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Quality of care in maternal and neonatal health in Jumla, rural Nepal: Women's perspective

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ABSTRACT

There has been a significant improvement in maternal and neonatal health in the last two decades around the world. However, many women still die during pregnancy and childbirth. Nepal is one of the United Nations (UN) Member States which is committed to achieving the Sustainable Development Goals (SDGs) to reduce maternal mortality Ratio (MMR) and Newborn Mortality Rate (NMR). Understanding the women's perspective on the maternity health service is vital for improving the utilisation of the maternity care services. Hence, this study explored women's perspective on quality of care in maternal and neonatal health (MNH) in the Jumla district of Nepal.

This study employed a qualitative methodology which consists of semi-structured interviews with pregnant women and mothers with children under two years of age, from Jumla district, Nepal. Two main themes that occurred during the interviews were experience of care, expected quality of care and MNH service in federalisation.

The participants in the study found that the communication and information were clear to them, and the waiting time was from no waiting time to half an hour. Some participants expressed concern about the health worker's behaviour during their visit to the health facilities. The women also expressed that quality of care for them meant having accessible health services in their local settings.

Women's experiences of care play an essential role in improving the quality of care in maternal and neonatal health. The health system needs to consider women's experiences while planning for maternal health system in order to improve the maternal and neonatal health outcomes.

Introduction

There has been a significant improvement in maternal and neonatal health in the last two decades around the world. However, many women still die during pregnancy and childbirth. According to the World Health Organisation (WHO), about 295,000 women died in 2017 during and following pregnancy and childbirth which could have been prevented with high quality maternity care (WHO, 2022). It is important to acknowledge that high quality maternity care could prevent

many deaths during pregnancy, childbirth and the postnatal period (Broek & Graham, 2009).

Nepal is one of the United Nations (UN) Member States which is committed to achieving the Sustainable Development Goals (SDGs) to reduce Maternal Mortality Ratio (MMR) and Newborn Mortality Rate (NMR) from currently 239 deaths to 70 deaths per 100,000 live births and currently 21 to less than 12 deaths per 1,000 live births by 2030 respectively (MoHP, 2019). Nepal has reduced the MMR by around 44% between 1990 and 2016. If the same pace continues, then the MMR of Nepal will be 180 deaths per 100,000 live births by 2030 and Nepal will not be able to meet the SDG target (Tamang et. al. 2021). According to the annual report by the Department of Health Services (DoHS) 2019/20, pregnant women receiving the first antenatal care (ANC) visit anytime is 107%, however, pregnant women receiving the fourth ANC visit as per the protocol is only 53%. The institutional deliveries have also been reduced from 56% in year 2018/19 to 53% in 2019/20 and the mothers who have all three postnatal care (PNC) is only 19% in 2019/20 (MoHP, 2020). It is important to increase the maternity service utilisation to improve the health indicators in maternal and neonatal health and hence prevent maternal and neonatal deaths. Understanding the women's perspective on the maternity health service is vital for improving the utilisation of the maternity care services. Hence, this study explored women's perspectives on the quality of care in maternal and neonatal health (MNH) in the Jumla district of Nepal.

Method

This study employed a qualitative methodology which consists of semi-structured interviews with the health service users (HSU) from the Jumla district, Nepal. Health service users were pregnant women and mothers with children under two years of age. The interviews were conducted in Nepalese by the researcher as the researcher is from Nepal. Then they were transcribed into English from Nepali from the audio recording. Thematic analysis was conducted using the process outlined by Braun and Clark (2006).

Participant recruitment

A purposeful sampling strategy was used for the semi-structured interviews in late 2019. Prior to the interview, participants were given a participant information sheet which explained the study and were given time to ask questions or seek clarification regarding the study. Then after, written consent was taken from the participants. The interviews were audio recorded unless participants objected, in which case only hand-written notes would have been taken. However, none of the participants objected for audio recording.

Study site

The Jumla district of Nepal was selected for the study. Jumla is one of the rural areas situated in the Karnali province of Nepal with a total population of 119,377, i.e. male - 59,836 and female - 59,541 (National Statistical Office, 2021). Pregnant women receiving four ANC visits as per the protocol is 66%; institutional deliveries is 78%; deliveries conducted by skilled birth attendants (SBA) is 62.7%; and mothers receiving the three PNC is 29% in Jumla (MoHP, 2021).

Ethics Approval

Ethical approval was obtained from both Liverpool John Moores University Research Ethics Committee and the Nepal Health Research Council. The support letter was obtained from the District Office of Jumla for the permission to conduct the study. The ethical application was also ratified by the School Research Ethics and Integrity Committee (SREIC), University of Huddersfield.

Participant profile

The interviews lasted between 15 minutes and 35 minutes. All of the interviews were conducted at a time convenient for the participants and prior to the interview, consent was taken. A total of 15 interviews were conducted with pregnant women and/or mothers with children of under two years of age. Out of the 15 study participants, the youngest age one was 20 years old and the eldest was 38 years old. The mean age of the women was 27.3 years old. None of the

participants had any form of disability. All the women had a single pregnancy.

The following table (see Table 1) shows the participant profiles from the health service users' interview:

Table 1: Participant profile of Health Service User

Participant number	Age (Years)	Number of pregnancies	No. of Live children	Age of current child under 2 years of age	Distance from nearest HF (by walk)	Remarks
HSU1	20	1	N/A	N/A	10 minutes	First time pregnant (4th Month of pregnancy)
HSU2	25	3	2	N/A	30 minutes	8th month pregnant
HSU3	22	1	1	1 month	5 minutes	
HSU4	23	2	1	N/A	5 minutes	8th month pregnant/ previous history of still birth
HSU5	34	3	2	N/A	15 minutes	7th month pregnant
HSU6	34	2	1	N/A	20 minutes	5th month pregnant
HSU7	26	2	2	12 months	10 minutes	
HSU8	33	4	4	18 months	10 minutes	
HSU9	29	3	3	9 months	5 minutes	
HSU10	27	2	2	12 months	10 minutes	
HSU11	23	1	N/A	N/A	15 minutes	7th month pregnant
HSU12	36	3	2	14 months	10 minutes	1 still birth
HSU13	25	2	1	N/A	5 minutes	8th month pregnant
HSU14	38	3	3	18 months	30 minutes	
HSU15	35	1	1	22 months	20 minutes	

Results

Three main themes that occurred during the interviews were: experience of care, expected quality of care, and MNH service in federalisation.

Experience of care

Under the experience of care as main theme, there were six sub-themes that emerged from the health service users' interview. The sub-themes were: waiting time, communication and information, health worker's behaviour, choice of companion, emergency birth preparedness, and referral which are further explained below.

Most of the women visited a health facility for either an immunization for their baby or an ANC visit. The waiting time varied from no time at all to half an hour, depending on the patient flow on the day of their visit. The women experienced extended waiting times more during specific days, such as immunization days or ANC days, as during those times all the mothers with young babies and pregnant women visited the health facility at the same time.

> *If I am later than others, then I have to wait for about one hour but if I am early then 5-10 minutes waiting time. I waited for about half an hour 1st time then later I*

started going early too and I waited about 15 minutes only. So, it depends on what time you go there. – HSU5, 34 years, 3rd Child

All the women found that the paperwork in the health facilities was easy as they did not have to fill out any forms. All the forms, such as the antenatal care (ANC) card and the immunization card, were filled out by the health workers themselves. However, the women were asked the questions and information required to fill out the form by the health workers. The health workers also gave enough time for women to explain their health condition as well as giving them the chance to ask any questions. All the women said that they understood the information given by the health worker. Most of the women said that they received counselling on eating healthy food for the health of both mother and baby. The most common information received by women at the time of their discharge from the health facilities was as follows (see Table 2):

Table 2: Information given to women at health facility during their visits

For Mother	For Baby
- How to maintain personal hygiene and stay safe (do not carry heavy things, have plenty of rest) - When to return to hospital or health facility (such as if there is severe stomach pain or headache; severe bleeding) - To eat healthy food for good health of both mother and baby like vegetables and meat - Information on iron tablet intake - Information on institutional delivery (its importance and where to go for delivery) - Emergency preparedness for delivery - Family Planning and Birth spacing - Follow up visits	- How to keep baby warm and safe - Breast feeding (BF) techniques and importance of BF - Immunization for baby - If baby feels unwell, then come back to health facility for checkup and treatment

A few of the women felt that it would be easier for them if some of the information mentioned above could be given to their families so that they could support them, such as that given regarding nutritional food:

> *… our families are the one who brings us food or give us money to buy them. So, I think it would have been helpful if the health worker tells this information to them so that they can bring us nutritious food, allow us to buy food that is healthy for both baby and us.* – HSU1, 20 years, 1st Pregnancy

> *… we eat whatever we get at home. We must do day to day housework whether we have babies or not. So, I wish sister (referring to nurse) could give some of the information like nutritional food and plenty of rest to our families rather than us so that they can support us.* – HSU4, 23 years, 2nd pregnancy

Women who were residing near non-birthing centre health facilities received counselling on where to go for the delivery as well as the importance of an institutional delivery. The women who were referred to other health facilities for delivery were also told to take all the paperwork and documents from their check-up with them to hospital when going for delivery at the hospital or referral centre (nearby birthing centres):

> *they tell us about giving birth at birthing centre where there are more qualified midwives. If we give birth at home, then if there are any problems during childbirth then it will be dangerous for both us and baby. But if we give birth at birthing centre, then we can get treatment easily and quickly. If mother has bleeding problem, then that can be treated quickly too. So, they (referring to health worker) say we must give birth at HF. My first two children were delivered at home but now I will deliver my 3rd child in birthing centre.* – HSU2, 25 years, 3rd pregnancy

Some women who were in their last trimester were also given information on emergency preparedness for delivery, such as saving emergency funds and the contact details of an ambulance in case of emergency. The women received financial support mostly from their families. However, some women also received financial support from their mother's group to which they had to return later on:

> *I was told to have my blood group checked and prepare 2-3 person who have similar blood group. It will be easier to contact them in case of emergency. Sister (referring to nursing staff) also gave me contact details of ambulance…... I have also stored rice and wheat in stock (laughs)* – HSU13, 25 years, 2nd pregnancy

Most women mentioned that they were given information about follow-up checks and when further investigated about the information provided for follow-up checks, they were told to visit health facilities if they or the babies had any health issues. None of the women mentioned counselling at PNC visits except for one woman. Very few women mentioned about family planning and birth spacing:

> *After my son's delivery at hospital, when I was discharged, I was told to come to hospital after 6 weeks for follow up visit. If feeling unwell then come I was told to come at any time otherwise come after 6 weeks.* – HSU7, 26 years, 2nd pregnancy

The majority of the women were not allowed to have any companion during labour and childbirth. However, few women have had a companion of their choice during labour and childbirth due to some complications in their pregnancy. All the women were allowed to have a companion of their choice after delivery when they were moved to the ward.

> *… I wasn't allowed to have anyone during delivery. But after delivery when I was shifted to ward, then my family were allowed to stay with me and baby. They were allowed to stay at the waiting area outside the maternity ward.* – HSU7, 26 years, 2nd pregnancy

Most of the women were not referred to the higher centre for health services. However, three of them were referred to the hospital for further investigations such as ultrasound, blood, and urine testing. For those who were referred, they were not given any referral slip but were told to take all their health records with them.

Most of the women were happy with the services they received and would refer their friends and families for the service. They have had trust and confidence in the health facilities that they were using for their health care services:

> *I used the health service in our local health post, and I am happy with the service so I will definitely recommend it to my friends and families. I know that they provide good health service from my experience. So, I will tell my friends and families in our community to go there.* – HSU8, 33 years, 4th pregnancy

The majority of the women felt that they were treated properly during their visit to the health facilities. However, some women experienced some of the health workers being angry at them, especially during the labour period. Those women who experienced health workers anger felt that the health workers behaviour towards them were good during other times. Health workers also got angry when the women went to health facilities with their children during immunization appointments if the health worker found that the children were underweight and malnourished. Those women received counselling on nutrition for the children from the health worker:

> *…in other times they are good but during the labour, I got scolded from the sister (referring to the nursing staff) saying to keep quiet and not make loud scream. I also heard that some other mothers experienced the same when I was sharing my experience with them. So, I guess that is normal in that period.* – HSU9, 29 years, 3rd pregnancy

None of the women knew what to do and where to go in case they were dissatisfied with the service that they received. The women were not confident about telling the health worker themselves as they were fearful of being mistreated on their next health visit, and that they would be dissatisfied with the service that they would receive:

> *… I have no idea on where to go for complaining if I am unhappy with the service that I receive… I cannot go and tell the health worker directly because then I have to go to health post again so the health worker might get angry and might not treat me well next time.* – HSU4, 23 years, 2nd pregnancy),

> *… I just share it with my friends to see if they experienced the same or if it was just me. I don't know whom to complain other than my friends here.* – HSU9, 29 years, 3rd pregnancy

The common meaning of quality of care for everyone was found to be the promotion of the health of mother and baby:

> *When doctors and sisters (referring to nursing staff) explain the importance of care for me and baby to our family, I feel happy because then they (referring to the family) care more for me and baby.* – HSU8, 33 years, 4th pregnancy

> *Whether they (referring to the family) care or not at home, but when health worker asks my family to care more for me at home during this time, I feel happy.* – HSU13,25 years, 2nd pregnancy

The majority of the women felt that they had been receiving good quality of care at the health facilities that they have visited. They felt that the health workers were looking after their and their baby's health. Some women also received a home visit by the health worker who lived nearby their home if they missed any planned visits due to personal reasons:

> *… Sometimes I forget about my baby's immunization day. Doctors and sisters (referring to nursing staff) remind me on those days…* – HSU8, 33 years, 4th pregnancy

Expected quality of care

Under the expected quality of care as main theme, seven sub-themes emerged from the interviews; they were healthy outcome of mother and baby; health worker's behaviour; communication and information; upgraded health facilities; accessible health services; choice of companion; and emotional support which are explained below.

A few women also faced some dissatisfaction during their delivery time from the health workers. So, they thought that it would be nice to have polite health workers during their visits:

> *… We are going through so much our self during the labour, and we get emotionally down. So, at such period, it would be nice to hear some polite words from health worker rather than their anger. Now I don't have to face that phase again, but it will be nice for future mothers.* – HSU9, 29 years, 3rd pregnancy

Some women who had to go to other nearby health facilities for further investigations, such as blood and urine check-ups, thought that they could have quality of care if those facilities were available in their local health post where they go:

> *In such time (referring to her current pregnancy), it would have been much easier if we can have all necessary services here in our health post such as video x-ray (referring to USG) and blood test. Sometimes, it is very difficult to travel as I get nauseated often…It is also difficult to go to hospital alone for someone like me who is not educated. They say to go in this room that room like that for the tests and it is confusing.* – HSU14, 38 years, 3rd pregnancy

> *…. if we can have all the necessary test here in our health post, then we do not have to go to district hospital. We can stay close to home during delivery and after delivery it is easier to go home.* – HSU7, 26 years, 2nd pregnancy

A few women who did not have vehicle access by road for their village also mentioned that they would be happy if they can get such access, so that in the case of an emergency, they could reach a health facility on time and easily.

Women who were residing near non-birthing centre health facilities wished that their local health facilities become birthing centre soon so that other women can receive health services near their home and in convenient way:

> *If we can have baby in our health post, then at least we can have hot food from our home…We do not have to travel long distance with the newborn... We can have many helping hands to look after baby if we have delivery in our local health post.* – HSU12, 36 years, 3rd pregnancy

Allowing a companion at the time of labour, during delivery and post-natal produced different opinions among the participants. Some women preferred having their mother, sisters or mother-in-law(s) present during labour and after delivery. They felt that it would give them comfort and emotional support to have someone who can understand them and give them encouragement. None preferred having anyone during delivery. None mentioned any preference of having their husband during labour and childbirth.

The majority of the women thought that quality of service for them meant having the services available to them when they visit health facilities and being available on time. If they received the necessary health service and medicine as per their need and if the health facility is open 24/7, then they would be much happier:

> *If we can get all the health services that will help in having healthy life for me and my baby, then that is quality of care for me… If we get health service whenever we go to the health post and get the necessary medicine, then that will make us happy.* – HSU10, 27 years, 2nd pregnancy

MNH service post-Federalisation

Pregnant women and mothers with children under 2 years of age did not find any difference in the service that they received after the federalisation. However, they did find that the health workers are present in the health facilities all the time after the federalisation:

> *… We have been receiving the same service before the federalisation and now. So, there is no change in the service we receive.* – HSU9, 29 years, 3rd pregnancy

> *… previously sometime there were health post closed due to staff training or leave. But now we have seen more health worker present at the health facility so we can get health service all the time.* – HSU2, 25 years, 3rd pregnancy

Discussion

This study identified the experience of care and expected quality of care from women's perspectives on maternal and neonatal health in Jumla, Nepal. It is important to understand the women's perspective on maternal and neonatal health and their expectations from the health service in order to improve the quality of care. For better maternal and child health outcomes, improving the quality of maternal and neonatal health services plays a vital role (Machira & Palamuleni, 2018). The waiting time to receive the maternity health services varied from no waiting time to half an hour in this study but was not of much concern to the women unlike other studies where women had to wait for long hours experiencing fatigue, pain, and hunger (Biza et al., 2015; Machira & Palamuleni, 2018).

Clarity of information is essential for the women to understand their health better, as well as following the advice given to them by health workers for their and their baby's better health. Effective communication is one of the eight standards for domains in the WHO quality of care framework which is an important part of the experience of care received by a woman and her family (WHO, 2016). In this study, the women found that the

communication was clear and health workers gave enough time to explain their health conditions and to ask questions which can have impact on positive childbirth experience for pregnant women and for women having newborns (WHO, 2016). However, a few of the women wished that the health workers had given some information to their families - such as nutritional or rest-related information - as they are dependent on their families.

Most infant and maternal deaths occur in the first six weeks after delivery, pointing towards the importance of the support and careful monitoring after the birth to reduce the maternal and infant deaths. Despite the importance of support and careful monitoring after the birth, only one woman in the study mentioned that she was given PNC related information which remains one of the neglected phases in the provision of quality maternal and newborn care (WHO, 2022).

Women's experience of the care that they receive is impacted by the health worker's behaviour both directly and indirectly. It plays a crucial role in the satisfaction of the health service received by women and their trust in the health system. Most of the women in the study experienced good treatment from the health workers. However, some women felt that they were not treated properly. They felt that the health workers could have been more supportive of them as they are going through so much themselves. Hence, having supportive and friendly health workers could result in a positive experience of care received by women which could have a positive result on the maternal and neonatal health outcomes (Bhattacharya et al., 2018).

Pregnant women and mothers also reported that they used to find the health facilities closed prior to federalisation due to various reasons like staff training or staff being on leave. However, they expressed positive experiences after federalisation as the health workers are available all the time. The increase in the nation's training of health professionals could be attributed to the increasing number of higher education institutions that provide a range of health sciences courses. This could explain the staffing availability at health facilities. This could also be due to the authority of local leaders being able to appoint temporary contracted staff after the federalisation (Tamang et al., 2021).

Conclusion

Women's experience of care plays an essential role in improving the quality of care in maternal and neonatal health. Their experience and satisfaction from the service that they receive is impacted by the health worker's behaviour. Hence, having supportive and friendly behaviour from health workers can result in the trust in health system by women.

References

Biza, A., Jille-Traas, I., Colomar, M., Belizan, M., Requejo Harris, J., Crahay, B., Merialdi, M., Nguyen, M. H., Althabe, F., Aleman, A., Bergel, E., Carbonell, A., Chavane, L., Delvaux, T., Geelhoed, D., Gülmezoglu, M., Malapende, C. R., Melo, A., Osman, N. B., . . . Betrán, A. P. (2015). Challenges and opportunities for implementing evidence-based antenatal care in mozambique: A qualitative study. *BMC Pregnancy and Childbirth*, *15*(1), 200. https://doi.org/10.1186/s12884-015-0625-x.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa.

Machira, K., & Palamuleni, M. (2018). Women's perspectives on quality of maternal

health care services in Malawi. *International journal of women's health*, *10*, 25–34. https://doi.org/10.2147/IJWH.S144426.

Ministry of Health and Population. Annual Report. Kathmandu; 2019.

Ministry of Health and Population. Annual Report. Kathmandu; 2020.

Ministry of Health and Population. Annual Report. Kathmandu; 2021.

Ministry of Health and Population (MoHP). Government of Nepal. 2019. Nepal Safe motherhood and Newborn Health Road Map 2030. Retrieved from Nepal Safe Motherhood and Newborn Health Road Map 2030 (nhssp.org.np).

National Statistical office. Preliminary report of National Population census 2021. 2021.

Tamang, P., Simkhada, P., Bissell, P., van Teijlingen, E., Khatri, R., & Stephenson, J. (2021). Health facility preparedness of maternal and neonatal health services: a survey in Jumla, Nepal. *BMC health services research*, *21*(1), 1023. https://doi.org/10.1186/s12913-021-07054-3.

United Nations. (2016). Sustainable development goals. 17 goals to transform our world. Retrieved from: http://www.undp.org/content/undp/en/home/sustainable-development-goals/goal-3-good-health-and-well-being/targets/.

van den Broek, N. R., & Graham, W. J. (2009). Quality of care for maternal and newborn health: the neglected agenda. *BJOG : an international journal of obstetrics and gynaecology*, *116 Suppl 1*, 18–21. https://doi.org/10.1111/j.1471-0528.2009.02333.x.

WHO. 2016. Standards for improving quality of maternal and newborn care in health facilities. Retrieved from: Standards for improving quality of maternal and newborn care in health facilities (who.int).

WHO. 2022. Raising the importance of postnatal care. Retrieved 24 October 2022 from https://www.who.int/activities/raising-the-importance-of-postnatal.