Women's views and experience of their maternity care at a referral hospital in Ghana

By Liz Floyd, Nicole Coulter, Susana Asamoah, Rebecca Agyare-Asante

Abstract

Reducing death and morbidity by promoting high quality maternal and newborn care is a key goal for global health programmes. A recent systematic review defined quality care as preventive and supportive care with effective treatment for problems when they arise (Renfrew et al, 2014). It showed that women want health professionals who combine clinical skills with interpersonal competence. This article describes a qualitative study to explore the experiences of eleven newly delivered women at a large referral hospital in Accra, to identify which factors contributed to a positive or negative birth experience. The study found that women's satisfaction or dissatisfaction were due to their perceptions of clinical competency (basic, practical, timely monitoring and treatment) and emotional support (respect, kindness and reassurance).

Keywords: **Midwifery, Ghana, Maternal welfare, Personal satisfaction, Clinical competence**

This article describes a preliminary study to explore women's views about the maternity care they received at a tertiary referral hospital in Accra, Ghana. The purpose of this study was to investigate the views and experiences of women who had given birth there to identify which factors the women interviewed felt contributed to a positive labour and birth experience and which did not. Identifying the aspects of care that are important to women should help to inform improvements in practice. Before this study was conducted, women at this hospital had not previously been asked about their experiences.

Globally, an estimated 289 000 mothers die each year during pregnancy and childbirth. Most of these avoidable deaths occur in sub-Saharan Africa (World Health Organization (WHO), 2014a). Maternal death has catastrophic consequences for families, communities and countries with significant economic consequences; households disintegrate and existing children become motherless. Yet it is apparent that the Millennium Development Goals, specifically 3, 4 and 5—promoting gender equality and the empowerment of women, the reduction of child mortality and improvement in maternal health, will not be achieved by 2015.

Key barriers to the adequate utilisation of healthcare for women that contribute to maternal death are the delay in the decision to seek care, delay in arrival at a health facility and lack of provision of adequate care (UNFPA, 2014). The '3 delays model', which was originally described by Thaddeus and Maine (1994), has underpinned initiatives to improve women's access to maternity care and promote birth in health facilities with skilled attendants (WHO, 2014b). In order to be able to provide this skilled care, a functioning health service, transportation, drugs, equipment and supplies are also necessary. To date, many global health programmes have aimed to prevent maternal deaths by improving the reliability, recording and investigation of the causes of deaths. Programmes include strengthening clinical competency, improving organisational systems and the referral process to reduce delays, improving monitoring and surveillance, establishing evidence-based clinical protocols and improving recognition and response to emergencies. Developing the skills and knowledge of health professionals through education and training has been a key part of this process (WHO, 2005).

Literature review

Mothers and babies die in childbirth as a result of poor quality care and many more suffer acute and chronic physical and psychological morbidity. Poor quality care is not simply the absence of services. Quality maternal and newborn care is concerned with the appropriate use of technologies and requires effective, sustainable and affordable improvements including education, training and leadership. A recent systematic review defined quality maternal and newborn care as the provision of preventative and supportive care and effective treatment for problems when they arise; respect for women and newborn infants including safety, privacy and dignity; the use of interventions only when they are indicated; and strengthening the capabilities of women to care for themselves and their infants. This review also identified the key elements that effect quality of care

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such as respect, good communication and tailored care that optimises the biological, physiological and sociocultural processes. The review concluded that 'women wanted health professionals who combined clinical knowledge and skills with interpersonal and cultural competence' (Renfrew et al, 2014: 4). Strong evidence now exists for the contribution that midwifery can make to this quality of care for women and infants globally, in terms of efficient use of resources and improved outcomes. Using the Lives Saved Tool (LiST), Homer et al (2014) calculated that scaling-up midwifery care would lead to a significant reduction in maternal and neonatal deaths worldwide. Research has shown that treatment that is disrespectful and abusive deters women from accessing healthcare. Furthermore, 'women choose where to deliver based in large part on the way they will be treated in the facilities available to them' (Freedman and Kruk, 2014:1). Models of care that are respectful, which keep women and newborns at the centre of care will be more attractive to women and more likely to be utilised (UNFPA, 2014). This principle was enshrined in The White Ribbon Alliance (2011: 1) *Respectful Maternity Care Charter,* which stated that 'the notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights...autonomy, dignity, feelings, choices and preferences'.

Birth is a major life event in all cultures. Ample evidence exists demonstrating that prenatal stress, anxiety and depression have an impact on perinatal outcomes (Dunkel Shetter, 2010), that women's experiences influence clinical and psychosocial outcomes for both mothers and babies and that fear, anxiety and lack of support influence the experience of pain (Hodnett et al, 2012). In order that the design and functioning of maternity services around the world is able to provide acceptable, accessible and respectful services that are responsive to women's needs, it is necessary to establish what matters to women in relation to their care (Redshaw and Heikkila, 2010; Hoope-Bender et al, 2014). 'Women's views should not be thought of as stand-alone extras to 'hard' clinical outcomes but as a key part of the process' and should be integral to every stage of research, policy, planning and service delivery (Green, 2012: 294). Therefore identifying and incorporating women's views are essential to improving health outcomes for mothers and babies.

There have been many studies in developed countries that have explored the perspective of service-users in order to evaluate patient satisfaction. A systematic review by Doyle et al (2013) reports that positive patient experience is consistently associated with patient safety and clinical effectiveness. However, far fewer studies have been conducted in developing countries. A major survey of the mistreatment of women in labour wards worldwide was undertaken and revealed examples of disrespect and abuse ranging from lack of privacy to physical abuse and detention (Reiss et al, 2012). A systematic review of qualitative studies of maternity care in sub-Saharan Africa showed that women express negative attitudes towards health care workers whose behaviour has been abusive or rude (Brighton et al, 2013) and that this is likely to influence their decision to seek care in the future. Social factors play an important role in the extent to which women are able to access facility-based care (Yakong et al, 2010; Moyer et al, 2013). In rural northern Ghana, fear of maltreatment and lack of support remain barriers to delivery in a health care facility (Crissman et al, 2013). A study conducted in Ghana described how women expected humane, professional, courteous treatment from professionals and that interpersonal aspects of care were essential to patient satisfaction (D'Ambruso et al, 2005). However, although the percentage of births attended by a professional is widely used as a measure of skilled attendance, studies have shown that women were often unable to identify the specific role of the attendant caring for them (Hussein et al, 2004).

Another study in Ghana described how women described being physically and verbally abused, as well as experiencing neglect, discrimination and the denial of their traditional practices (Moyer et al, 2013). As well as wanting to feel supported during labour, women also described valuing cleanliness and tranquillity in their surroundings (Mensah et al, 2014). Negative experiences reported by South African women included poor relationships with staff, lack of information, neglect and abandonment (Chadwick et al, 2013). In Ethiopia, women described feeling left 'alone' during labour despite the presence of health professionals and disliking being forced to lie down often with their legs in stirrups (Bedford et al, 2013).

Context of the study

In Ghana, the majority of maternity care is provided by midwives in polyclinics within the community, where women receive antenatal, intrapartum and postnatal care. Women who develop complications are referred to specialist centres. Midwives provide the majority of the skilled care at delivery. Across the country as a whole, 58% of births are attended by a skilled birth attendant (Ghana Ministry of Health/ Ghana Health Service, 2011) although in the capital Accra, this figure is much higher. A philosophy of 'women- or patient-centred care' is promoted by the Ghana Health Service who state in their *National Safe Motherhood Service Protocol* that care should be comprehensive, individualised and people-centred (Ghana Health Service (GHS), 2008; GHS, 2009). The *Ridge Hospital Annual Report 2012* (Asamoah and Srofenyoh, 2013), where this study was undertaken, states that the labour ward core values are friendliness and family-centredness, citing 'client satisfaction' and 'creating a friendly atmosphere' as key objectives. However, so far no attempt has been made to evaluate how well this has been achieved or to identify what women have experienced. In order to design a maternity service that is responsive to women's needs, it is necessary to identify what women believe to be good care and what they believe to be poor care as well as to establish what matters to the individual women who give birth.

This preliminary study was carried out at Ridge Regional Hospital in Accra, Ghana. Ridge Hospital is a tertiary referral centre for women who develop complications in pregnancy or labour. The hospital delivered 7591 babies in 2013. This figure is substantially less than in 2012, where 11 006 births took place. This decline may be due to strengthening of peripheral facilities in the region. Reported maternal mortality overall in Ghana was 380/100 000 live births in

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2013 (WHO, 2014a). Like most other developing countries, there is no national recording system of maternal deaths and stillbirths so this figure is considered to be highly unreliable. Instead each institution collects its own figures. As a referral centre, 70% of the women who gave birth at Ridge Hospital in 2013 were transferred from other peripheral units with complications. During 2013 there were 32 maternal deaths for 7591 live births, equating to a maternal mortality ratio of 422/100 000. The main causes of these deaths were haemorrhage, hypertensive disorders, unsafe abortion and ruptured ectopic pregnancy (Asamoah and Srofenyoh, 2014). Ridge Hospital maternity unit is old and overcrowded and is currently housed in the oldest part of the hospital which was built in the 1920s. The labour ward is situated on the first floor and currently has a small triage area, eight delivery beds with two additional delivery beds in an alcove, plus a small area for women who have recently given birth. There is a nearby female ward and a postnatal ward on the ground floor. The recently refurbished maternity theatre is a 10 minute walk away. The caesarean section rate is approximately 35%. Women labour close to each other, on adjacent beds, do not have labour companions and rarely receive analgesia.

This study was undertaken alongside other work carried out at Ridge Hospital with Kybele. Kybele is a multidisciplinary humanitarian childbirth organisation (www.kybeleworldwide.org) that has been working with Ridge Hospital and the Ghana Health Service since 2006 (Engmann et al, 2010). Its key long-term objective is to improve maternal and newborn health care in line with WHO global standards (WHO, 2007) and most recently with the *Every Newborn Action Plan* (WHO, 2014c). Work to date has focused on a model of partnership working through observation, advocacy and support, training packages, leadership development and quality improvement. The author has worked with this project since 2011 and some of this work has been described elsewhere (Engman et al, 2010; Srofenyoh et al, 2012; Floyd, 2013). The purpose of this study was to identify women's views and experiences in maternity care at the health facility, not simply as an academic study but also so that findings could be shared with staff to support improvements in clinical practice.

Method

Without reliable knowledge about factors that are culturally and socially relevant to the women delivering at Ridge Hospital, it was decided to use an exploratory, qualitative approach for this preliminary study. The qualitative approach aims to collect rich, narrative data from a small sample of women in order to understand events, by exploring their attitudes, beliefs, values and experiences. This richness of data is more important than the sample size. Qualitative data analysis requires a formal systematic process of the interpretation of the findings incorporating description, categorisation and conceptualisation of the findings (Harding and Whitehead, 2013).

One advantage of the qualitative approach is that it involves a close relationship with the participant providing an opportunity for the informants to tell their own stories and describe their feelings (Rees, 2011). Using a qualitative interview technique provided an opportunity for the women to have 'a voice' and to be treated respectfully as partners in their care (Green, 2012). Data were analysed using a thematic analysis approach (Braun and Clarke, 2006) which involves producing a thematic description of the entire data showing the important themes then coding them by a process known as inductive analysis. Using this method of analysis enables an interpretation of the responses.

Rigour in the qualitative method can only be verified by the credibility of the study and the 'trustworthiness' of the data (Schneider, 2014). Findings must be faithful to everyday reality so that others can judge their importance for their own practice. Credibility, accountability and 'fittingness' were achieved by sharing the findings with as many of the maternity unit staff, as soon as possible after the study was completed.

In-depth semi-structured interviews were conducted with a sample of 11 postnatal women. The interview schedule is shown in *Table 1*. The interviews were conducted at the bedside, over a 4-day period during September 2013. Any woman who had a live baby and agreed to be interviewed was included. Women are discharged rapidly following delivery so for practical purposes all the women were interviewed on the postnatal ward within 24 hours of delivery. It is known that women are highly likely to express satisfaction when they have just given birth and are reluctant to criticize their care-givers (van Teijlingen, 2003). Evidence from patient satisfaction surveys shows that when women are asked about their experiences after the end of their maternity care, it can be difficult to identify exactly which aspects of care are being judged. This was known to be an issue but was the only practical way of interviewing mothers.

Ethical approval

Ethical approval was granted from the medical director and senior midwifery and nursing managers following scrutiny of the questionnaire (*Table 1*), interview process and analysis techniques.

Interviews

An explanation of the study was given to the ward staff. Interview sheets were identified numerically ensuring anonymity of interview subjects. Any comments made about hospital staff were anonymised. Although there are several local languages spoken in Accra, English is the official language particularly among educated people. Approximately half the women who attend Ridge do not speak English and many do not read or write. Communication and fluency with English was problematic for some of the women and so it was important that non-verbal communication methods such as body language, eye contact, facial expressions and touch were used throughout interactions. The interviews were conducted by a UK volunteer midwife under the supervision of an experienced midwife researcher. The interviewer had already spent several days on the ward as an observer, so ward staff were familiar with her. One member of staff was keen to act as an interpreter, to enable the views of the non-English speaking women to be heard. However, when these women were approached for consent by the Ghanaian staff member, all declined to be interviewed, despite the fact they

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Table 1. The semi-structured interview schedule
1. When was your baby born? Age/Occupation/Parity
2. Were you expecting to deliver your baby at Ridge? Why was your baby born here?
3. Did you have any problems before or while your baby was being born? What were they? Can you tell me what happened?
4. Did you have a normal birth or a caesarean? Were expecting to have a normal birth or a caesarean?
5. Do you think this is a good hospital? Why? Would you want to come here again?
6. Who looked after you when you were in labour? Do you remember anyone in particular? Can you tell me anything about them?
7. Did any of the staff introduce themselves by name? If not, how did you know who they were?
8. What do you think about the care that you received?
9. Is there anything that would have made your labour and delivery easier/better?
10. What do you think about the idea of having a companion with you in labour? Do you like the idea? Who would want to have with you?
11. Can you tell me how you felt while you were having your baby?
12. Do any of these words describe any of the staff who cared for you? Rushed/unhelpful/supportive/rude/explained everything/sense of humour/sensitive/abrupt/ Kind/bossy/insensitive/considerate/polite/inconsiderate/gentle

had already seen other women being interviewed in English. It was therefore surmised that they did not want to be interviewed with this staff member as translator. This factor is an important bias in this study because better educated women (i.e. English speakers) are usually better able to articulate their needs. However, the use of hospital staff as an interpreter could also have biased the results.

The interviewer approached all the women herself. Having established there was a baby with the mother she then asked if the women spoke English. If she did not, the interviewer spoke warmly to the mother in English, congratulating her on her baby, but did not conduct the interview. If the woman did speak English the interviewer spoke warmly, asking if she could ask the mother some questions and explained the purpose of the interview. The aim was to build trust and encourage women to answer questions as fully as possible, particularly if they were speaking critically about their experiences. Space was limited so the interviewer stopped the interview if any staff approached nearby, to ensure confidentiality for the woman. The interviewer's use of active listening techniques enabled the her to check and verify what the woman was saying and thereby improve the reliability of the findings. Written notes from each interview were analysed individually as well as collated together.

Results

The demographic details of the subjects are shown in *Table 2.* All the women interviewed were willing and able to describe the 'story' of their birth experience and how they felt about what had happened to them with considerable clarity. They all largely understood the significance of their obstetrical problems and were able to judge whether they had been well cared for or not.

The women were asked if they thought Ridge was a good hospital and whether they would want to come back again if they were pregnant. Every woman who said they thought it was a good hospital (n=8) said they would want to come back again if they were pregnant. Every woman who said it was not a good hospital (n=3) would not want to return (*Table 3*). All the women who said they thought it was a good hospital said their care had been good. The women who said they were happy with their care gave their reasons as: 'the midwife spoke nicely', 'midwife was calm and made me feel calm', 'she listened to me, she helped me', 'very supportive, observations made before theatre' 'told about CS, counselled, reassured.' The women who thought it was not a good hospital described their care as: 'very bad, not explaining, shouting at me', 'X shouted at me and said if you want to go home just go', 'very upsetting', 'X shouted at me because I was having pain', 'X doesn't know how to treat patients.'

When asked who had looked after them in labour, subjects reported that only one midwife had introduced herself by name whereas three other women had read the midwife's name on her badge. Four women said they believed the person caring for them was a midwife 'because she was

Table 2. Demographics of participants (n=11)	
Age	**Frequency**
21–30	4
31–40	5
No age recorded	2
Parity	
1	3
2	5
3	1
4+	2
Type of delivery	
Spontaneous vaginal delivery	5
Caesarean section	6
Expecting to deliver at Ridge?	
Yes	3
No	8

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Table 3. Can you tell me how you felt while you were having your baby?

Subject	Who said it was a 'good' hospital (in response to Q5)	Who said it was a 'bad' hospital (in response to Q5)
1.	'atmosphere good, welcoming, reassured, counselled'	
2.	'scared when pushing'	
3.	'scared of childbirth, but safe, supported, considerate'	
4.		'safe but nervous before CS'
5.	'worried about the baby, but they listened to the baby and they said I would be okay'	
6.	'fine, no worries, comfortable, happy I was awake' (for CS)	
7.	'dizzy, nauseous, safe, they were in control'	
8.		'alone, unsafe, nervous about pain, I didn't feel pain but I was scared'
9.		'felt okay'
10.	'very safe, felt baby was safe'	
11.	'scared, but the midwife helped me, she was patient with me when I was screaming'	

Table 4. Words used to describe behaviours of those caring for women in labour

Positives	*n*	Negatives	*n*
Supportive	7	Unhelpful	2
Kind	7	Rushed	1
Polite	4	Rude	1
Gentle	4	Insensitive	1
Considerate	3		
Sensitive	2		
Explained everything	1		

working on the labour ward', 'because she was wearing white' or 'I assumed she was a midwife because she was on the labour ward'. Only one doctor was mentioned by name.

When asked whether anything would have made labour easier (question 9), the women who thought it was a bad hospital said they wanted 'better explanations, more support, for staff to be polite and respectful.' 'Support, kindness, knowing how to treat a patient, respect' 'more support and better care.' Of the women who said it was a good hospital; one answered that she would have liked 'more food and water and the midwife to stay with me more.' Several women mentioned that having sufficient food and water made them more comfortable. Another said she would have liked 'more support during labour before my baby was born.'

The women were asked what they felt about having a companion with them during labour and nine women said they would have liked someone to be with them in labour or while they were waiting to go to theatre. They mentioned their husbands, mother or sister. One woman said she would have liked 'a nurse to hold my hand in theatre'. Two women did not like the idea of a labour companion.

The women were asked how they had felt while they were having their baby (question 11). Their responses are tabulated in a matrix against whether the women thought it was a 'good' or a 'bad' hospital (*Table 3*). Women were asked to choose words to describe the care they had received during labour. Most women used positive words to describe the staff caring for them (*Table 4*).

Interpretive analysis

The purpose of this study was to try to identify which factors the women interviewed felt contributed to a positive labour and birth experience and what was important to them. Once the data was recorded, it was coded in order to organise the data into meaningful groups. This enabled the aspects of care that contributed to positive and negative feelings about the birth experience, to be identified. These were then cross referenced so that the main themes were grouped together.

At a simple level these themes could be divided into positive and negative statements about the women's experience, their feelings during labour, the care they received and the people who had looked after them. When the responses were listed it became clear that they fell into two categories, one related to practical aspects of care and the other relating to the way women felt about their care (*Table 5*). These categories are described here as 'clinical competency' and 'emotional support'.

The first category 'clinical competency' relates to the basic, practical clinical care that the woman received. This included timely medical and obstetric management in the hospital, monitoring the wellbeing of her and her baby, her basic safety as well as having enough to eat and drink.

The second category relates to 'emotional support' and describes staff or activities that helped them, who were kind and friendly, who treated them with respect or who spoke to them nicely.

When describing their birth experiences all the women were able to describe how they felt about what was happening. They were able to judge whether their care was clinically competent and felt reassured when it was. Women were also able to talk about the extent to which they felt supported and reassured by staff while in labour. Emotional support was clearly very important for these women. Several of the women who said they thought it was a good hospital only mentioned factors categorised under emotional support. All the women who said they did not think it was a good hospital reported a lack of emotional support as well as lack of clinical competency. While this is not necessarily significant in a qualitative investigation such as this, it does demonstrate how important kindness and respect are to women in labour. All the women who said it was not a good hospital and would not want to return reported that staff had shouted at them.

Discussion

No woman in this study declined to be interviewed, and all were able to describe their experiences in detail and

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Table 5. Clinical competencies and types of emotional support contributing to women's positive and negative feelings

	Clinical competency	Emotional support
Positive	'quick referral'	'good midwives who were nice'
	'quick caesarean section (CS)'	'they helped me a lot'
	'manual removal of placenta'	'supportive, they held my hand'
	'sort your problems'	'made me feel better'
	'they looked after me well'	'they gave their best to me'
	'they listened to the baby'	'when I was scared they helped me'
	'explained everything'	'kind'
	'happy to be awake for CS'	'midwife was calm and made me feel calm'
	'felt baby was safe'	'welcoming atmosphere, reassurance'
	'observations before theatre'	'supportive, considerate'
	'was told about CS'	'look after me'
	'comfortable'	
	'competent'	
	'efficient'	
	'quick'	
	'helped me push baby out'	
	'sufficient food and water'	
Negative	'nervous before CS'	'unhelpful and insensitive'
	'nervous about pain'	'rushed'
	'scared of childbirth'	'unhelpful and rude'
	'I am here to be monitored but no monitoring was done.'	'not explaining'
	'Lack of observations'	'shouting at me'
	'no review after CS, not seen by doctor or midwife'	'very upsetting'
	'I have to call for medicine'	'shouted at me because I was having pain'
	'No checking'	'very bad'
	'they did not tell me my baby was breech'	'..doesn't know how to treat patients'
	'need more medication'	'scared when pushing'

with insight. Ridge hospital is a referral centre for women who develop complications in pregnancy or labour. The study established that all the women who were interviewed understood the reasons why they had been referred to Ridge hospital, why they needed specialist care and why they and their babies were at risk. The study also showed that despite appearing quiet and not making overt complaints, all the women interviewed had strong views about how they had felt. Investigating the experiences of a small group of women, means that the findings should not be generalised to other groups, including non-English speaking women. Non-English speakers are likely to have less understanding of their complications, feel more anxious and therefore require more explanations and support.

The study showed that most of the women were happy with the care they received, thought Ridge was a good hospital and would be happy to return. However, some women did not think it was a good hospital and felt very unhappy with their treatment. All the women understood why they had been referred and were very dissatisfied when they felt that they had not received the appropriate level of care, adequate observation or monitoring that they felt they should have had. Some women described being ignored, spoken to rudely or harshly and some women described being shouted at.

The underlying reasons for women's satisfaction or dissatisfaction were due to their perceptions of 'clinical competency' and 'emotional support'. The women interviewed in this study recognised and valued good clinical skills and competent practitioners, supporting the findings of previous studies (Doyle et al, 2013; Renfrew et al, 2014). The women interviewed recognised that emotional support was an essential part of good quality care and were much happier if they had experienced kindness, respect, calmness, someone holding their hand and being given explanations. These acts improved their overall experience of labour and birth and support the findings of previous research that women benefit from continuous support (Hodnett et al, 2012). Negative experiences occurred when women were treated insensitively or rudely, were left alone, did not receive explanations or were shouted at. These findings also support previous studies (D'Ambruso et al, 2005; Reiss et al, 2012; Brighton et al, 2013; Moyer et al, 2013). The three women who were unhappy with their care all described being shouted at by a midwife or doctor.

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One of the problems for the women in this study was that they had no reliable way of identifying who was providing their care. On the labour ward, the author's observation was that different grades of staff wear various coloured scrubs, doctors often wear their street clothes and hardly anyone wears a name badge. In this study, only one woman reported that her midwife had introduced herself by name. Of greater concern was the fact that so many women assumed that someone 'wearing white' or who was 'on the labour ward' was automatically a skilled professional. In fact porters, cleaners and support staff can be indistinguishable from trained healthcare workers and during busy periods sometimes undertake healthcare tasks causing further confusion of roles. This problem has also previously been identified (Hussein, 2004).

Several women reported the importance of food and water to their wellbeing. All women received intravenous fluids in labour, but the women in this study described that they felt more comfortable when they had sufficient water to drink.

Staff feedback

These findings have been disseminated back to Ridge hospital staff informally and through meetings; feedback to all staff is considered to be an important part of the improvement process through collaborative working. Sharing the results of the study with doctors, midwives, nurses, managers, support staff and students is important because it provides evidence for the importance of a supportive culture on the labour ward and within the maternity theatre. This ensures that women are not fearful or reluctant to attend hospital because stress and anxiety are known to affect clinical outcomes. The study has been a valuable method of producing evidence about the quality of care given within the institution and to raise awareness about deficiencies in care. It has provided an opportunity to discuss what sort of care is important to women and what is meant by high quality care. The findings from this study were received with interest from all the staff, which has led to further discussion and debate. One midwife said that she was surprised that the responses were so positive. She described how she travels to work by public transport and frequently overhears women discussing their experiences very negatively. This illustrates the known unreliability of eliciting women's views so soon after birth.

During discussions with staff it was agreed that all staff should treat their patients with dignity and respect and no member of staff should ever shout at a patient. Women should easily be able to identify the staff caring for them. Although it is recognised good practice for staff to introduce themselves by name, this study has provided evidence that this frequently does not occur. There has also been discussion about the advantages of supplying name badges for all staff to wear. Although it is standard practice for all women to have an intravenous infusion when in labour, there have also been discussions about the advantages of women being able to drink water. Consideration should also be given to enabling women, for whom it is not contraindicated, to be able to have food. Women frequently wait for many hours before or after arriving on the labour ward and more attention needs to be paid to their wellbeing, comfort and safety.

Limitations

One of the disadvantages of this study was that only the views of women who spoke English could be identified and a reliable method of identifying the views of non-English speaking maternity patients needs to be established. In this study the non-English speaking women were clearly unwilling to speak to a staff member acting as translator and so any future research should endeavour to find a way of overcoming this barrier. However, in order to obtain meaningful data across all demographics, an interviewer would need not only considerable clinical knowledge but also understanding of local languages. It may be that another independent clinical person could act as interviewer.

The women in this study were interviewed very soon after birth on the postnatal ward. When women's views are seen only as an 'outcome' measure they do not accurately identify their values and beliefs, or their expectations of the care they would like to receive. Interviewing women earlier in pregnancy would enable aspects of care that women feel are important to them, to be better identified. This is vital information to gather if women's values and beliefs are to be incorporated into the design of future culturally appropriate maternity services.

Conclusions and recommendations

A larger scale study should be undertaken interviewing more women to test the themes identified here and to validate the findings of this preliminary work. This study of women's experiences at a busy hospital showed that women understood the reasons for their referral and were able to judge whether they felt they had been well cared for. Their satisfaction or dissatisfaction with their care was due to perceptions of the clinical care they had received including basic care, monitoring, timely treatment and surgery. It was also influenced by the emotional support, respect, kindness and reassurance they received. The women who use the service are in a strong position to judge whether their treatment and care is respectful to them and orientated towards their needs. Autonomy, dignity and respect for women must be at the heart of high quality maternal and newborn care. **AJM**

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Key Points

- Women who use maternity services are in a strong position to judge whether their treatment and care are respectful and orientated towards their needs
- Women were able to tell their 'birth stories' and to make judgements about the care they received
- Women's positive and negative views were related to their experience of 'clinical competency' as well as 'emotional support.'
- Most women were happy with the quality of care they received but others described being ignored, spoken to harshly or shouted at
- Sharing findings with hospital staff provides evidence for the importance of a supportive culture on the labour ward

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