International Journal of Community Medicine and Public Health
Konlan KD et al. Int J Community Med Public Health. 2018 Jul;5(7):2699-2704
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: http://dx.doi.org/10.18203/2394-6040.ijcmph20182602

Original Research Article

Perception of pregnant women on maternity care services at the Volta Regional Hospital, Ghana

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Received: 18 March 2018
Revised: 24 May 2018
Accepted: 25 May 2018

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ABSTRACT

Background: Maternity period is crucial and sensitive in the life of women due to various physiological changes that take place in the body during pregnancy and after. These changes need close monitoring to help optimize maternal and foetal health. This study explored pregnant women's perceptions of maternity care services in the Volta Regional Hospital.
Methods: Multiparous women (170) in the Ante Natal Clinic responded to a pretested questionnaire. The sample size was determined using Fischer's formula for sample size calculation. Respondents were chosen using the convenient sampling method. The data was analysed using Statistical Package for Social Sciences version 20 in to descriptive statistics.
Results: This study identified that women (42.5%) were never encouraged by health care providers to bring their partners during antenatal visits. Pregnant women (62.9%) reported that health care professionals did not allow their support persons including their husbands to be with them during labour. Women (34.1%) during labour were sometimes assaulted while 2.9% were always assaulted. Majority (74.2%) of the women received this five cardinal services that included vitamin K, eye care, cord care, bathing and immunization during the post natal period as 60.7% were introduced to family planning by midwives.
Conclusions: Partner involvement in maternal health care needs to be encouraged by midwives to improve support from partners during pregnancy, labour and the post natal period. Support persons should be allowed to stay with women during labour to give the necessary support and encouragement and also take part in decision making concerning women's care.

Keywords: Maternity, Care, Labour, Pregnancy, Perinatal

INTRODUCTION

Maternity period is crucial and sensitive in the life of women due to various physiological changes that take place in the body during pregnancy and after. These changes need close monitoring to help optimize maternal and foetal health. An array of services is provided to pregnant women during this period. These services include prenatal care and counselling, skilled delivery, and assistance in all cases by skilled person without excessive recourse to caesarean sections.[1] The risk of maternal mortality rate in the developing world is very high at 1 in 38 women as compared to 1 in 3700 women in the developed world leading to increased number of

women seeking maternal health.[2] Ensuring optimal maternal health is therefore of importance to the health care providers. Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. Whiles some mothers have positive and fulfilling experiences, some may experience negative ones such as suffering, ill-health and even death.[2]

Depending on a particular woman, varied experiences are encountered in seeking maternal health care services. These service experiences are varied based on the cultural and socioeconomic as well as ecological variables that influences health within a particular setting. Rijnders et al in the Netherlands recorded that, three years after delivery, most women looked back positively on their birth experience, but more than 16% looked back negatively.[3] More than 1 in 5 primiparous looked back negatively compared with 1 in 9 multiparous women. They then concluded that a substantial proportion of Dutch women looked back negatively on their birth experience three years postpartum.[3]

Perception of quality maternity services differed significantly by the type of facility used by women. In Napal, women considered the private hospitals to provide quality maternity services due to the availability of amenities and equipment as well as good midwife-client relationship.[4] In addition, attitudes and behaviours of maternal health care providers influence health care seeking and quality of care.[4] Greater attention is required to the attitudes and behaviours of maternal health care providers within efforts to improve maternal health, for the sake of women, children and health care providers.[5] Midwives play a central role in ensuring that women have a safe and life-enhancing experience based on their expectations during maternity care and that their babies and families have the best possible start in life. Women and their families expect a service that provides clear communication and explanations, effective team work, a safe caring environment and continuity of care. Midwives are therefore supposed to ensure that expectations are understood and met. Midwives inability to give information and clear explanations to mothers during labour contributes to feeling of disappointment which later generates negative experiences.[6]

Srivastava, Avan, Rajbanyshi and Bhattacharyya, (2015) reported that determinants of maternal satisfaction covered all dimensions of care across structure, process and outcome. Process of care dominated the determinants of maternal satisfaction in developing countries. Interpersonal behaviour was the most widely reported determinant, with the largest body of evidence generated around provider behaviour in terms of courtesy and non-abuse. Other aspects of interpersonal behaviour included therapeutic communication, staff confidence and competence and encouragement to labouring women.[7] In Ghana, multiple factors such as caregivers and clients interactions, culture among others influence maternal satisfaction with care during pregnancy, labour and postpartum period.[8] There is therefore the need to investigate the influence of process structure and outcome factors on midwifery services with regard to the type of maternity services provided to women during childbirth.

Problem statement

Client's expectations and satisfaction with maternity services have influential factors ranging from good relationship and communication between clients and their caregivers, deliveries attended by skilled personnel to type of facility accessed during pregnancy and delivery. Inter-personal aspects of care are key to women's expectations, which in turn govern satisfaction.[9] In Ghana, three-quarters of all maternal deaths occur during birth and the immediate postpartum period. However, 56.6% as the current rate of skilled birth attendants or supervised delivery does not only remain low in Ghana but also significant equity gap exist across and within regions-urban and rural disparities as cited by Akoto.[10]

The goal

This study explored pregnant women's perceptions of maternity care services in the Volta Regional Hospital of Ghana.

METHODS

Study design

The research design was a cross-sectional descriptive sample survey. Data was collected once and using simple descriptive statistics the factors related to maternal care service provision in the Volta Regional Hospital was explored.

Study settings

The study took place in the Volta Regional Hospital in Ho. The Volta Regional Hospital lies between latitudes 6° 207 N and 6° 55 N; and Longitudes 0° 127 E and 0° 53 E. The hospital can be found along the Ho-Denu/Aflao highway and covers an approximate land area of 3,325 square meters. The Volta Regional Hospital is a 320-bed capacity hospital serving as a referral health care facility and has a staff strength of Six Hundred and Fifty (650). The antenatal clinic forms the core of the maternal and child health unit. The ANC Unit has five (5) consulting rooms, eleven (11) midwives, two consulting obstetrics and gynaecology doctors and attend to at least fifty clients in a day.

Study population

The study population comprised all multiparous pregnant women of all ages who attended antenatal services at the Volta Regional Hospital. In total one hundred and

seventy (170) pregnant women at the antenatal clinic of the VRH were recruited to respond to a questionnaire.

Sampling

Convenience sampling method was used to select one hundred and seventy pregnant women who attended ANC in the Volta Regional Hospital. The convenience sampling method was adopted because of the difficulty in establishing a reliable sample frame for this population. The sample size was determined using Fischer's formula to calculate the sample size for unknown populations. Using a margin of error of 0.05, 95% confidence interval with an estimated proportion of 0.87 and a 5% anticipated non-response rate a sample size of 170 was computed.

Data collection

Data was collected using a pretested questionnaire. The questionnaire contained the demographic characteristics of respondents and responses pertaining to the perceptions of pregnant women on maternity care services. Respondents who could not read and write were assisted by the researchers to respond to the questionnaire while those who could read and write were made to complete the research questionnaire after a brief orientation. The data was collected within a two (2) month period spanning from January 2017 to March 2017.

Data analysis

Data was analysed in consonance with the objectives of the study. Data was checked for completeness and appropriateness of responses and entered into Microsoft excel spread sheet. The data was then coded and transferred to the Statistical Package for Social Sciences (SPSS) version 20. Simple descriptive statistics were used as basis for analysis.

Ethical consideration

Permission was sought from the Human Resource Manager (HRM) at the Volta Regional Hospital to conduct the study in the Hospital. A written consent and permission was sought from the pregnant women. All data obtained was handled anonymously. Respondents who agreed to participate in the study gave consent before they were enrolled into the study.

RESULTS

The study recruited pregnant multiparous women between the ages of 11 to 50 years. The mean age of participants was 31.1 (±1.7). Majority 54, (31.8%) attained Senior High School Education and then those with tertiary education were 49 (28.8%). Some (78, 45.9%) were traders with 133 (78.2%) married. The respondents were Ewes (115, 67.6%), Akans (35, 20.6%), Dagombas (8, 4.6%). The rest were gas, guans, fantes and Ga-Adangbes forming 2.4%, 1.8%, 1.8%, and 1.2% respectively.

Table 1: Distribution of demographic characteristics.

Distribution	Responses	Frequency	%
Age distribution	11-20	10	5.9
	21-30	69	40.6
	31-40	76	44.7
	41-50	15	8.8
Religious distribution	Christianity	146	85.9
	Islam	19	11.2
	African traditional religion	4	2.4
	Others	1	0.6
Level of education	Never schooled	7	4.1
	Primary	23	13.5
	JHS	36	21.2
	SHS	54	31.8
	Tertiary	49	28.8
	Others (Arabic education)	1	0.6
Distribution of occupation	Civil servant	31	18.2
	Trading	78	45.9
	Farming	13	7.6
	Other	48	28.3
Marital status	Married	133	78.2
	Single	15	8.8
	divorced/separated	5	2.4
	Widowed	1	0.8
	co-habiting	16	9.8

Obstetric history

Respondents had varied numbers of pregnancy as 57 (33.5%) had three pregnancies, 53(31.2%) had two pregnancies and 37 (21.8%) had four pregnancies. Five and six pregnancies were 15 (8.8%) and 8(4.7%) respectively. History of abortion showed some (47, 28.0%) pregnant women and 33 (70.2%) had spontaneous abortions while 14 (29.8%) were induced. Those who had previous abortions had their age distribution as 28 (59.6%) between the ages of 31-40, 13 (27.7%) were 21-30, 5 (10.6%) 41-50 and 2.1% were 13-20. Respondents (68, 40.0%) had delivered only one child, 56 (32.9%) had two children, then 26 (15.3%), 13 (7.6%), 7 (4.1%) gave birth to three, four, and five children respectively. Most (143, 84.1%) delivered per vagina whereas 27 (15.9%) via caesarean section.

Some (32, 18.8%) had experienced specific problems during previous delivery. The specific problem included Post-Partum Haemorrhage (PPH) 12(37.5%), 8(25.0%) prolonged labour, then 5(15.6%) Cephalo- Pelvic disproportions (CPD). The rest were 3 (9.4%), 1 (3.1%), 1 (3.1%) experienced anti partum haemorrhage (APH), Foetal death (FD), hyperemesis, pregnancy induced hypertension (PIH) respectively. Women (155, 92.0%)

had easy access to the health facility when in labour whereas 15 (8.0%) encountered problems reaching a health facility. Those who had the challenges; 11 (73.4%), had problems with transportation, 2 (13.3%) financial issues, 2 (13.3%) with personal issues. Some (14, 93.3%) had planned ahead the means of transportation if they got into labour. The time of first ANC visit during the last pregnancy were three months 47 (35.6%), two months 43 (32.6%) and four months 26 (19.7%). The rest were either eight months (6.1%), four (3.0%), two (1.6%) and a month (0.8%). During their last pregnancy, women visited the antenatal (ANC) five times 33 (19.4%) six 29 (17.1%) four 11 (6.4%) and the rest had more than six visits. Most 107 (62.9%) often had more waiting hours, 53 (31.2%) always had waiting hours whiles 10 (5.9%) did not spend longer waiting time. Out of the 160 respondents who often or always spent more waiting hours at the antenatal clinic, 90 (56%) spent more than 2 hours, 59 (37%) usually spent 2 hours while 11 (7%) spent one hour.

Majority 72 (42.3%), were never encouraged on partner's involvement in Antenatal care while others were sometimes 61 (35.9%) and always 37 (21.8%) encouraged to bring partners during ANC visits. Majority 104 (61.2%) were educated on all the nine (9) topics of ANC which include: personal and environmental hygiene, exercise, rest and sleep, birth preparedness and complication readiness, immunizations, malaria prevention, nutrition, and danger signs. Majority (123, 74.2%) had done all the nine (9). Ghana Health Service (GHS) recommended screenings and laboratory investigations for pregnant women which include: Hepatitis B, Blood group, Rhesus factor, G6PD, Haemoglobin level, VDRL, HIV/AIDS, Rapid diagnostic test (malaria) and ultrasound scan during the period of pregnancy.

Respondents perception of midwifes Interpersonal relationship include, Kindness- 129 (75.9%), Respect-126 (74.1%), ensured Privacy-122 (71.8%), high Confidence level 122 (71.8%) and good Communication skills-116 (68.2%). Majority 92 (54%) indicated they were given information during labour. Most (77.2%) of the information received was on progress of labour especially cervical dilatation. Women (94, 55.3%) did not have a midwife present with them throughout labour while 76 (44.7%) had a midwife with them throughout labour. Majority 107 (62.9%) did not have support persons including their husbands in the delivery room during labour. Many (79.4%) indicated the midwives' attitude was friendly, 14.1% agreed the attitude was very friendly and 6.5% said the attitude was unfriendly. Education given during puerperium included 43.5% importance of exclusive breastfeeding, 31.3%, proper positioning and fixing baby to breast, 24.1%, on danger signs for both baby and mother, 1.1%, support during breastfeeding after delivery. Majority 85.9% were not visited by the community health nurse or the midwives during the postnatal period.

Many (60.7%) were introduced to family planning services in the post natal period. The type of method chosen by puerperal women included 46% who chose none of the methods, 23.5% Injectable, 14.7% implants 7.8% oral pills, 4.9% condoms, 2.0% preferred intrauterine devices, and 1% chose the lactational amenorrhea method. The perceived problems associated with use of the method included, 65.5% of respondents encountered no problems during the use of the contraceptives as 14.5% had general problems such as pain and difficulty in breathing. Others (12.7%) had problems relating to gynecological issues such as amenorrhoea, irregular bleeding and bleeding while 7.3% of women however gained excess weight during the period.

DISCUSSION

This study explored pregnant women's perceptions on maternity care services rendered at the Volta Regional Hospital. Out of 47 women who had miscarriages, majority (59.6%) were between the age group of 31-40 while few, 2.1% were between age group of 11-20. Pregnancy in women under the ages of 20 and above 35 poses increased risk of not only maternal morbidity and mortality but also increased risk of miscarriage, preterm delivery, low birth-weight infants, and infants with high risk of infant mortality.[11]

Ante natal period

The hospital serves wide array of people from and without the region and major maternal complications are bond to occur. This may be stemming from cultural to socio economic barriers that will result from delayed care seeking. The impact of this enumerated problems can only be mitigated by employing drastic and concise measures. Major problems encountered by pregnant women included: Antepartum Haemorrhage (APH), Postpartum Haemorrhage (PPH), Cephalo-pelvic disproportion (CPD), foetal death, hyperemesis gravidarium, prolonged labour, and Pregnancy induced hypertension during their previous deliveries.

All pregnant women had at least one ANC contact during the last pregnancy. The success story of Antenatal care in Africa is based on the knowledge of pregnant women. Over two-thirds of pregnant women (69%) in Nigeria had at least one Antenatal contact.[12] Most of the knowledge pertaining to care and the birth process can only be gotten through antenatal care services. Majority of the women (104, 61.2%) were educated on all the nine (9) topics of ANC which included: Personal and environmental hygiene, exercise, rest and sleep, Birth preparedness and complication readiness, immunizations, malaria prevention, nutrition, and danger signs. Majority (123, 74.2%) had practiced all the nine (9) Ghana Health Service (GHS) recommended screenings and laboratory investigations for pregnant women which include: Hepatitis B, Blood group, Rhesus factor, G6PD,

Haemoglobin level, VDRL, HIV/AIDS, rapid diagnostic test (malaria) and ultrasound scan during the period of pregnancy.

In a culturally inclined Ghanaian community where male dominance is pronounced, partner involvement in maternal care services remain central in controlling the devastating impact of child birth and the complications associated with the process. A proportion (42.5%) of the pregnant women indicated they were never encouraged to bring their partners during antenatal visits. The extent of men's support for their partners' and spouses' reproductive health care can significantly affect outcomes. Men's knowledge of their partners' reproductive health needs during pregnancy and delivery, danger signs and how to address them, making delivery and transportation plans and so forth, can be enhanced through their presence during antenatal visits and discussions.[13]

The kind of relationship established by the midwife and client is central to the amount of trust established and the extent of that care activities implemented in the absence of the midwife especially at home. Interpersonal relationship in terms of kindness, respect, privacy, confidence level during antenatal, labour and postnatal was good. Interpersonal relationship seen in terms of the interpersonal and informative aspects of care has a major influence on satisfaction.[14] The determinants of maternal satisfaction covered all dimensions of care across structure, process and outcome. Process of care dominated the determinants of maternal satisfaction in developing countries.[7] Interpersonal behaviour was the most widely reported determinant, with the largest body of evidence generated around provider behaviour in terms of courtesy and non-abuse. Other aspects of interpersonal behaviour included therapeutic communication, staff confidence and competence and encouragement to labouring women.[7]

Labour period

Pregnant women (92.0%) in labour had easy access to the health facility. For those who could not access the health facility, they had issues pertaining to the means of transportation and lack of financial resources to access the facilities. Antenatal birth preparedness is central in planning towards delivery and aggregating resources towards the attainment of this goal. This had a good reflection on antenatal birth preparedness outcomes with greater percentage getting easy access to the health facility. As the impact of antenatal birth preparedness has proven to be fruitful, the proportion who showed signs of poor preparedness still remains a cause to be worried of. Bulk (62.9%) reported that health care professionals did not allow their support persons including their husbands to be with them during the labour process. A study in Senegal found a significant association between maternal satisfaction and the reception of empathetic support[14] from significant others including clients husbands. Maternal satisfaction increases when mothers receive support from their caregivers; this influences their perception of compliance with standard care and contributes to their future use of health care facilities.[14]

Analysing maternal perception with regard to whether or not midwives present encouraged them through labour, majority were always or sometimes encouraged while few were never encouraged. A considerable number 34.1% were sometimes assaulted while 2.9% were always assaulted. Out of the number that were assaulted during labour, verbal assault was the highest form of assault (85.7%). Disrespectful and abusive treatment prevents women from going to the health facilities therefore women choose where to deliver based on health provider attitude. It is therefore important that clients are treated with respect and dignity to enhance patronage of maternity services.

Postnatal period

Most of the respondents (60%) spent one day at the hospital after delivery. Melese, Gebrehiwot et al, reported that clients who stayed longer in the hospital tended to have higher satisfaction with the health care. This result may be due to the mother's perception of getting a better care through longer stay and clearing the fear of other complications as a result of early discharge from the hospital.[16]

During the post natal care period, post-partum women are expected to receive five cardinal care services. Majority (74.2%) of the women received this five cardinal services (vitamin K, eye care, cord care, bathing and immunization). The amount of services rendered to post natal women and the baby is central in reducing the risk of maternal morbidity and mortality and improving pregnancy and labour outcomes in general. Pregnant women were educated on the following during antenatal care services, importance of breastfeeding, proper position and fixing of baby to breast, support during breast feeding, danger signs for both mother and baby. Majority of the respondents (60.7%) were introduced to family planning by midwives. The most preferred method of family planning services among post-partum women were the injectable (23.5%). Family planning methods still remain the most viable means of providing adequate spacing for children and allowing proper care to be rendered. A good proportion of the women did not choose any method of family planning making them have a high risk of getting pregnant in the shortest possible time.

CONCLUSION

Based on the findings of this study, the following actions are recommended in order to improve maternity services at the Volta Regional Hospital. Partner involvement in maternal health care needs to be encouraged by midwives to improve support from partners during pregnancy since

from the study, about half of the respondents were never encouraged on partners' involvement. Support persons should be allowed to stay with women during labour to give the necessary support and encouragement and also take part in decision making concerning women's care. The support persons should be allowed into the labouring room. Midwives must hand over women appropriately to the Public Health Nurses/Community Health Nurses to ensure continuity of care of both mother and baby after delivery.

ACKNOWLEDGEMENTS

We are most grateful to the Almighty God for his divine guidance and protection throughout the research period. We are sincerely thankful to the staff and management of the Volta Regional Hospital as well as the participants for the study. Their immense support and co-operation during the data collection process was highly valued. We are much indebted to friends and all researchers, whose materials, comments, suggestions and support has made this work a reality.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Konlan KD, Kombat JM, Japiong M, Konlan KD. Perception of pregnant women on maternity care services at the Volta Regional Hospital, Ghana. Int J Community Med Public Health 2018;5:2699-704.