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QUALITY OF MIDWIFERY CARE IN SOROTI DISTRICT, UGANDA

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ABSTRACT

Objectives: To determine the quality of care provided by midwives in Soroti district; and specifically, to identify training needs, gaps in knowledge and other barriers to accessibility of emergency obstetric care (EmOC) services in Soroti district.

Design: Cross-sectional descriptive study.

Setting: One regional hospital, one district hospital, two health centres and four dispensaries, all health units in the district.

Subjects: Patients admitted in the health units with pregnancy complications; attendants of patients (above); midwives delivering health care at the health units; pregnant women exiting from (after attending) antenatal clinics; and health unit records.

Interventions: Participatory observation, midwife and client interviews, records review, facility assessment and focus group discussions with clients and patients.

Main outcome measures: Ability of midwives to provide antenatal care of a minimum standard, or recall causes, signs, symptoms or the management of common obstetric complications; and patients and patient attendants' perception of care received.

Results: Many midwives were providing care of poor quality for both antenatal and delivery care due to their inability to identify and manage women with or at risk of pregnancy complications.

Conclusion: The main factors identified as responsible for the poor quality of care were inadequate pre-service and in-service training, lack of technical support supervision and absence of standard treatment guidelines.

INTRODUCTION

A midwife is a person trained to provide care to women during pregnancy, labour and after delivery; trained to recognise problems, and whose training is recognised by the government that provides a licence for him/her to practice(1). This is the international definition that is recognised by the World Health Organisation, the International Confederation of Midwives (ICM) and the International Federation of Gynaecologists and Obstetricians (FIGO). Such a midwife is trained to act decisively and independently in conducting births; ascertain risks of women in pregnancy and labour and (where possible, depending on need) manage complications as they arise(2).

Good quality maternal health services are those which, among others, are readily accessible; are safe, effective, acceptable to potential users and are staffed by technically competent people; provide prompt comprehensive care and/or linkages to other reproductive health services; provide continuity of care, and where staff are helpful, respectful and non-judgmental(3,4).

During a Needs Assessment for provision of emergency obstetric care (EmOC) in Soroti district, the quality of care provided by the midwives was assessed as part of the situational analysis for EmOC availability in the district.

The general objective was to assess the quality of care provided by midwives in Soroti district and, specifically, to identify gaps in knowledge and training needs, and to design strategies for provision of emergency obstetric care for prevention of maternal mortality in the district.

MATERIALS AND METHODS

Soroti district has one non-governmental organisation (NGO) hospital and one 250-bed government hospital which is the regional referral hospital for the surrounding three districts. These are the only two comprehensive EmOC facilities. There are also three health centres (offering basic EmOC facilities) and 12 sub-dispensaries.

Study design: A cross-sectional descriptive study was designed to assess the two hospitals, two health centres and four sub-dispensaries over a two-month period. At each of the study sites, the study, carried out from 20th September to 20th November, involved:-

- Assessment of the process of care: (i) participatory observation of midwives while they conducted their duties in antenatal clinics and during delivery; (ii) interview of midwives, patients and clients (patients/clients were interviewed at exit from the clinics)
- Review outcome of care: review of records to identify the commonest complications in patients seen in the health units.

- Assessment of client satisfaction: this was done through focus group discussion with patients and antenatal clients.
- Assessment of the infrastructure of the health facilities.

Data collection and management: Data were collected by a team consisting of social scientists, obstetricians, midwives and a public health specialist using two sets of standard guidelines:- Safe Motherhood Needs Assessment guidelines(5) and Guidelines for assessing availability of EmOC(6). Translators were utilised to interpret proceedings into English. The data were analysed qualitatively and quantitatively.

RESULTS

Assessment of the infrastructure: The facilities at the hospitals and the health centres were found to be adequate in terms of available space, equipment, drugs, sundries, waste disposal facilities and record registers. At the sub dispensaries, the one or two roomed units had limited

space for privacy for antenatal care and deliveries. There were no telephones, ambulances, or radio-calls linking peripheral units to the hospitals. All of the peripheral units and one of the hospitals had no electricity supply.

Staff assessment: A total of 36 midwives out of 76 (47.4%) were interviewed. They had varying basic qualifications and formed 52.2% of all midwives at these health units. The mean number of years in service was 15.1 for hospital staff, 8.6 for health centre staff and 13.5 for dispensary staff with ranges of two to 30 years, five to 14 years and three to 23 years respectively.

Most of those trained in LSS in Soroti hospital (60%) had been deployed elsewhere other than the antenatal clinic or maternity ward. Most of those without LSS training lacked basic knowledge on causes and management of obstetric emergencies such as haemorrhage, obstructed labour, sepsis, abortions and eclampsia.

Table 1

Basic qualifications, posts available and number interviewed

	Hospitals			Health centres			Dispensaries		
	P	I	(%)	P	I	(%)	P	I	(%)
Health visitors	2	2	(100)	-	-	-	-	-	-
Registered nurses	8	2	(25.0)	1	1	(100)	-	-	-
Registered midwives	13	6	(46.2)	4	4	(100)	2	2	(100)
Enrolled midwives	27	11	(40.7)	6	4	(66.7)	6	4	(66.7)
*LSS trained	10	4	(40.0)	3	2	(66.7)	2	2	(100)
Total	50	21	(42.0)	11	9	(81.8)	8	6	(75.0)

Key

I = Number interviewed and their percentage

P = Post available and filled

*LSS = Trained in Life Saving Skills for Safe Motherhood

Table 2

In-service training and support supervision

Time from last training	General midwifery		Family planning	
	No.	%	No.	%
Less than 6 months	14	38.9	3	8.3
More than 7 months but Less than one year	9	25.0	5	13.9
1 year to five years	4	11.1	6	16.6
# Never Received	9	25.0	22	61.1
"Hands-on" Training	20	74.1	5	35.7
No "hands-on" training	7	25.9	9	64.3
<i>Last support supervision visit by trainers</i>				
Less than 1 month ago	4	14.8	0	0
1 to 6 months ago	12	44.4	2	14.3
7 months to 2 years ago	8	29.6	4	28.6
More than 2 years ago	2	7.4	6	42.8
Never received	1	3.7	2	14.3

NB. # Seven of the 9 (without any in-service training) had worked for more than 10 years at enrolled level.

Nine staff (25%) had never received any in-service training in midwifery. Of those who had received any, 25.9% did not receive "hands-on" (practical) training, and many had spent long without any on-the-job support supervision. Only 14 midwives (38.8%) had in-service training in Family Planning. Only 12 (33.3%) had received practices in counselling techniques.

Quality of antenatal care provided: On four separate occasions over a two-months period, eighty clients exiting from the antenatal clinic were randomly chosen and interviewed and their records reviewed.

Assistance provider at last delivery: Assistant at last delivery was a midwife for 40(50%) clients. In the remainder, it was a relative in seven (8.8%), a doctor in five (6.3%) and a traditional birth attendant in six (7.5%) of cases. Nineteen were primigravidae (23.8%) while three had delivered outside the district (3.7%). For twenty of the clients (25%) this index visit was the first, however 50 clients (37.5%) had attended the units more than three times.

Parity of the client: Nineteen clients were primigravidae (23.8%). Those para 1-4 were 26(32.5%).

Table 3

Service provided during the day's visit

	Service provided								
	Examination		Advice given					Others	
	BP	Wt.	Obst.	Nutr.	STI	FP	Iron	T.T	VDRL
Yes	48	76	80	48	20	24	64	70	66
Percentage	60	95	100	60	25	30	80	8.8	82.5

STI - Sexually transmitted Infections

FP - Family Planning

Yes - Respondents who had the service provided

BP - Blood pressure measurement

T.T. - Tetanus Toxoid

Wt. - Weight

Obst. - Obstetric

Nutr. - Nutrition.

Iron - Iron Supplements

Those para 5 and above were 35 (43.8%). Most of the clients were aged 16 to 35 years. Only thirteen were aged above 35 years (16.3%).

Assessing activities done: Only 60% had blood pressure measured, and in many cases, essential advice for care in pregnancy or after was not given. All the clients had history taken with emphasis on obstetric risks. Forty three clients (70.5%) had not received postpartum care on the previous delivery. Though five clients had history of Caesarean section and eight had still births on last delivery, they were not among the 32 clients (40%) who were given advice on place of delivery. Only 30% received advice on Family Planning, and the history taking and examination were routine monitoring with little follow up on abnormal findings.

Advice to clients on warning signs and client satisfaction: Only few patients could spontaneously recall any warning signs of pregnancy complications. Clients named them as: haemorrhage 35 (43.7%), fever 55 (68.8%), abdominal pain 74 (92.50%); and vaginal discharge 50 (62.5%). Regarding labour, only 12 (15%) identified prolonged labour (lasting more than 24 hours) as dangerous. On client satisfaction, 70 (87.5%) had spent more than two hours at the clinic and 16 (20%) said staff were unfriendly. These delays before clients are attended to were confirmed by the time motion studies.

Conduct of a normal delivery: In all the units assessed, midwives assisted the labour process well. The only deficient areas were in infection prevention procedures and immediate care of the newborn. However, only 12 out of 36 (33.3%) could fill or interpret a partogram.

Identification and management of labour complications: From review of records, postpartum haemorrhage, ruptured uterus and obstructed labour were found to be the commonest causes of maternal death in the previous one year. They were also the commonest complications in patients referred from health units or admitted as referrals to the hospitals.

Spontaneous responses were therefore elicited on how the two conditions (obstructed labour and postpartum haemorrhage) are recognised and managed. The answers were compared with the checklists in the guidelines(5). On identification of obstructed labour only 12 midwives (33.3%) could confidently use or interpret a partogram and only eight (22.2%) could perform a pelvic assessment.

On identification of causes of postpartum haemorrhage, only 30 identified genital tears (83%); 24 (66.7%) identified retained placenta; 27 (75%) identified uterine atony.

None identified ruptured uterus as a possible cause of postpartum haemorrhage, while 13 (36.1%) thought native medicines were responsible. On management of PPH, twenty (55.5%) identified checking vital signs (pulse, blood pressure, respiration) as essential; and 27 (75%) identified rubbing a contraction. Only nine (25%) knew of bi-manual compression of the uterus, only 28 (77.7%) saw need to empty the bladder, while 14 would put up intravenous lines in complications (38.8%).

Client and patient satisfaction: report of focus group discussions: Four focus groups of eight to twelve patients/clients were organised as follows: two at Soroti hospital (one for patients and one for antenatal clients) and two at health centres (for antenatal clients.) Discussions were on knowledge of warning signs, decision making to seek care, accessibility of services, assessment of care at facilities and recommendations for improvement. Patients and clients reported that most staff are rude and harsh, that they do not give attention on time; that they rebuke and blame patients who go to hospital late (with complications), Others reported that staff demand for fees even before delivering any service (for registration or to buy some drugs). Patients thought this was because the staff are few and over worked. Patients said they only go to hospital when they feel unwell or have complications as staff are not welcoming.

DISCUSSION

Antenatal care has little impact on the reduction of maternal morbidity and mortality if it cannot detect problems during pregnancy or services to manage them are non-existent(7). The midwife is the most cost-effective and appropriate health care provider for the care of women during pregnancy and childhood(1-4). He/she must be able to recognise and manage or refer women at risk or with complications.

In the study, the antenatal care offered was routine with no emphasis on the women at risk. This may be the reason why clients could not recall complications at exit interviews. Many midwives could not readily recall the symptoms, signs or causes of pregnancy complications notably the two that were the commonest cause of death or reason for admission. This indicates poor quality of care provided(1,2,4,7). These study findings apply to many units. This study identifies several areas where the quality of care provided was inadequate. Some of the causes identified leading to this are:

- *Understaffing*: This leads to overwork. Most of health centres have two or three midwives who conduct all deliveries and run the antenatal clinic. Overwork reduces staff morale(1,4) and lowers ability to screen and refer women with high risk pregnancies always with childbirth complications.
- *Gaps in basic knowledge*: This may be due to lack of continuing medical education or non inclusion of practical aspects of midwifery into refresher training programs.
- *Inadequate on-the job technical supervision* of those trained in special skills to strengthen them.
- Deployment of staff trained in new skills to areas where they do not practice them.
- Failure of those trained to pass on knowledge to others through practice or demonstrations to others at the place of work.
- Absence of standard management guidelines in the wards, clinic or labour ward in the areas assessed.

Standardised training in essential midwifery skills and refresher training together with regular on-the job supervision are essential to ensure quality of care. Competence must be taught using models or “hands-on” experience if a skill is to be learnt and maintained. Basic

and in-service training should have a component on counselling, communication, advocacy for women’s rights, community health, record keeping and audit, supervision and basic management. For the way forward health units should have standard management and treatment guidelines or protocols for the common illnesses or complications seen at the units, which form a basis for training and supervision. There is need to train more midwives in Life Saving Skills if quality of care is to improve. Such midwives can, and should, evaluate their services regularly from both service provider and client perspective, and improve as needed(8). There is need to improve the referral system by providing communication between referral units and peripheral units via ambulances or telephone. Lastly, prevention of maternal mortality depends on early recognition and treatment of complications. The midwife is the pillar in the endeavour, and must function as an administrator, researcher, clinician, educator, planner and counsellor(9).

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