate. The six midwives represented 40% of the total midwife population in the facility used.

8.4 RECOMMENDATIONS

The following further recommendations are made for nursing/midwifery research and policy.

8.4.1 Recommendations for future research

- Extension of this study: This study focused on child-birth care in only one regional capital (Kumasi), Ghana. It is recommended that the study is done on a larger scale to cover the other nine administrative regions in Ghana.

- The study should also be a guide for any intervention programmes for health professionals in Ghana and Africa that are aimed at improving health outcomes.

8.4.2 Recommendation for policy decisions

- The study findings and the programme developed should form part of the continuous professional assessment course requirement (for nurses and midwives) of the nursing and midwifery council of Ghana.
- Findings of the study should inform review of the nursing and midwifery curricula
- Administrators of facilities should train their nurses and midwives on the developed programme through periodic in-service training workshops.



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APPENDICES

Appendix 1 A

INTERVIEW GUIDE (ENGLISH)

1. Explain research to participant and seek consent

Thank you so much for coming today and being a part of this group. As you may be aware, we are hoping to learn about issues surrounding your expectations and experiences with having babies, and how this affected your satisfaction with the care you received. It is our hope that you will answer these questions as honestly and fully as you can. As has already been explained to you, there are no “right” or “wrong” answers; we are looking for your opinions about these questions. If at any time you do not feel comfortable answering a question, you may skip it. If you want to end your participation at any time, you are free to do so. There will be no negative consequences to you if you decide that you do not want to answer any questions. The interview will take about 45 minutes. ***Ensure written consent form is signed and collected before the interview commences.***

2. Turn on tape recorder and start interview

Name of facility	Antenatal Client..... Postnatal client.....	Respondent code #..... Parity.....
Age.....	Qualification.....	Occupation.....

3. In your opinion, how many children do women in your community want to have?

- How many children do you desire to have?
- Who are those who influence this decision?
- Why are these people important in making this decision?

4. Please tell me about the care you received during **pregnancy**

Probes:

- *Tell me about how responsive staff were to you. Give me examples of it*
- *How empathetic were the staff to you?, tell me about that with examples*
- *Have you experienced neglect during your care? How did it happen?*

5. How well did care you received during pregnancy meet your expectations?

Probes:

- *How well did the physical aspects of the service meet your expectations?*

- *What were your expectations before coming to the hospital?*
- *What did you like most about the care you received?*
- *What will you want done differently?*
- *Tell me things you will want your care givers to do for you during Pregnancy?*

6. Please tell me about the care you received during **Labour**

Probes:

- *Tell me about how responsive staff were to you. Give me examples of it*
- *How empathetic were the staff to you?, tell me about that with examples*
- *Have you experienced neglect during your care? How did it happen?*

7. How well did care you received during Labour meet your expectations?

Probes:

- *How well did the physical aspects of the service meet your expectations?*
- *What were your expectations before coming to the hospital?*
- *What did you like most about the care you received?*
- *What will you want done differently?*
- *Tell me things you will want your care givers to do for you during Labour?*

8. Please tell me about the care you received **after delivery (Puerperium)**

Probes:

- *Tell me about how responsive staff were to you. Give me examples of it*
- *How empathetic were the staff to you?, tell me about that with examples*
- *Have you experienced neglect during your care? How did it happen?*

9. How well did care you received after delivery meet your expectations?

Probes:

- *How well did the physical aspects of the service meet your expectations?*
- *What were your expectations before coming to the hospital?*
- *What did you like most about the care you received?*
- *What will you want done differently?*
- *Tell me things you will want your care givers to do for you after delivery?*

10. What does respectful patient care mean to you?

11. Tell me about your experience with the midwives during pregnancy, labour and delivery and the puerperium.

12. Were you denied the opportunity to perform any traditional/religious rites in child-birth?
13. Some people say, it does not matter what goes on in labour so long as mother and baby are well at the end. What do you say?
14. Will you recommend this facility to a friend?
 - If Yes, why
 - If No, why not

Thank you for your time



Appendix 1B

INTERVIEW GUIDE (TWI)

ANKOPANKOPZ NΣEMBIΣA NHΩEΣOE

Με διν δε..... Με ψζ αδωυμα ωξ..... α ζωξ.....να ψζ πζ σζ ψζσυα νιμδεζ κακρα φα σζνεα ωξν α ζγψε αωοξ ζδωενε φα ζνοξμα βι ηο. Μζγψε ωα αδωενκπερζ, να εμμοι καε σζ, ωο μμυαψζ νψιναα ψζ μα αδεσυα ψι.

Ζδι καν νο, μεπζ σζ μεδα ωοασε σζ ωαμα με ακωανψα ψι σζ μενι ωο ντωετωε σαα νκξμμξ ψι

Ανσα να ψζβζ ηψζ ασεζ νο, ηυνυ σζ ζνψζ ξηψζ σζ ωοβζ κα σαα αδεσυα ψε ηο. Ωοβζ τυμι α γψαε μβερζ βιαρα α ωοπζ. Βιο νσο, ωοβζ τυμι αβζ ατρα ασζμβισα βιαρα α ωοννπζσζ ωοβζ ψι ανο. Καε ηυνυ σζ ωαηιντασεμ ηο ηια ψζν ντι νο, ψζβζ βξ ωομμυαψζ νψιναα ηο βαν. ψζ βζ κπερε ψζν νκξμξ ψι αγυ απααωα σο να ζμοι, ψζν μβξ ωοδιν ωξ αδεσυα ψι μυ.

Σζ ωογψε τυμ σζ ωοβζ κα σαα νκιταηο ψι ηο α, ηυνυ σζ ψζδε ωομυαψζ νο βζψζ ασυαδεζ. Ω εψι κπερζ σζ, ψζβζ τυμι δε ωομμυαψζ νο ατωιρζ αδεσυα νκραταα αβρζ α ψζν μβξ ωο διν ωξ σαα κραταα νο μυ.

Νε κορακορα, ΓΗΣ,ΚΝΥΣΤ,Υνιπερσιτψ οφ Μιχηγαν νε Βροων Υνιπερσιτψ IPB αγψε σαα α δεσυα ψι ατυμ.

Ανσα να ψζβζ ηψζ αδεσυα ψι ασε νο, σζ ωοωξ νσεμβισα βιαρα α ωοβζ τυμι αβισα.

[ΜΑ ΞΩΟΓΨΕΝΙ ΝΟ ΝΣΙΓΝ ΚΡΑΤΑΑ Α ΖΚΨΕΡΖ ΣΖ ΩΑΓΨΕ ΑΔΕΣΥΑ ΨΕ ΜΥ ΝΗΨΕΗΨΖ ΨΕ ΑΤΟΜΥ]

ΝΣΕΜΒΙΣΑ ΝΦΙΤΙΑΣΕΖ

1. Μεπαωοκψεω κα ωοηο νσεμ κακρα κπερζ με.

[Μα ωοανι νκξ ξωογψεφοξ νο μφιε, νε νιμδιε γηιναβρζ (Χερτιφιχατε,Διπλομα,Δεγρεε, Ποστ-Γραδυατε), Μφιε δοδοξ α ξωογψεφοξ νο απζ αδωυμα]

2. Μεδασε. αφει ζηνεφα να ωοψζ αδωυμα?

Νηωεσοξ: Ννοξμα βζν να ωο ψζ ωξ αδωυμα μυ?

ωαδωυμα νο ωξ κρο κεσεζ μυ αναα ζκρο κετεωα μυ? Να ωαδωυμα νο τξ σινι ωξ ακαδεζ α μο δε ψζ αδωυμα νο μυ αναα?

ζκωαν βζν σο να ωοβζ ψζζ αδωυμα ωο ηα?

ζψζ δεν να ωοβζ ψζ αδωυμα ωξ σαα μανταμ ψι μυ?

3. Αφει, μαμε μμισα ωο. Σζ ψζ κασζ ΒΒια α ωοτξσινι ωξ ακαδεζ μυΒ α, ωοντεασεζ νι σζν?

Νσζμβισα Νηωζσοξ:

ζδεζν να βια βι τξσινι ωξ ακαδεζ μυ? Βια α ωοτξσινι ωξ ακαδεζ μυ νε κρο κιτιωα ζψζ πζ αν αα? Νσοσοψζ α ζδα ωον μυ νε σζν?

ξβι φοφορο ωξ αδωενε κπερζ βι φα ωαε ηο αναα?

Appendix 2 A

Criteria for robustness and assessment of robustness

	Assessment criteria	Yes	No	unclear
1	There is congruity between the stated philosophical perspective and the research methodology			
2	There is congruity between the research methodology and the research questions or objectives			
3	There is congruity between the research methodology and the methods used to collect the data			
4	There is congruity between the research methodology and the representation and analysis of data			
5	There is congruity between the research methodology and the interpretation of the results			
6	There is a statement locating the researcher in the research, and the research in the researcher			
7	There is influence of the researcher on the research			
8	Participants and their voice are adequately represented			
9	The research is ethical according to current criteria or for recent studies; there is evidence of ethical approval by an appropriate body			
10	Consensus drawn in the research report appears to flow from analysis or interpretation of the data			

Appendix 2 B

Critical appraisal of research findings based on the review instrument

Criteria											
Authors	1	2	3	4	5	6	7	8	9	10	Score
Bluestone et al., ., 2013	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9
Opiyo & English, 2015	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	9
Lin et al., 2010	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9
Norgaard et al., 2012	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	9
Kerfoot et al., 2007	Y	Y	Y	Y	Y	U	Y	U	Y	Y	8
Coomarasamy and Khan, 2004	Y	Y	Y	Y	Y	U	Y	U	Y	Y	8
Majumdar et al., 2004	Y	Y	Y	Y	Y	U	U	Y	Y	Y	8
Bruppacher et al., 2010	Y	Y	Y	Y	Y	U	Y	U	Y	Y	8
Ngongo et al., 2012	Y	Y	Y	Y	Y	U	Y	N	Y	Y	8
Crofts et al., 2007	Y	Y	Y	Y	Y	Y	N	U	Y	Y	8
Rowe et al., 2002	Y	Y	Y	Y	Y	U	N	Y	Y	Y	8
Reynolds et al., 2010	Y	Y	Y	Y	Y	Y	U	U	Y	Y	8

Key: Y= yes; N= no; U= unclear

Appendix 3:

Summary of articles focused on teaching techniques

	Study design	Participants	Intervention	Key findings
Norgaard et al., (2012)	An effectiveness study to investigate the impact of an in-house training course implemented in 2008 and 2009 in the real world and adapted to local settings	Doctors, nurses, midwives 181 participants: 21 doctors, 102 nurses, 30 nursing assistants	Compulsory communication skills course to increase self-efficacy and patient care satisfaction. Problem-focused training workshops using strategies such as video recording for feedback. The course was designed to ensure that the skills learnt were immediately applicable in health care professionals' clinical practice.	The effect of the training was still seen 6 months after the training. The training methods used contributed to the success of the programme
Bluestone et al., (2013)	Integrative literature review, using multiple data bases e.g. PubMed, Cochrane library and CINAHL literature review of 37 systematic reviews and 32 RCTs	Health workers	Educational techniques to enhance learning among health professionals Use of multiple techniques e.g. case-study, clinical simulation, practice and feedback allows for	Targeted repetitive interventions results in learning and improvements in clinical behaviours

			interaction and enables learners to process and apply information	
Lin et al., 2010	RCT to determine if peer-tutored, problem-based learning (PBL) is preferable to didactic-based instruction for teaching nursing ethics	Nursing students Intervention group= 72, control group= 70	Intervention group received PBL technique: control group received didactic-based instruction. PBL versus didactic teaching technique	Peer-tutored PBL was significantly more effective than didactic lecture. Peer-tutored technique is useful in resource constrained environments
Bruppacher et al., (2010)	Prospective, single-blinded RCT to determine if simulation or interactive techniques are better for teaching how to wean a patient from anaesthesia	Health professionals (Anaesthesiology trainees, post-graduate year 4)	Intervention group received simulation-based training and control group received an interactive seminar. Simulation versus interactive teaching presented as a single intervention	Simulation group scored significantly higher than the seminar group on both post-test and retention test
Majumdar et al., (2004)	RCT, 114 health care providers and 133 patients were randomly assigned to experimental and control groups and were followed for 18 months' qualitative	Health care providers	Culturally sensitive training to improve care using role play and lectures	Increased open-mindedness and cultural awareness, improved understanding of multiculturalism and ability to communicate. A culturally sensitive training

	analysis to identify and analyse themes from journals kept by participants			program not only improved knowledge and attitudes among health care providers, but also yielded positive health outcomes for their patients.
Ngongo et al., (2012)	Using an environment of supportive supervision, continuing education, enabling policies, and access to equipment and referral facility to promote excellence in clinical care	Midwives	Providing on-going professional development through in-service education	In-service education and supportive supervision facilitated the midwives' professional growth leading to improvement in care to mothers and their new-borns in Freetown.
Rowe et al., (2002)	Review of trials of the effectiveness of interventions aimed at improving communication between health professionals and women in maternity care. Search of electronic data bases e. Medline, PsychLit, The	Health professionals	Lecture for communications skills training, 4 trials provided women with extra information about antenatal care, 3 trials of women-held maternity records suggested that these increase women's involvement in and control over their care	Improvement in communication between midwives and mothers

	<p>Cochrane Library, BIDS Science and Social Science Indexes, Cinahl and</p> <p>Embase. 95 potentially eligible papers were identified, 11 were finally included</p>			
Reynolds et al., (2010)	RCT to relate knowledge of students. Used simulation or didactic lectures	Midwifery students	Simulation versus didactic lectures, a single intervention with a control group and an intervention group. Control group received didactic lectures with print visuals and intervention group received simulation-based training	Greater learner satisfaction and reinforcement of knowledge was noted Using simulation-based lectures to teach routine management of normal delivery and management of shoulder dystocia was successful

Appendix 4:

Summary of articles focused on frequency/duration

Citation	Study design	Participants	Intervention	Key findings
Kerfoot et al., (2007)	RCT to determine if spacing principles can improve acquisition and retention of medical knowledge	<p>Health professionals</p> <p>5 cohorts with 76 to 80 urology residents in each cohort. Out of 537 participants, 400 (74%) completed online staggered tests and 515 (96%) completed in-service examination.</p> <p>Cohort 1= bolus, single intervention; cohort 2= multiple, spaced intervention</p>	<p>Using self-directed technique, the interventions were introduced as a multiple and single means.</p> <p>Cohort 1 received bolus education of 96 study questions in June; cohort 2 received daily emails over 27 weeks from June to December, each with one or two questions in spaced pattern. In November, all participants completed a urology exam. Participants were randomized to five cohorts and completed a 32-item online test at staggered time points (1 to 14 weeks) after completion of spaced education</p>	Communication skills training leads to positive outcome on patient care

Crofts et al., (2007)	A prospective randomized controlled trial. A total of 140 participants were studied	Doctors and midwives	Practical, multi-professional, obstetric training. 1-day course at local hospital, 2-day course with team training at local hospital and 2-day course with team training	Improvement in performance. No significant difference between training method and duration
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Appendix 5:

Summary of articles focused on setting

Citation	Study design	Participants	Intervention	Key findings
Opiyo & English (2015)	32 RCTs Cochrane library, MEDLINE, Ovid SP RCTs, non-randomised trials, controlled before and after studies that compared the effect of in-service emergency care training versus usual care	Health professionals	In-service training in the hospital	Improvement in health Professionals' treatment of patients
Coomarasamy and Khan, (2004)	Effect of stand-alone teaching method versus clinically integrated teaching	Health professionals	Both single and multiple intervention which was multiple and case-based in the simulation laboratory and in the hospital	Clinically integrated teaching has advantages over stand-alone education. Knowledge was improved through stand-alone teaching; however teaching did not improve skills and attitude significantly. Clinically integrated teaching showed improvements in knowledge, skills, attitudes and

				behaviour
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Appendix 6:

CONTENT OF PROGRAMME

The content is structured to provide details on the delivery of the module. It also serves as a guide to the timing for the delivery of the programme. It further breaks down the contents into units with appropriate teaching methods and facilitators role during the delivery. The teaching methods with some teaching examples are marked with pink backgrounds, whilst the facilitators' role is marked with blue backgrounds. Detail of the content of each module is presented below.

MODULE 1: Dignified and respectful patient care

Purpose of the module: The purpose of the module is to enable midwives to acquire knowledge, skills and attitudes towards patient-centred care

Expected outcomes: Midwives will acquire knowledge, skills and attitudes to provide dignified and respectful patient care that will lead to client satisfaction with child-birth care.

Expected learning outcomes: At the end of the module midwives should be able to:

- Define dignity and respectful patient care
- Discuss patients' rights
- Express the need to provide dignified and respectful patient care
- Discuss legal, ethics and ethical issues in nursing/midwifery practice

Time needed for the session: Eight hours (2 hours for power point presentations (30 minutes/unit), 2 hours for role play (30 minutes/unit), 2 hours for group discussion (30 minutes/unit), and 2 hours for questions and answers and conclusion (30 minutes/unit).

Teaching methods: Power point presentation, group discussion and role play

Teaching materials: Handouts, flipchart or whiteboard and markers, cell phones, computers, projectors

Study unit 1.1: Patients' rights

Study unit 1.2: Respectful patient care

Study unit 1.3: Ethics and ethical issues in nursing/midwifery practice

Study unit 1.4: Practical issues in patient care

Content: The patient charter, patients' rights, respecting patients in health care, effect of respect on health care, practical issues in patient care, effects of providing disrespectful patient care to mothers during child-birth and

ethics, and ethical and legal issues in nursing/midwifery practice to include; patient freedom versus nurse control, reproductive rights, honesty versus information, empirical knowledge versus personal belief, patient responsiveness, competence, responsibility, attentiveness

Introduction: Welcome participants and ask participants to form pairs. Each pair should introduce the other and their expectations of the workshop. Facilitator now introduces the programme and its purpose.

Define patient-centred care: “It is healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care” (Institute of Medicine, 2001).

Patient-centred care concepts: Discuss the following patient-centred care concepts and their application to patient care through role play, discussions and brainstorming the following concepts:

Communication, advocacy, involvement, participation, trust, partnership, empowerment, choice, and assessment.

Respectful patient care:

Role play

Madam A discusses her child-birth experiences with a friend Mrs B.

Madam A: It is not as if I have not heard of what the midwives do. I have experienced it before: the shouting, hitting and verbal abuse. I have experienced all of them. I remember an unfortunate incident that happened during my first child-birth. I got to the hospital in the morning just when the night nurses were about to hand over to the morning staff, who were not present at that time. She told me to wait for the morning staff irrespective of the strong contractions and labour pains I was going through. She was very heartless. I pleaded with her but it yielded no positive results. I decided to push out at the nurses’ station and later when they got to know that indeed the baby was almost out, they rushed me to the delivery bed. It was appalling and dehumanizing.

Mrs B: I have my own experience also, I was shouted at in labour and hit on my thigh.....because the midwife said I was not pushing, but I was. She spoke to me as if I was

her little girl. Earlier at the antenatal clinic the midwife had told us that if we fail to push in labour we will be beaten. She also showed us a whip she alleged was the one from the labour ward. I did not like that at all, are we children?

Facilitator's role: Encourage each participant to participate, keep the group's attention on the subject for discussion and allow every participant the opportunity to participate. Using the role play ask participants to discuss and brainstorm issues of disrespectful patient care in the scenario. Have the participants discuss in groups the identified issues and outline solutions. Participants should also identify other personal issues of disrespectful care that occur during child-birth care, and outline solutions. Participants should identify acceptable ways of ensuring cooperation with mothers in labour. Facilitator asks participants how this role play makes them feel. Identify disrespectful issues highlighted by the role play. Outline acceptable ways to deal with such occurrences. Ask participants to brainstorm how they can ensure that mothers receive respectful care. Reconvene as a large group and receive presentations from all groups through discussions. Summarise main points and be sure to discuss participants' points. Also discuss with participants the following crucial issue: **Ensuring the practice of patient-centred care on your ward**, which requires that the midwife becomes a consistent role model of patient-centred care. Practise patient-centred care concepts and demonstrate patient-centred care concepts during all patient care procedures.

Discuss the medical model as compared with the patient-centred care model of care

Medical model

1. Patient's role is passive
(The patient is quiet.)
2. Patient is recipient of treatment
(The patient does not voice concerns.)
about other options)
3. Provider (usually a doctor) dominates
patient in making decisions
(Provider offers no options)
4. Disease-centred

Patient-centred model

1. Patient's role is active
(The patient asks questions.)
2. Patient is a partner in treatment
(Patient asks for information
about other options)
3. Provider collaborates with
patient in making decisions
(Provider offers options and discusses
pros and cons)
4. Quality of life centred

- | | |
|--|--|
| 5. Provider does most of the talking
(Provider does not allow time for questions) | 5. Provider listens more and talks less
(Provider allows time for discussion) |
| 6. Patient complies
(Patient does not comply) | 6. Patient adheres to treatment plan
(Patient accommodates changes) |

Ethics and ethical issues in nursing/midwifery

Discuss recommended articles and identify ethics and ethical issues in the articles.

Facilitator's role: Help each member of the group to be involved in the discussion. Make sure that each group identifies ethical issues in their practice. Brainstorm for ways to deal with ethical issues in practice. Keep a close observation on timing for the exercise. Be watchful and close down any conversation that side-tracks discussion. Manage the reconvening of the plenary and receive presentations from all groups through discussions. Summarise main points and be sure to discuss participants' points.

Personal characteristics of and skills required of a midwife

Excellent people skills

You need to be able to provide professional support and reassurance to a diversity of women, during some of the most emotionally intense periods in their lives

Good communication and observation

You need to be good at listening and communicating with women, their partners and families.

Show Interest in the physical, psychological and physiological needs of mothers/Happy to work as part of a team

You remain mindful that you are part of a multidisciplinary team liaising with obstetricians and other support staff.

Dealing with emotionally charged situations

You have to stay calm and alert in times of stress, and enable women to feel confident and in control. On the rare occasions where something goes wrong, you have to be ready to react knowledgeably, quickly and effectively. You need to be good at listening and communicating with women, their partners and families.

Facilitator's role

In groups, allow participants to discuss the characteristics of a good midwife. Participants should consider if they have these characteristics. Outline how these characteristics help their patients. Identify ways in which these characteristics could be attained and maintained. Reconvene in plenary and chair a presentation session with all groups reporting back and discussing. Summarise main points and be sure that all participants' points are given attention.

Case study

Madam Ama, 30 years old, 37-week pregnant woman was brought to your facility in labour and bleeding per vaginum. She was in the company of her husband. On arrival 2 midwives were at the nurses' station documenting, and they ignored the client and her husband. Her husband looked helpless. A patient's relative showed him where to pick up a wheel chair and explained the procedures to follow. He finally got his wife to the nurses' table. This time, the midwives were engaged in a conversation. They waited. When the conversation was over, one of the midwives then collected Madam Ama's ANC records card and glanced through it. She pointed at a bed and asked the husband to get Ama into it. The couple waited for 30 minutes without knowing what was happening. Madam Ama continued all the while to experience pain and to bleed.

Facilitator's role

Put participants into groups and ask each of them to identify disrespectful issues in Madam Ama's care. Have them indicate whether they have witnessed such incidents before. Ask participants to play this role, one as Madam Ama and the other as the Midwife, and later change roles. Ask participants how it felt like to be in the role of Madam Ama? Get them to discuss other patient care issues and brainstorm for better ways of dealing with them.

Discussion: During the discussion point out that there is a direct link between patients' perception of quality care and their relationship with their nurses (Fosbinder, 1994). There

should be attempts at forming a caring relationship based on warmth, empathy, and respect (Ashmore & Banks, 2004). The nurse should offer reassurance, and convey an understanding of patient problems. This is always appreciated by patients and should form the basis of care.

MODULE 2: Communication in patient care

Aim: The aim of this module is to assist midwives to develop their communication skills, by providing information regarding different forms of communication and their appropriate uses.

Expected outcome: Midwives will acquire knowledge and skills to effectively communicate with mothers during child-birth.

Expected learning outcome: At the end of the training workshop, midwives will be able to:

- Describe the process necessary for effective communication.
- Identify barriers to effective communication.
- Demonstrate techniques for active listening.
- Use appropriate forms of communication with mothers.
- Appreciate the importance of non-verbal communication.
- Appreciate the importance of obtaining consent/permission.

Time needed for the session: Eight hours (2 hours for power point presentations (20 minutes/unit), 2 hours for group discussion (20 minutes/unit), 2 hours for role play (20 minutes /unit), and 2 hours for questions and answers and conclusion (20 minutes /unit).

Teaching delivery methods: Power point presentation, group discussion, group exercises and role play

Teaching delivery materials: Hand outs and flipchart or white board and markers

Study unit 2.1: Communication

Study unit 2.2: Forms of communication

Study unit 2.3: Barriers to effective communication

Study unit 2.4: Techniques for active listening

Study unit 2.5: Seeking patient consent

Content: Communication, forms of communication, characteristics of effective communication, barriers to effective communication, techniques for active listening, seeking patient consent and dealing with conflicts and complaints.

Define communication: As a process of exchanging information, ideas, thoughts, feelings and emotions through speech, signals, writing, or behaviour. In communication process, a sender (encoder) encodes a message and then using a medium/channel sends it to the receiver (decoder) who decodes the message, and after processing information, sends back appropriate feedback/reply using a medium/channel.

Types/Forms of Communication

People communicate with each other in a number of ways that depend upon the message and the context in which it is being sent. The choice of communication channel and your style of communicating also affect communication. Communication must be done competently, compassionately and with empathy to be effective.

Types of communication based on the communication channels used are: Verbal Communication, Non-verbal Communication

Verbal Communication: Verbal communication refers to the form of communication in which the message is transmitted verbally; communication is done by word of mouth and/or a piece of writing. The objective of every communication is to have people understand what we are trying to convey. **In verbal communication remember the acronym KISS** (keep it short and simple).

When we talk to others, we assume that others understand what we are saying because we know what we are saying. But this is not always the case. Usually people bring to a situation their own attitudes, perceptions, emotions and thoughts about the topic and this could create barriers to delivering the right meaning. So in order to deliver the right message, you must put yourself on the other side of the table and think from your receiver's point of view. Would he understand the message? How it would sound on the other side of the table?

Non-verbal Communication: Non-verbal communication is the sending or receiving of wordless messages. We can say that communication other than oral and written, such as **gestures, body language, posture, tone of voice or facial expressions**, is called non-verbal communication. **Non-verbal communication is all about the body language of the speaker.**

Non-verbal communication helps the receiver in interpreting the message received. Often, non-verbal signals reflect the situation more accurately than verbal messages. **Sometimes a non-verbal response contradicts verbal communication** and hence affects the

effectiveness of a message. Keep in mind your tone of voice and facial expressions in non-verbal communication.

Barriers to effective communication:

The facilitator uses group exercises, discussions and the role play to assist participants to identify the characteristics of, and barriers to effective communication.

Role play

Midwife A enters her patient's cubicle to administer her medications at 2pm and assess her vital signs. Upon entering the room, she finds her patient sitting in bed, holding her husband's hand, and crying. Midwife A proceeds to wash her hands, ask for her patient's name and birthdate, and administer the medications. The midwife asks her patient to stretch out her arm for the blood pressure check. She leaves the room without asking about the tears or if there is anything that she can do to help.

Facilitator's role

Ask three participants to play this role while all other participants observe. Then conduct a group discussion of the communication gaps in this scenario, and the soft skills issues reflected in it. Ask participants in this role how it felt being the patient. Ask participants to identify cases in which communication in patient care have been flawed and brainstorm for best practice in communicating with patients.

Techniques for active listening and seeking patient consent:

Case study

Madam G, 28 weeks pregnant, reports to the antenatal clinic (ANC). She has no problem with her current pregnancy. Madam G was persuaded to attend ANC today; she had not wanted to attend because of her previous encounters with various midwives. She claims midwives do not listen to her and always look hurried and unapproachable. She also states that midwives do whatever they like with your body without telling you anything.

Facilitator's role

Focus group's attention on identifying the following in the case study. What are Madam G's issues with her care? What are active listening and communication skills? How important is consent in patient care? Conduct brainstorming and discussions for ways in which active listening and patient consent may be enhanced/sought during care

Active listening skills

Close the door to guarantee that the dialogue is between you and the mother alone. Ensure confidentiality. Give full attention to the client and avoid any impression that you have other things to do. Be non-selective in your listening. Do not interrupt the client; this is to make her feel that what she is saying is important. Acknowledge what the patient has said by repeating. Be open and non-judgemental because seeing things from the client's perspective ensures trust and understanding and ensures compliance with care. Sit facing the client and lean forward, this shows interest. Maintain eye contact and relax, this conveys interest and your readiness to help.

Facilitator's role

Pair up participants to perform these skills of active listening. Ensure that one participant plays the role of a mother and another midwife, while other participants observe and comment on the dynamics and the skills.

MODULE 3: Focused antenatal care [FANC])

Purpose: Expose midwives to the concepts and principles of FANC and the basic differences between FANC and the traditional approach to antenatal care approaches

Expected outcome: Midwives will practice FANC after participating in the workshop

Expected learning outcome: At the end of the training workshop, midwives will be able to:

- i. Discuss the principles of FANC
- ii. Differentiate FAC from the traditional antenatal
- iii. Discuss basic and specialized components of FANC
- iv. Describe the schedule, objectives and procedures covered in each of the four FANC visits for women
- v. Advise pregnant women on birth preparedness and complication readiness plan

Time needed for the session: Eight hours (2 hours for power point presentations 24 minutes/unit), 2 hours for group discussion (24 minutes/unit), 2 hours for role play (24 minutes /unit), and 2 hours for questions and answers and conclusion (24 minutes/unit).

Teaching delivery methods: Power point presentation, group discussion, group exercises, brainstorming and role play

Teaching delivery materials: Handouts, posters and flipchart or white board and markers

Study unit 2.1: Principles of FANC

Study unit 2.2: Differentiate between FANC and traditional antenatal care

Study unit 2.3: Basic and specialised components of antenatal care

Study unit 2.4: Schedule, objectives and procedures in FANC

Study unit 2.5: Birth preparedness and complication readiness plan

Content: Basic principles of focused antenatal care: Antenatal care service providers make a thorough evaluation of the pregnant woman to identify and treat existing obstetric and medical problems. They administer prophylaxis as indicated, e.g. preventive measures for malaria, anaemia, nutritional deficiencies, sexually transmitted infections, including prevention of mother-to-child transmission of HIV and tetanus.

- With the mother, they decide on where to have the follow-up antenatal visits, how frequent the visits should be, where to give birth and who will be involved in the pregnancy and postpartum care.
- Provided that quality of care is given adequate emphasis during each visit, and couples are aware of the possible pregnancy risks, the majority of pregnancies progress without complication.
- However, no pregnancy is labelled as ‘risk-free’ till proved otherwise, because most pregnancy-related fatal and non-fatal complications are unpredictable.
- Pregnant women and their husbands are seen as ‘risk identifiers’ after receiving counselling on danger symptoms and they are also ‘collaborators’ with the health service by accepting and acting on recommendations.

Discuss Advantages of FANC, and the basic differences between traditional and focused antenatal care. Also discuss the basic steps in the FANC service.

Discuss objectives and procedures at each FANC visit using the recommended articles.

The first FANC visit



The first FANC visit should ideally occur before 16 weeks of pregnancy have elapsed. You are expected to achieve the following objectives:

- Determine the woman's medical and obstetric history in order to collect evidence of her eligibility to follow the basic component of FANC, or determine if she needs special care and/or referral to a higher health facility. Provide the routine antenatal care.

The second FANC visit should be at 24-28 weeks of pregnancy. Provide care as for the first visit. In addition:

- Address any complaints and concerns of the pregnant woman and her partner.
- For first-time mothers and anyone with a history of hypertension or pre-eclampsia/eclampsia), perform the dipstick test for protein in the urine.
- Review and if necessary modify her individualised care plan.
- Give advice on any sources of social or financial support that may be available in her community.

The third FANC visit should be between the 30th and 32nd weeks of gestation. The objectives of the third visit are the same as those of the second visit. In addition you should:

- Direct special attention toward signs of multiple pregnancies and refer her if you suspect there is more than one foetus.
- Review the *birth preparedness* and the *complication readiness* plan (discussed later in this study session).
- Perform the dipstick test for protein in the urine for all pregnant women (since hypertensive disorders of pregnancy are unpredictable and late pregnancy phenomena).
- Decide on the need for referral based on your updated risk assessment.
- Give advice on family planning.
- Encourage the woman to consider exclusive breastfeeding for her baby.

Remember that some women will go into labour before the next scheduled visit. Advise all women to call you at once, or come to you as soon as they go into labour. Don't wait!

You should also emphasise the importance of the first postnatal visit to ensure that the woman is seen by you either at her home or at the Health Post, as soon as possible after the birth. The most critical postnatal period for the mother is the first 4 hours; this is when most cases of postpartum haemorrhage (PPH) occur.

The fourth FANC visit should be the final one for women in the basic component and should be between the 36th and 40th weeks of gestation. You should cover all the activities already described for the third visit. In addition:

- The abdominal examination should confirm foetal lie and presentation. On this visit, it is extremely important that you discover women with a baby in breech presentation or a transverse lie and refer them to the nearest health facility for obstetric evaluation.
- The **individualised birth plan** should be reviewed to check that it covers all aspects of birth preparedness, complication readiness and emergency planning.

Individualised birth plan

An individualised birth plan is a guide for healthcare providers developed in discussion with the individual woman and her partner (or main support people) which reflects her preferences about the planned birth. Discuss her birth plan.

Birth preparedness, complication readiness and emergency planning

Birth preparedness is the process of planning for a normal birth. **Complication readiness** is anticipating the actions needed in case of an emergency. **Emergency planning** is the process of identifying and agreeing on all the actions that need to take place quickly in the event of an emergency, so that the details are understood by everyone involved, and the necessary arrangements are made. First let us discuss normal birth preparedness.



Educate the mother and her family to recognise the normal signs of labour. Provide clear instructions on what to do when labour starts (e.g. in the event of cramping abdominal pain or leaking of amniotic fluid). Make sure that someone will call you or another skilled attendant for the birth *as soon as possible*.

Birth preparedness should also cover:

- Honouring the client's choices. You should give all the necessary information about safe and clean delivery, but ultimately you should respect a woman's choice of where she wants to give birth and who she wants to be with her.

- Helping her to identify sources of support for her and her family during the birth and the immediate postnatal period.
- Planning for any additional costs associated with the birth.

In an emergency

Make sure the woman and her husband and other family members know where to seek help.



- Alert the client and her family to plan for transportation with vehicle owners.
- Advise them to save money for transportation, drugs and other treatments.
- Decide who will accompany her to the health facility.
- Decide who will care for her family while she is away.

There are three types of delay, all of which can be serious for the mother and her baby:

- Delay in healthcare-seeking behaviour (delay in deciding to seek medical care)
- Delay in reaching a health facility
- Delay in getting the proper treatment.

Providing Focused Antenatal Care

(The Open University) (The OU)

MODULE 4: Effective birthing positions

Purpose of the module: The purpose of this module is for midwives to gain knowledge, skills and attitudes for the management of the second stage of labour in various labour enhancing positions

Expected outcome: Midwives will acquire knowledge, skills and attitudes to use varied birthing positions during child-birth that will contribute to clients' satisfaction with child-birth care.

Expected learning outcomes: At the end of the module midwives should be able to:

- Identify various birthing positions.
- Discuss the advantages of these birthing positions.
- Teach mothers the birthing positions during antenatal sessions.
- Demonstrate the use of these effective birthing positions.

Time needed for the session: Eight hours (2 hours for power point presentations (24 minutes/unit), 2 hours for group discussion (24 minutes/unit), 2 hours for demonstration and

return demonstrations (24 minutes/unit), and 2 hours for questions and answers and conclusion (24 minutes/unit).

Teaching methods: Power point presentation, group discussion and demonstration and return demonstrations

Teaching materials: Handouts, posters and flipchart or white board and markers

Study unit 1.1: Positions used in child-birth

Study unit 1.2: Advantages of the positions

Study unit 1.3: (application to practice) Education of mothers on the positions

Study unit 1.4: Demonstration of use of these positions during child-birth

Facilitator's role

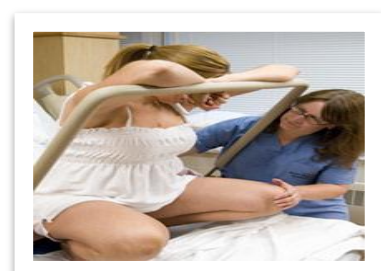
Through group exercises assess participants' knowledge on positions used in child-birth. Find out which of the positions they use in their facilities and why. Assess their knowledge on the advantages and disadvantages of the positions. Then discuss details of the birthing positions with the group.

Demonstrate the use of the positions (as a mother and how to conduct the delivery as a midwife in the positions).

Pair up participants to practise the roles as a mother and as a midwife.

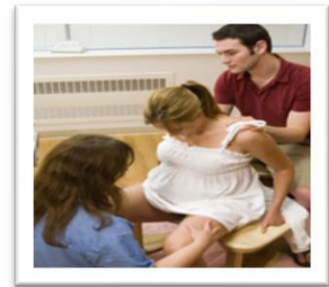
Birthing bar

A birthing bar is an attachment that can be added to most labour beds to help facilitate a squatting position. The squatting position helps to expand the size of your pelvis, and uses gravity to promote the downward movement of your baby. When using the bar, the foot of the bed can be dropped, and the head of the bed raised high. Between contractions, you can sit, supported by the head of the bed, and then during contractions, move forward to squat, supported by the bar. There is an alternative way to use the birthing bar. The vertical supports of the bar are used to rest your feet, and a sheet or towel is looped over the top of the bar. During the contractions, you grasp and pull back on the sheet as you push downward. This alternative might be helpful if you are too short to be comfortably supported by the bar in the squatting position or if you have had an epidural and your legs are too numb to safely support you in a squatting position.



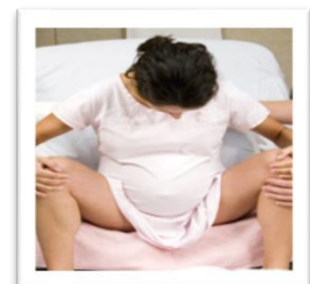
Birthng stool

A birthng stool can help you push in a very familiar position: the position you are used to using for having a bowel movement. Additionally, the low height of the stool flexes your legs and expands the size of your pelvis, and the upright position helps use gravity to promote the downward movement of the baby. You would push in the position shown, and then between contractions can lean backward to rest, supported by your partner.



Sitting upright

This upright sitting position is a variation on the use of a birthing stool. Notice how the mother is curled forward around her baby, with her elbows out as she pushes. The head of the bed is raised high, and the foot of the bed is lowered, giving you a place to put your feet. Like the use of the stool, this position helps you use gravity effectively. Between contractions, you can lean backward supported by the bed. If you like, your partner can also sit behind you in bed.



Kneeling

Pushing or giving birth while resting on the knees is a technique that may be used by any woman. It may be especially effective if you have had back pain during labour, as it helps to encourage movement of the baby. During the contraction, you flex your hips and lower your

buttocks slightly as you push. Between contractions, you can drape yourself over the head of the bed to rest and relax. You may try this position on your hands and knees, but, as your wrists may quickly become tired of supporting your body, you may find it easier to rest on your forearms as illustrated by this mother. In an alternative to this position, you may drape your upper body over a birthing ball.



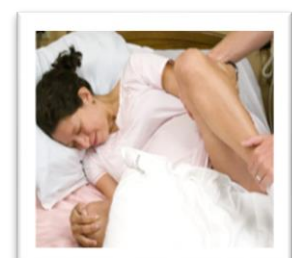
Semi-seated, with support

This position is not as effective in opening the pelvis as the upright positions illustrated above, but is probably the most common position used for the actual birth of a –baby – not necessarily because it is the best position for birth but, as you can imagine, it is the most convenient position for your doctor or midwife. In this illustration, notice that the head of the bed is raised to at least 30 degrees or greater, and that the mother has a pillow placed under her right hip, helping her turn slightly to the left. These adjustments help keep the weight of her uterus and baby from interfering with blood flow through the vessels that flow behind them. Notice also that she is curled forward around her baby, holding behind her knees, and that her support people are merely supporting her legs and her upper back, not pushing on them.



Side, curled position

The side-lying position is especially useful in promoting rest and relaxation between pushing



contractions. Some research suggests that this is the most effective birthing position for preventing tears.

Conclusion

In this chapter, the patient-centred care in-service training programme for midwives to facilitate satisfactory child-birth care was designed and developed. This training programme was based on results that emerged from Phases I and II of the study (Rothman and Thomas, 1994). The developed programme consists of four modules each with units. In the next chapter a report of the feasibility and usability of the training programme is presented.

Appendix 7 Facilitators' assessment tool

Teaching methods

Were the teaching methods (lectures, discussion, group work, etc.) used in the training successful in increasing participant knowledge/understanding? Yes

Did some methods work particularly well? Yes

Did some methods not work and do these need to be changed? No

Content

Was the content at the appropriate depth and breadth for the audience? Yes

Was the reading level of the module too difficult/easy? Neutral

Were the right topics covered? Yes

Were there topics missing? No

Were there stories, examples, cases mentioned during the workshop that could be incorporated into the curriculum? Yes

Materials

Were the materials user-friendly for both trainers and participants? Yes

Did the trainers use all of the materials? (Handouts, case studies, role play) Yes

Did participants refer to the training materials? Yes

Effectiveness

Did participants acquire the intended knowledge and skills from the training? Yes

Timing and flow

Was there too little time allocated for individual activities? Yes

Was there too little time allocated for the workshop as a whole? Yes



Appendix 8

Daily and final written evaluation form for recipients

WORKSHOP EVALUATION

PARTICIPANT EVALUATION FORM (ON-GOING)

SESSION 1: Respectful patient care and dignity in patient care module

Please complete this form to let us know your reaction to this module. Your input will help us to revise and improve upon the module. Please be as honest as possible with your responses.

On a scale of 1 – 5, 1 = poor and 5 = excellent						
1. To what extent has the workshop met your expectations?						
Not at all	1	2	3	4	5	Very much so
2. To what extent have your knowledge, skills and attitudes regarding patient care improved or increased as a result of this workshop?						
Not at all						Very much so
3. What are your views about the workshop materials provided to you?						
Too many		Just right		Too few		
4. Did you find the workshop useful for your work?						
Very relevant		Satisfactory		Not at all relevant		
5. Please indicate your specific comments:						
6. Suggestions for improvement:						
Thank you for your time!						

WORKSHOP EVALUATION

PARTICIPANT EVALUATION FORM (ON-GOING)

SESSION 2: Communication in patient care

Please complete this form to let us know your reaction to this module. Your input will help us to revise and improve upon the module. Please be as honest as possible with your responses.

On a scale of 1 – 5, 1 = poor and 5 = excellent

1. To what extent has the workshop met your expectations?

Not at all	1	2	3	4	5	Very much so

2. To what extent have your knowledge, skills and attitudes regarding patient care improved or increased as a result of this workshop?

Not at all						Very much so

3. What are your views about the workshop materials provided to you?

Too many	Just right	Too few

4. Did you find the workshop useful for your work?

Very relevant	Satisfactory	Not at all relevant

5. Please indicate your specific comments:

6. Suggestions for improvement:

Thank you for your time!

WORKSHOP EVALUATION

PARTICIPANT EVALUATION FORM (ON-GOING)

SESSION 3: Focused Antenatal care and positions used in labour

Please complete this form to let us know your reaction to this module. Your input will help us to revise and improve upon the module. Please be as honest as possible with your responses.

On a scale of 1 – 5, 1 = poor and 5 = excellent

1. To what extent has the workshop met your expectations?

Not at all	1	2	3	4	5	Very much so

2. To what extent have your knowledge, skills and attitudes regarding patient care improved or increased as a result of this workshop?

Not at all						Very much so

3. What are your views about the workshop materials provided to you?

Too many	Just right	Too few

4. Did you find the workshop useful for your work?

Very relevant	Satisfactory	Not at all relevant

5. Please indicate your specific comments:

6. Suggestions for improvement:

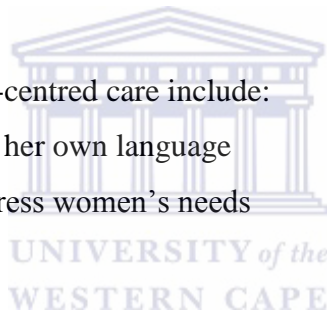
Thank you for your time!

Appendix 9

PRE- AND POST-TEST INSTRUMENT

INSTRUCTIONS: For each question choose the most appropriate answer or indicate whether the statements are true or false:

1. Patient-centred care means that:
 - a. Mothers have access to hospital and doctors for primary care
 - b. Women are protected from information about themselves or their care when danger signs or dangerous conditions appear
 - c. Women are empowered to become active participants in their care
 - d. A & B
 - e. A & C
 - f. All of the above
2. Some examples of patient-centred care include:
 - a. Speaking to the woman in her own language
 - b. Individualized care to address women's needs
 - c. Respecting cultural norms
 - d. All of the above



Answer True or False

3. Midwives will learn to provide patient-centred care if an instructor or mentor offers consistent rebuke and punishment for their not being friendly.....
4. Patient-centred care is life-saving, as women may refuse to seek care from a provider who “abuses” them or does not treat them well, even if the provider is skilled in preventing and managing complications.....
5. The following are concepts of patient-centred care EXCEPT
 - a. Involvement
 - b. Partnership
 - c. Empowerment
 - d. Routine care

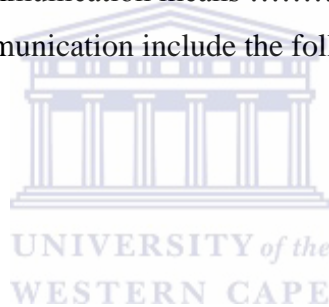
6. Regarding communication, the following are personal characteristics required of a midwife EXCEPT:
- a. Excellent people skills
 - b. Good communication and observation
 - c. Showing an interest in the physical, psychological and physiological needs of mothers
 - d. Dealing with emotionally charged situations

Answer True or False

7. Choice of communication channel and the style of communication does not affect communication.

Complete the following statement:

8. The acronym KISS in communication means
9. Non-verbal forms of communication include the following EXCEPT
- a. Tone of voice
 - b. Facial expression
 - c. Body language
 - d. Talking



Answer True or False

10. Body language could be a barrier to effective communication?.....

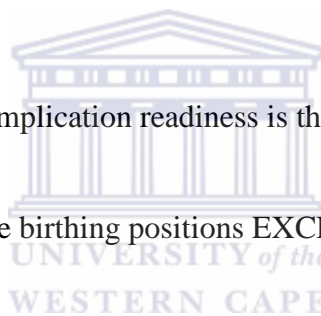
Choose the correct option:

11. In Focused Antenatal care, ideally the first FANC visit be done atweeks.
- a. 12
 - b. 16
 - c. 20
 - d. 24
12. During the second FANC visit, which of the following should not be done?
- a. Address any complaints and concerns of the pregnant woman and her partner
 - b. Review and if necessary modify her individual care plan
 - c. Give advice on any sources of social or financial support that may be available

- d. Give group care
- 13. For emergency preparedness, which of the following would you advise for the labouring woman?
 - a. Alert her to plan for transportation with vehicle owners
 - b. Advise her to save money for transportation, drugs, etc.
 - c. Decide who will accompany her to the facility
 - d. Decide who will care for her family while she is away
- 14. Delays are known factors contributing to maternal and neonatal mortality, which of these is not a factor?
 - a. Delay in healthcare seeking behaviour
 - b. Delay in reaching the health facility
 - c. Delay in getting the proper treatment
 - d. Delay in transportation

Answer True or False

- 15. Birth preparedness and complication readiness is the process of planning for a normal birth.....
- 16. The following are effective birthing positions EXCEPT
 - a. Birthing bar
 - b. Birthing stool
 - c. Sitting upright
 - d. Lithotomy position
- 17. What advantage does the upright position have over the lithotomy position?
.....
- 18. If a mother chooses to deliver in the birthing stool, between contractions she can lean backwards to rest supported by her partner. True/false.....
- 19. In the sitting upright position, the head of the bed is raised high and the foot of the bed is lowered. True/false
- 20. In the kneeling position, a mother may be supported over a birthing ball. True/false
.....



Appendix 10

OBSERVER'S GUIDE FOR ASSESSMENT OF FEASIBILITY AND USABILITY OF THE TRAINING PROGRAMME

The observer observes and notes the following

1. Were training materials used by trainers? **Yes**
2. Was there good interaction between trainer and participants? **Yes**
3. Were the participants engaged during the programme? **Yes**
4. Did any activity take longer than the stipulated time? **Yes** **Demonstration**
5. Did any activity take less than the stipulated time? **No**
6. Did participants appear confused at any point? **No**

If yes to 6. Note the point of confusion.....

7. Were there any activities that did not work out well? **No**

Summary of comment

The programme maintained the attention of all participants throughout the sessions and participants interacted well during the process. However, the demonstration session needs more time to be adequately done.

APPENDIX 11

INFORMATION SHEET

Project Title: Development of an intervention to promote satisfaction with child-birth care service in public health centres in Kumasi, Ghana.

What is this study about?

This is a research project being conducted by Veronica Millicent Dzomeku at the University of the Western Cape. You are being invited to participate in this research project because you meet the inclusion criteria of being an antenatal/postnatal client. The purpose of this research project is to develop an intervention to promote satisfaction with child-birth care service in public health centers in Kumasi, Ghana. This will help improve service provision during child-birth and will also guide maternal health policy formation.

What will I be asked to do if I agree to participate?

You will be asked to participate in an individual interview for 1 hour. You will be asked to take about your expectations and experiences with child-birth care service. We will also be asked about your expectations of a satisfactory child-birth care. Also about areas in which you desire that changes occur in the current child-birth care service. If you decide to participate in this study, I will make an appointment with you for the interview after you have been attended to. This interview will be tape recorded to keep accurate records of our conversation. I will also take notes during the interview process to keep track of events.

Would my participation in this study be kept confidential?

Your personal information will be kept confidential. To help protect your confidentiality, I will use codes and not your name on all records or data sheet. Information you provide will be kept in a locked filing cabinet and only the researchers will have access to the password.

This research project involves making audiotapes of you. Audiotaping will allow me to capture all our discussions during the interview. This I will type out (transcribe) later and store in a pass-word protected computer file. They will be destroyed 6 months after the research.

If I write a report or article about this research project, your identity will be protected.

What are the risks of this research?

There may be some risks associated with participating in this research study such as bringing back memories of unpleasant experiences that you may have had during your child-birth care. This would be managed by referral to a specialist at Komfo Anokye Teaching hospital immediately.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about the expectations and experiences of mothers during child-birth. Also about what mothers expect in a satisfactory child-birth care. I hope that, in the future, other people might benefit from this study through improved understanding of mothers expectations and experiences with child-birth care.

The study will also guide policy formulation in maternal and child health.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

You will be referred for specialist medical care immediately at Komfo Anokye Teaching Hospital if you are negatively affected.

What if I have questions?

This research is being conducted by me Veronica Millicent Dzomeku a post graduate Nursing student at the University of the Western Cape. If you have any questions about the research study itself, please contact my supervisor, Prof. Brian van Wyk at the University of the Western Cape.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Prof. Karien Jooste

Private Bag X17

University of the Western Cape

Bellville 7535

Dean of Community and Health Science Faculty: Prof. José Frantz

Private Bag X17

University of the Western Cape

Bellville 7535

Ph: 021-959 2613



Research Supervisor: Prof. Brian van Wyk

School of Public Health

University of the Western Cape

Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and the ethics committees of the Komfo Anokye Teaching Hospital (KATH) and the Kwame Nkrumah University of Science and Technology.

APPENDIX 12

CONSENT FORM

Title of Research Project: Development of an intervention to promote satisfaction with child-birth care service in public health centres in Kumasi, Ghana

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

I further understand that this research study involves making audiotapes of me and that this audiotape will be transcribed and kept in a password protected computer file. Only the researcher will have access and these tapes will be destroyed five years after the research.

___ I agree to be audiotaped during my participation in this study.

___ I do not agree to be audiotaped during my participation in this study.

1. Participant's name.....
2. Participant's signature.....
3. Witness.....
4. Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Prof. Brian van Wyk

Private Bag X17

University of the Western Cape

Bellville 7535

APPENDIX 13 ETHICAL APPROVAL



UNIVERSITY of the
WESTERN CAPE

OFFICE OF THE DEAN DEPARTMENT OF RESEARCH DEVELOPMENT

30 January 2015

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Mrs V Dzomeku (School of Nursing)

Research Project: Development of an intervention to promote
childbirth care service satisfaction in public
health centres in Kumasi, Ghana.

Registration no: 14/10/29

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

A place of quality,
a place to grow, from hope
to action through knowledge

APPENDIX 14 CERTIFICATE OF REGISTRATION



KOMFO ANOKYE TEACHING HOSPITAL
RESEARCH AND DEVELOPMENT UNIT (R & D)
CERTIFICATE OF REGISTRATION

REG. NO* RD/CR14/187

This is to certify that

Prof/Dr/Mrs/Mr/Ms Veronica M. Dzomeku
has registered his/her proposed study titled Development of an Intervention
to Promote Satisfaction with Childbirth Care Service
.....
.....with the Research and Development Unit.

Date 25th November 2014 A CENTRE OF EXCELLENCE

Name of issuing officer

Mr. Benerd Arbin

Signature

1338962

Receipt No

**This certificate does not constitute ethical clearance for the conduct of the study but proof of registration of study with KATH. Ethical clearance from the Committee of Human Research Publications and Ethics (CHRPE) is required to conduct the study

APPENDIX 15 APPROVAL OF STUDY



KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICAL SCIENCES / KOMFO ANOKYE TEACHING HOSPITAL
COMMITTEE ON HUMAN RESEARCH, PUBLICATION AND ETHICS



Our Ref: CHRPE/AP/007/15

8th January, 2015.

Mrs. Millicent Veronica Dzomeku
School of Nursing
College of Health Sciences
University of Western Cape
South Africa.

Dear Madam,

LETTER OF APPROVAL

Protocol Title *"Development of an Intervention to Promote Satisfaction with Childbirth Care in Public Health Centres in Kumasi."*

Proposed Site: *KATH, Antenatal Clinic and Post Natal Clinics of KATH.*

Sponsor: *KNUST/KATH.*

Your submission to the Committee on Human Research, Publications and Ethics on the above named protocol refers.

The Committee reviewed the following documents:

- A notification letter of 25th November, 2014 from the Komfo Anokye Teaching Hospital (study site) indicating approval for the conduct of the study in the Hospital.
- A Completed CHRPE Application Form.
- Participant Information Leaflet and Consent Form.
- Research Proposal.
- Interview Guide.

The Committee has considered the ethical merit of your submission and approved the protocol. The approval is for a fixed period of one year, renewable annually thereafter. The Committee may however, suspend or withdraw ethical approval at any time if your study is found to contravene the approved protocol.

Data gathered for the study should be used for the approved purposes only. Permission should be sought from the Committee if any amendment to the protocol or use, other than submitted, is made of your research data.

The Committee should be notified of the actual start date of the project and would expect a report on your study, annually or at close of the project, whichever one comes first. It should also be informed of any publication arising from the study.

Thank you Madam, for your application.

Yours faithfully,

Osomfuor Prof. Sir J. W. Acheampong MD, FWACP
Chairman

APPENDIX16 COMMENCEMENT OF RESEARCH STUDY



KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES

FACULTY OF ALLIED HEALTH SCIENCES
DEPARTMENT OF NURSING

2ND JANUARY, 2015

DEPARTMENT OF NURSING

KNUST, KUMASI

Dear Sir,

COMMENCEMENT OF RESEARCH STUDY

With reference to your letter number CHRPE/AP/007/15 giving me approval to conduct research. I am pleased to inform you that the study on "Development of an Intervention to Promote Satisfaction with Childbirth Care in Public Health Centers in Kumasi" has stated with data collection at the antenatal and postnatal clinics of Komfo Anokye Teaching hospital.

Thank you

Veronica Millicent Dzomeku (Mrs)

Principal Investigator



UNIVERSITY of the
WESTERN CAPE

Private Mail Bag, University Post Office, Kumasi, Ghana. Phone: 233-3220-63963.

- Fax 233-3220-63962

233-3220-60302

E-mail: nursing@knust.edu.gh

website: www.knust.edu.gh

APPENDIX 17 PERMISSION TO CONDUCT RESEARCH

In case of reply the number
and the date of this letter
should be quoted

My Ref. No: KM/NA-1/14/11

Your Ref. No:

Tel. No. 03220 – 24106 / 27639

Fax. No. 03220 - 24106

E-mail: ksighs@yahoo.com



METRO HEALTH DIRECTORATE
GHANA HEALTH SERVICE
P. O. BOX KS 12588
KUMASI

12th November, 2014

THE MEDICAL DIRECTOR
KUMASI SOUTH HOSPITAL
KUMASI

ALL MEDICAL SUPERINTENDENTS
GHANA HEALTH SERVICE
KUMASI

THE DEPUTY CHIEF PHYSICIAN ASSISTANT
APATRAPA CLINIC

THE IN-CHARGE
AYEDUASE CLINIC



**RE: PERMISSION TO CONDUCT RESEARCH/COLLECT
DATA IN YOUR FACILITY**

The bearer of the letter is conducting a study on the experiences and expectations of midwifery clients during care with the aim of developing a tool to improve satisfaction with care.

Permission has been granted to her to collect data in your facilities.

Kindly offer her the necessary assistance.

Thank you.

DR. KWASI YEBOAH-AWUDZI
METRO DIRECTOR OF HEALTH SERVICE
KUMASI

APPENDIX 18 PERMISSION FOR IN-SERVICE TRAINING



KWAME NKURUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES

FACULTY OF ALLIED HEALTH SCIENCES
DEPARTMENT OF NURSING

29TH MARCH, 2016

THE MEDICAL SUPT

JUABENG GOVERNMENT HOSPITAL

JUABENG

PERMISSION TO CONDUCT AN IN-SERVICE TRAINING FOR MIDWIVES

I am conducting a study on midwifery client's satisfaction with their childbirth care services within the Kumasi Metropolis. The ultimate goal is to develop an intervention to improve midwifery client's satisfaction with their childbirth care. I have sought and obtained permission for the study from the Metro director of health for Kumasi and have subsequently conducted same using four hospitals within the Kumasi metropolis.

From the previous phases of the study, the need for an in-service training for midwives on patient-centered care has become necessary as the intervention for the desired client satisfactory services.

I write to seek your permission to pilot test this program in a 3-day in-service training program for midwives in your facility.

Thanking you in Anticipation

VERONICA MILLICENT DZOMEKU (MRS)

Private Mail Bag, University Post Office, Kumasi, Ghana. Phone: 233-3220-63963.
E-mail: nursing@knust.edu.gh
website: www.knust.edu.gh

APPENDICE 19 APPROVAL FOR IN-SERVICE TRAINING

In case of the reply the number
and the date of this letter
should be quoted

My Ref. No: GHS/JH/ASR/G.

Email: juabenghospital@yahoo.com
Tel: 0502 779399, 0578 597870



JUABEN GOV'T HOSPITAL
P. O. BOX 34
JUABEN/ASHANTI
GHANA

29TH MARCH, 2016

MRS. VERONICA MILLICENT DZOMEKU
FACULTY OF ALLIED HEALTH SCIENCE DEPARTMENT OF NURSING
KNUST - KUMASI

APPROVAL TO CONDUCT AN IN-SERVICE TRAINING FOR MIDWIVES

We refer to your letter dated 29th March, 2016 seeking approval to conduct an in-service training for Midwives in the Juaben Hospital and write to give you permission for the exercise.

Thank you.



.....
DR. PROSPER GBKOR
MEDICAL SUPERINTENDENT

DR. PROSPER K. GBKOR
MEDICAL SUPERINTENDENT
JUABEN GOV'T HOSPITAL
P. O. BOX 34, JUABEN-ASH.

UNIVERSITY of the
WESTERN CAPE