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QUALITATIVE STUDY

Expectations and needs of Ugandan women for improved quality of childbirth care in health facilities: A qualitative study

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Synopsis: Hope for a live baby motivates Ugandan women to seek facility-based childbirth. Women expect effective communication, respect, kindness, and emotional support, but this can be limited by willingness/capacity to pay.

Abstract

Objective: To describe the experiences, expectations, and needs of urban Ugandan women in relation to good-quality facility childbirth.

Methods: Women who had given birth in the 12 months prior to the study were purposively sampled and interviewed, or included in focus groups. Thematic analysis was used, and the data were interpreted within the context of an existing quality of care framework.

Results: Forty-five in-depth interviews and six focus group discussions were conducted. Respect and dignity, timely communication, competent skilled staff, and availability of medical supplies were central to women's accounts of quality care, or a lack of it. The hope for a live baby motivated women to seek facility-based childbirth. They expected to encounter competent, respectful, and caring staff with appropriate skills. In some cases, they could only fulfill these expectations through additional personal financial payments to staff, for clinical supplies, or to guarantee that they would be attended by someone with suitable skills.

Conclusion: Long-term improvement in quality of maternity care in Uganda requires enhancement of the interaction between women and health staff in facilities, and investment in staff and resources to ensure that safe, respectful care is not dependent on willingness and/or capacity to pay.

1. Introduction

The WHO defines quality of care as “the extent to which health care services provided to individuals and patient populations improve desired health outcomes” [1]. To achieve this, health care needs to be safe, effective, timely, efficient, equitable, and people-centered [2]. In Uganda, maternal and perinatal death reviews [3] and population situation analysis reports [4] suggest that gaps in quality of care have been responsible

for delayed attainment of the country's targets for reduction of maternal mortality. In 2011, the maternal mortality ratio (MMR) in Uganda was 438 deaths per 100 000 live births. Despite the reduction to 336 deaths per 100 000 live births, the country still failed to attain its Millennium Development Goal target of 131 per 100 000 live births by 2015 [5]. For Uganda to attain its health targets and consequently its economic targets, the existing gaps in quality of maternal and newborn health care must be addressed [6].

Several government policies in Uganda reflect the importance of providing quality care and its role in reducing maternal and newborn mortality and morbidity [4,6,7]. For example, one of the main objectives of the second national health policy is to improve access to quality hospital services at all levels in both public and private sectors [7]. The goal of Uganda's quality improvement framework and strategic plans is to ensure that, by 2020, all people accessing healthcare services in Uganda attain the best possible health outcomes, and that consumer acceptability and satisfaction are improved [8]. This is recognized as a means to achieving the health sector development plan of accelerating the movement toward universal health coverage with essential health services that are needed for promotion of a healthy and productive life. The plan recognizes the need for safe, effective, efficient, accessible, equitable, and patient-centered care services, with optimal professional performance as a way to achieve consumer acceptability and satisfaction. Skilled birth attendance with quality labor and childbirth management is among the top four high-impact interventions presented in Uganda's investment case (2015–2020) for the Global Financing Facility. This is seen as one of the key interventions that will prevent 95% (4600) of maternal deaths that are projected to occur in that period if the status quo is maintained [8]. Uganda's challenge, therefore, in providing patient-centered quality maternity care, is clearly not a result of suboptimal focus on quality or the absence of a supportive policy environment, but the need for information on how to bridge the policy-to-practice gap.

Improving quality of care for women requires an understanding of their cultural values, previous experiences, and perceptions of the role of the health system. This then helps to bring reproductive health service providers and the community together to map out a

shared vision of quality [9]. For example, the 2013 maternal and perinatal death review report reveals that delayed care-seeking was an important avoidable factor that contributed to 56% of maternal deaths [3]. While the delays in women recognizing danger signs contributed to delays in care-seeking behavior, delays in making a decision to access health facilities also contributed to this problem. The decision to go to a health facility was influenced by the extent to which women and their families felt that their needs and expectations would be met when they arrived at the health facility [9]. Although meeting the needs and expectations of women is an important part of client-centered care, client satisfaction in health facilities in Uganda is low [9]. There have been limited efforts to improve satisfaction, as the focus has been largely on meeting clinical and technical standards.

Accelerating the reduction of intrapartum-related maternal, fetal, and newborn mortality and morbidity in a low-income country like Uganda will require deliberate efforts and interventions to address weaknesses in the process of labor care, and also the disconnect between the health systems and the communities. Consequently, the WHO embarked on the BOLD (“Better Outcomes in Labor Difficulty”) project to develop innovative tools, designed together with community groups and healthcare providers, to promote access to respectful, quality care for pregnant women at the time of childbirth [10]. To inform the development of these tools, formative qualitative research was carried out in Uganda to explore the needs and expectations of both women and healthcare providers, in relation to improving the quality of labor and childbirth care, including birth experiences and outcomes [10]. This paper describes the needs and expectations of Ugandan women with regard to improving the quality of labor and childbirth care in health facilities.

2. Materials and methods

2.1. Study design

The findings reported here are part of a larger qualitative study conducted among women, healthcare providers, and administrators [10–12]. Since this paper focuses on

women's perspectives and experiences of quality of care in health facilities during childbirth, this section outlines the methods for the women participants only.

2.1.1. Study sites

The study was conducted in the catchment areas of four busy urban health facilities in Kampala district: a public referral hospital and three private not-for-profit mission hospitals. The four study facilities and their corresponding catchment areas were chosen in collaboration with the local principal investigator (a Ugandan obstetrician-gynecologist) using pre-specified inclusion criteria for the larger BOLD cohort study. The criteria were that the chosen center was a major healthcare facility in the region (not a primary health unit); intrapartum care was provided by skilled birth attendants; the clinical staff had stable access to cesarean delivery, augmentation of labor, and assisted vaginal birth; and that there was a record of good-quality intrapartum care practices [10].

2.1.2. Data collection, quality control, and management

In-depth interviews (IDIs) and focus group discussions (FGDs) were conducted with women of reproductive age (15–49 years) who resided in the study hospitals' catchment areas of up to 5 km radius, and who had given birth in any health facility in the previous 12 months. Women were recruited with the assistance of community health workers, who identified those women who met the inclusion criteria.

IDIs and FGDs were conducted by use of topic guides to explore the needs and expectations of women related to improving quality of care. IDIs provided individual women an opportunity to reflect and provide rich, detailed descriptions of their experiences of care during childbirth. FGDs provided a forum for participants to share, compare, and contrast their experiences and expectations of care with others while allowing researchers to gain a better sense of community norms and values regarding intrapartum care in the study area.

The domains that were explored all related to facility birth. They included perceptions of care provided, decision-making to seek facility care, the meaning of good-quality intrapartum provision, expectations and perceived needs, and potential changes to enhance the provision of quality intrapartum care. Full IDI and FGD guides are available as Supporting Information S1.

Data were collected from December 2014 to April 2015 by eight graduate research assistants, five females and three males, with Bachelor's degrees either in Social Sciences or Public Health, and training in qualitative research. We chose to use data collectors who were nonclinical, to reduce the risk of social desirability bias. All research assistants resided in Kampala, and underwent a two-day training and piloting workshop prior to commencement of data collection.

The study involved a single contact with each study participant, during which the research assistant introduced herself, provided an overview of the study objectives, and obtained informed consent from the participant. All FGDs and IDIs took place in private settings, within homes for IDIs and community meeting spaces for FGDs, with only participants present. They were all audio-recorded, and they lasted between 40 and 90 minutes. Participants received refreshments and were reimbursed for transportation costs. Names of participants were protected, and de-identified transcripts were stored on a password-protected computer. The presentation of this paper adopted the consolidated criteria for reporting qualitative research (COREQ) guidance [13].

The research assistants audio-recorded all FGDS and IDIs, maintained field notes, and transcribed and translated all audio recordings on an ongoing basis as data collection progressed. Study team members regularly met to review progress, shared field experiences, and reviewed transcripts to ensure quality. IDIs and FGDs conducted in English were transcribed in English, and those conducted in a local language (Luganda) were translated and transcribed simultaneously by the research assistants. Data collection continued until thematic saturation was reached.

2.2. Ethical considerations

Scientific and technical approval was obtained from the WHO Human Reproduction Programme Review Panel on Research Projects. Ethics approval was obtained from the WHO Ethical Review Committee (protocol ID, A65878) and the Makerere University School of Health Sciences Research and Ethics Committee (protocol ID, #SHSREC REF 2014-057) and cleared by the Uganda National Council of Science and Technology (SS: 4172). Written informed consent was obtained from all participants, and confidentiality was assured and ensured. We did not experience any refusal from the participants.

2.3 Data analysis

A thematic analytic approach was used, as described by Braun and Clarke [14]. Preliminary data analysis occurred concurrently with data collection, particularly during the regular meetings with research assistants and investigators to review the progress and process of data collection. The process of transcription and reading of the transcripts provided an insight into emerging themes, and was an important part of preliminary data analysis and identification of thematic categories. A list of themes was then identified to form part of the framework for a code book. The study objectives and tools used as guides for the IDI and FGDs were also utilized to generate the coding framework. Under each major theme derived from the framework, between 5 and 20 subthemes were identified.

The compiled data were then imported into Atlas.ti software, version 7.5.18 (ATLAS.ti Scientific Software Development, Berlin, Germany), to enable a more systematic management, coding and retrieval of data. Segments of related data themes were identified through imported materials from IDIs and FGDs, categorizing relevant themes by assigning them with suitable codes using code manager. In addition, we wrote memos regarding our thoughts about the selected segments. The memos and codes combined formed the basis for the thematic analysis of women's needs and expectations by establishing the patterns and meanings. Impressions, explanations, and arguments were eventually developed, guided by the five domains influencing the

quality of care women experience according to the WHO's quality of care framework for maternal and newborn health: effective communication, respect and dignity, emotional support, competent and motivated human resources, and the availability of essential physical resources [2].

Preliminary findings were presented during a two-day workshop held with a subset of participants, local investigators, and the WHO study team to further interpret the findings in the Ugandan context. We considered questions of reflexivity throughout the study period, including identifying and reflecting on our own assumptions and preconceptions regarding what constitutes quality care, and continuously exploring emergent findings.

3. Results

A total of 45 IDIs and six FGDs were conducted among a total of 85 women (Table 1). Most women (74%) were younger than 30 years old, and had given birth two or more times in health facilities (74%).

The data are presented in two key areas, supported by a total of eight themes. First, we present women's expectations of facility-based childbirth, which generated three themes. We then present the five themes that illustrate what women need to experience if they are to perceive their maternity care as high quality.

3.1. Expectations of women

3.1.1. Newborn survival

The primary motivation for the respondents to give birth in health facilities was to ensure the survival of their babies. Where respondents discussed this outcome, it overrode their perception of the kind of care they experienced. While mothers often recounted stories of having to tolerate some undesirable conditions in the health facilities, they gave credit to facility staff for helping them to give birth to a live baby:

“I delivered in the [hospital], the only memorable moment is they helped the baby’s life, but me I did not see any care... helping to have a live baby was the only good thing. I am still having my baby.” (Married woman, 30–45 years)

The context of HIV infection in the population contributed to this expectation. Many women reported that they were aware of the dangers of infecting their babies during childbirth if they were HIV positive, and that they had been informed that trained health workers in facilities would help to prevent mother-to-child HIV infection.

Although the desire for a positive childbirth experience is almost universal to women, the emphasis on a live and healthy baby in this setting reflects the fact that intrapartum-related stillbirths and neonatal deaths are not uncommon in this population. Several women have personally experienced or witnessed their colleagues or relatives experience the loss of a baby during childbirth or the immediate postnatal period. For many, the hope for a live and healthy baby was a strong motivator to use facility care, despite some of the negative features of such care, explored in more detail below.

3.1.2. Appropriate competencies and skills of skilled birth attendants

Women’s accounts suggested that the desire to receive care from skilled health personnel greatly influenced their choice of which health facility to attend to give birth. Women in this study resided in urban areas and tended to choose the larger hospitals, partly because of a greater chance of being supported by skilled health workers in such hospitals. In these settings, respondents anticipated care from a number of competent staff members, with the necessary skill mix, who they perceived were able to collectively identify complications, and advise each other on the best course of action. One respondent contrasted this with lower-level facilities and clinics, where birth is often undertaken by a single practitioner, whose skillset may be limited:

“Another thing is that a clinic has only one health worker but at least a big hospital has many health workers and they can advise each other on what to do on several issues. For instance, for me after giving birth, the blood pressure rose so high and if I was in a clinic, by now I would have died already. The health

workers were at least many and they advised each other.” (Cohabiting woman, <30 years)

When describing good memories of the care they had received, some women’s responses centered on situations where many doctors and midwives consulted with each other about the best approach to their particular situation, and where they were attended by people with a range of skills, especially in the context of complications. This desire to have skilled and experienced staff was one of the reasons some women were willing to pay extra for some specific services, even in public hospitals where these services were supposed to be free of charge. For example, some respondents perceived that, when they provided money as a tip to healthcare providers, the chances of being attended by skilled professionals increased.

Due to their anticipation of skilled and experienced health personnel, several women expressed disappointment and concern when attended by student midwives or interns without adequate supervision from experienced personnel. Similarly, some of those who experienced the death of their babies, or other adverse events, attributed this to being attended by staff that were not yet fully trained:

“The one that helped me give birth was a student. She was with a doctor, but after delivery the student stitched me. She stitched me badly and I had to be stitched again. The doctor should have been there to stitch me.” (Married woman, 30–45 years)

The skilled health workers were expected to be present and available, especially when women did not have family or other companions to attend to them, or provide them with the needed care and support. This support included taking a bath, getting food and drink, as well as mobility from one facility location to another, for example to the postnatal ward after childbirth.

3.1.3. Requisite equipment and supplies

Women recognized that health workers require equipment and supplies to enable them to effectively provide good quality maternity services. In this setting, women are encouraged to purchase basic materials for care of the mother and the baby just before and immediately after the baby is born, including razor blades, surgical/disposable gloves, and a mackintosh (plastic sheet), which are usually included in the so-called “mama kit.” These materials are occasionally provided with funding from development partners and nongovernmental organizations, but women are also willing to purchase them to facilitate their childbirth care. However, for the participants in this study, there were some medical supplies that women expected to be provided for free. Expectations were not met, and frustrations were evident, when women or their family members were requested to purchase materials such as drugs, intravenous fluids, or other supplies.

3.2. Perceived needs for quality childbirth services

3.2.1. Timely information and effective communication

Respondents felt that knowing about what was happening to them throughout labor was an important requirement for good quality of care. Therefore, they expressed a need for clear and open communication from health workers about the condition of their unborn baby, and what they should expect throughout the labor and childbirth process. Many women and their attendants were anxious about the process of labor and childbirth. Some respondents were even concerned that inexperienced first time mothers might experience a stillbirth if they were not informed about the progress of their labor.

Many women, particularly those giving birth for the first time, were unfamiliar with the general organization of the health facility, and therefore required clear and accurate directions of where to go to get the care they needed. However, as is apparent in the following quote, some women were disappointed by brusque and disrespectful responses from health staff:

“You reach [the facility] when you are in serious labor pains, you ask a staff ‘where is the labor ward?’; she shouts at you, ‘go there’ and you may take a different direction.” (Married woman, <30 years)

Women expressed concerns about long delays in being attended, without clear explanations about what to expect. They preferred to be warmly welcomed to the facility, carefully led to the delivery bed on admission, and given clear explanations about the position of their baby, the time they should expect to give birth, and what to expect throughout labor. Recognizing the constraints on health workers' time, some respondents noted that older and more experienced women in the community could be a possible alternative to close this information gap.

Women were concerned when health workers only asked them questions to complete medical records, without explaining to them what information they were collecting, what it would be used for, and what it told the healthcare worker about the situation for the woman and her baby:

"I also need to know what is going on. And sometimes you would ask a health worker something and she does not answer you, yet it would be better for her to tell you and she could advise you accordingly. They don't want to be asked questions and if you do, they take you to be stubborn." (Married woman, <30 years)

The communication gap between health workers and women contributed to women's interpretation that decisions taken by health workers were in the health staff's own self-interest rather than for the well-being of the woman or her baby. For example, some participants felt that midwives gave women intravenous drugs to worsen uterine contractions and punish those who had not obliged them with money:

"They [health workers] put you on a drip even when you already have contractions simply because there you will have to pay them 20,000 [about USD 6] for the drip water." (Cohabiting woman, <30 years)

While this may be a false allegation, the gap in communication leaves room for such labor practice to be misconstrued. Similarly, some women felt that they had not been given sufficient time to progress through labor and insinuated that they were taken for a

cesarean delivery because the doctors wanted money or were in a hurry to go to their private clinics.

Somewhat in contrast to this view, several participants felt that some women do not take the delivery process seriously, and that health workers should be stricter with them. Even so, they felt that health workers should have an approachable demeanor when communicating, rather than a hostile, threatening, or militant approach:

“To me good quality care is when a health worker talks to you well without shouting.” (Cohabiting woman, <30 years)

In the study settings, it is a common practice for the health workers to separate the baby and mother after birth, especially those babies taken to the special care units, and women were often left in the dark about the condition of their babies. Respondents reported that they needed good communication with health workers as much after their baby was born, as during the labor itself.

3.2.2. Respect and preservation of dignity

All respondents considered respectful staff attitudes, and the preservation of their dignity, to be important components of good quality care. However, most had previously experienced disrespectful care. “Let them care about us. Let them know that we are also human beings” was a typical response, as women described difficult scenarios while explaining what good quality of care was not.

Women viewed respect as being talked to, listened to, and as consideration of their opinions, and participation in decisions pertaining to their care during labor. They emphasized that health personnel should believe what the women tell them rather than overlooking their concerns and dismissing their calls, which they likened to dismissing the attention-seeking efforts of a “spoiled child” (locally known as “*kyejo*”).

Among the most commonly reported experiences of mistreatment during childbirth was harsh handling by providers. Some women reported being slapped during labor. In fact,

when asked what they would change in health facilities, most women recommended that health workers should stop slapping the mothers when they assist them during birth.

“They [health workers] should stop slapping mothers when they are working on them, but have some empathy because they also know that it [childbirth] is painful.” (Married woman, <30 years)

However, some respondents did report encounters with empathetic health workers who understood that childbirth is a painful process.

In this setting, inadequate infrastructure, coupled with a heavy workload, results in congested hospitals, and constrains the ability of staff to ensure privacy for all women. It is common for several mothers to labor and give birth in a single room at the same time. Respondents were concerned with situations where many mothers are put in one ward, “and everyone is looking at you,” as one participant noted. While being with only women in the labor room reduced the shame felt, participants noted that it was not a desirable situation. Women recommended the provision of basic facilities to ensure at least some privacy, such as curtains or cubicles.

Some respondents also felt that midwives made unreasonable demands, such as insisting that a woman should lie still on her back as the midwife repairs an episiotomy without anesthesia. They noted that there is a risk of being slapped or abandoned whenever they flinch or hold the hand of the midwife in response to the perineal pain inflicted by episiotomy repair:

“After delivery she told me to lie well so that she removes the placenta and when she was trying to remove it I held her hand and she asked me ‘who told you to hold my hand?’ and she just walked away leaving me there in so much pain.”
(Cohabiting woman, <30 years)

Women were also unhappy when health workers showed a lack of respect for locally valued (traditional) childbirth practices, for example the use of herbal medicines to

facilitate labor. They reported being scolded for use of local herbs. As the following quote illustrates, some respondents felt that health professionals attributed complications and poor birth outcomes to the woman's use of herbal remedies:

"When you go with local medicine they can abuse you to death and in case of any problem or complication it is directed to the local herb." (Married woman, 30–45 years)

3.2.3. Psychosocial and emotional support

Participants noted that pregnancy and labor are stressful situations that require psychological and emotional support. They expressed the need to be understood, encouraged, and reassured by health workers, family members, and their local community, but felt that this type of support was lacking. This was captured in the desire to be both cared about, and cared for, in the following quote:

"A woman who is going to give birth needs great care. Because the health workers sometimes think we are pretending, they don't care about us and yet we do need that care." (Cohabiting woman, <30 years)

Traditionally, hospitals in Uganda allow patients to have attendants such as family members and relatives. Most women in this study desired the presence of a birth companion (often their sister, mother, friend, or husband), to provide emotional support, as well as to ensure access to supplies, food, drink, mobility, communication with health workers, and help with caring for the newborn. In reality, overcrowding in the maternity facilities often prevents the continuous presence of a birth companion, so it is common that attendants wait outside the labor ward, and only attend to the woman's needs from time to time when requested by the health worker.

The findings from this study indicate that, when labor companionship is not possible, or when the woman arrives alone, she will desire support, encouragement, and motivation from midwives or other health staff to comfort and empower her to give birth.

3.2.4. Appropriate physical environment

Women noted that good-quality care included a clean and safe physical environment, in the wards, beds, and toilets. However, some respondents decried the conditions in some of the public health facilities where the general hygiene was lacking. They lamented situations where mothers have to use a delivery bed when it is still “wet” (not cleaned). They suggested that there should always be a member of staff available to clean the bed between one labor and the next. Moreover, some delivery beds were reported to be very old but not replaced.

Nevertheless, some women had positive experiences with the facility environment, and appreciated feeling comfortable and able to access the required care:

“[Hospital] should stay as it is...they even have a place where you can prepare tea, the bed is also good, the place is also spacious enough and there is also a place where you can hang your clothes. The labor ward is okay.” (Cohabiting woman, <30 years)

3.2.5. Money as a necessity (“The care is poor to someone who is poor”)

As alluded to in some of the themes above, some respondents reported money was necessary even in public health facilities, which are expected to provide free services. There was a general assumption that, without extra funds to pay for staff attention, and clinical resources, laboring women would not get a good quality service:

“You have to dip into the wallet in case you want to be worked on. It is a government hospital but if you do not have money on you, the health workers don’t attend to you.” (Cohabiting woman, <30 years)

Consequently, women expected financial support from their spouses, families, and other relatives to enable them to access better quality services. As noted above, while several women acknowledged willingness to pay to access certain aspects of the maternity services, they expressed frustrations and disappointment over rigid health workers who wanted to be paid in advance, and who neglected those who had not yet paid, even when in a critical condition. Some women complained that health workers

asked for unnecessary drugs and supplies, thereby requiring them to spend more money than they had originally planned.

Women were of the view that health workers should prioritize saving their lives and ask for money later. Women giving birth in private not-for-profit facilities noted that by the time they choose them, they are aware of their obligation to pay, but that they should still be attended to before payment is demanded, to minimize the risk of delayed assistance and negative health consequences. Indeed, as the following quote illustrates, poor outcomes due to delayed treatment could lead to a reduction in willingness to pay after the event:

“The good quality of care is to first care for the mother to treat her so well such that she stabilizes, her baby to be cared for then later the issue of money comes in. But not to first think about money than life because if someone dies they will not be happy to pay you.” (Married woman, 30–45 years)

4. Discussion

We have presented findings relating to women’s needs and expectations of good quality of care during labor and childbirth in Uganda. In this context, many respondents were motivated to give birth in a health facility in the hope that this would ensure the survival of their newborns. However, they expected far more than just a healthy baby. They also wanted to interact with staff with appropriate competence and skills for their specific care needs, who would provide them with timely information about their labor and childbirth process, and who would respect them, care for them, and maintain their dignity. They also expected the facilities to be clean, and to be supplied with the necessary equipment and supplies. However, women in this study reported that they were often disappointed because these expectations were not realized. In some cases, paying extra fees for staff attention, and/or for clinical resources, was tolerated, but not when staff prioritized the *a priori* payment of these fees over the immediate clinical care needed by women and/or their babies.

The needs and expectations of women expressed in this study are similar to those reported in the 2016 *Lancet Midwifery* series [15]. Specifically, this includes effective treatment for complications if they arise, respect for women and newborn infants, responsiveness to women's needs for safety, privacy, and dignity, and use of interventions only when necessary [15]. Our findings also parallel other research conducted in Uganda, for example, regarding the noninvolvement of women in decision-making during labor and childbirth. Kigenyi et al. [16] quantitatively measured the quality of intrapartum care at a national referral hospital in Uganda through exit interviews and found that women perceived the quality to be low (overall mean index score 49.4%), with just 10% of clients in their study having been given the opportunity to ask questions, and 9% being asked about their care preferences. Low staffing levels at facilities in Uganda result in staff being overwhelmed by a heavy workload, and contribute to poor and limited interactions between staff and women. Using the workload indicators of staffing need, Namaganda et al. [17] showed that health facilities in Uganda have 53%–67% fewer midwives than is required, which implies that they have to cope with almost double their expected workload. The context of resource scarcity influences other unfavorable service delivery practices that constrain women from experiencing their desired quality of services, including skilled personnel as and when they are needed.

Kaye et al. [18] explored women's perspectives of quality intrapartum care during duty handovers in Mulago Hospital, and concluded that handovers were “triggers for several problems that affected quality of care, created gaps in continuity of care, and increased patient morbidity or mortality” due to communication failures. Finally, Wilunda et al. [19] explored barriers to utilization of facility-based delivery services in rural Karamoja region and found that lack of beds, drugs, equipment, and supplies, shortage of staff, and long waiting times were reasons for not utilizing health facilities. Our study highlights how these unmet needs and expectations are equally important in urban and peri-urban contexts in Uganda.

Resource constraints also influence the environment in which providers (particularly midwives) work, which in turn contributes to the poor handling of clients. The midwives' work environment (especially in the public sector) is characterized by poor remuneration, poor health service infrastructure, lack of essential equipment and supplies, inadequate protection from infections, high workload, lack of outcome-oriented supportive supervision, and few opportunities for continuing professional development [20].

The 2015/16 Health Sector Development Plan of Uganda's Ministry of Health acknowledges that high-quality delivery of services remains a challenge, and women lack confidence in using the services [21]. Nevertheless, the Government of Uganda has initiated several interventions such as promotion of mutual accountability for maternal and newborn survival, as outlined in the sharpened Development Plan [8], and effected by implementation of the country's RMNCH scorecard [22]. Other interventions are the implementation of maternal and perinatal death reviews [23], development and dissemination of the Quality Improvement Strategic Plan and tools [24], and performance-based financing to improve staff motivation and outputs [25]. The country is also building and renovating/expanding health facilities and functionalizing lower health units to decongest overburdened hospitals. Health staff capacity is being enhanced through provision of staff housing, and by strengthening the midwifery profession and image to align with the International Confederation of Midwives' definition. This includes regulation and association, training health workers in customer care, and on-job mentoring and support supervision of midwives. In addition, there is an establishment of structures for health workers to receive feedback from communities, such as community barazas and patient representation on Health Unit Management Committees [8,26].

Moving forward, establishing facility-level standards and indicators to improve quality of care is an important step to improve audit and accountability. Providing the infrastructure to enable every woman to have a companion of her choice with her

throughout the labor and childbirth process may improve women's experiences of care and provide her with the emotional support needed during this critical time.

4.1. Strengths and limitations

The strengths of this study are that it did not select women who had a particular type of birth experience or those who had had a particular type of birth outcome. Therefore, our findings represent women with both positive and negative childbirth experiences, along with those who had uncomplicated vaginal births as well as those who had serious labor and childbirth complications. Our sample specifically selected women who had given birth in the recent past, and, therefore, who had fresh memories of the birthing experience. Although the women who participated in this study were recruited from catchment areas around four of the major hospitals in Kampala, the study did not restrict itself to those who had given birth in these specific facilities, which encouraged diverse opinions about the context of giving birth in Kampala.

A limitation is that the women were recruited primarily from urban and peri-urban settings, and therefore the findings may not be transferable to women residing in rural settings. Women often spoke about their experiences giving birth in different types of health facilities, and it was not always possible to determine whether they were referring to a lower-level health center, a general/regional hospital, or a private/non-profit hospital. Uganda has a high teenage adolescent pregnancy rate of 24%, and it is important to understand the specific needs and expectations of adolescents. However this study did not delineate the special concerns of this age group, or of any other specific subgroup who may or may not experience different standards of maternity care.

4.2. Conclusions

In this study, the participants valued effective communication, respectful care, emotional support, and competent, motivated staff. Despite experiencing some disappointments when these needs were not realized, hope that they will leave the hospital with a live baby motivated them to give birth in hospitals. The present situation of resource scarcity was reflected in the requirement for participants to provide tips for staff, and to buy

some necessary clinical resources. At the extreme, lack of provision of such personal funds was reported to limit the willingness of staff to provide essential care. This illustrates that women in Uganda need financial and logistical support to be able to access childbirth services that are free, available, accessible, and of good quality at the point of need. Long-term investments in improving quality of care should include improving infrastructure and human resources, as well as strengthening community and family support to women in accessing childbirth services from health facilities.

Further research is needed to better understand the magnitude of the problem of unmet needs and expectations (and of mistreatment) of women in childbirth care in Uganda; the types of mistreatments that they experience; the perpetrators of this mistreatment; root causes of poor treatment of women during childbirth; and evidence-based interventions to improve women's experience of high-quality childbirth care in both public and private sectors. Outcomes of such research should be used to tailor appropriate interventions to improve quality of care, and to ensure that women experience a positive labor and birth.

Author contributions

This analysis was planned by DK with input from KM and MAB. Data analysis was conducted by DK and KM, with support from MAB. DK and KM wrote the first draft of the paper. All authors commented on and approved the final manuscript.

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Conflicts of interest

The authors have no conflicts of interest.

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SUPPORTING INFORMATION

Additional Supporting Information may be found online in the supporting information tab for this article.

Supporting Information S1: Full in-depth interview and focus group discussion guides.

Table 1.

Characteristics of the women participating in the study.

Characteristics	IDIs		FGDs	
	No.	(%)	No.	(%)
Age, y				
<30	37	(82.2)	26	(65.0)
30–45	8	(17.8)	14	(35.0)
Number of facility deliveries				

1	10	(22.2)	12	(30.0)
2	19	(42.2)	9	(22.5)
3	7	(15.6)	8	(20.0)
>3	9	(20.0)	11	(27.5)
Religion				
Catholic	21	(46.7)	11	(27.5)
Christian (Non-Catholic)	18	(40.0)	17	(42.5)
Muslim	6	(13.3)	12	(30.0)
Educational level				
Primary	9	(20.0)	7	(17.5)
Secondary	33	(73.3)	26	(65.0)
>Secondary	3	(6.7)	7	(17.5)

Abbreviations: IDIs, in-depth interviews; FGDs, focus group discussions.