Assessing Clients' Satisfaction at a Free Antenatal Care Clinic in a Limited-Resource Population

Uzoma M. Agwu, Odidika U.J. Umeora, Boniface N. Ejikeme
Department of Obstetrics and Gynaecology, Ebonyi State University Teaching Hospital, Abakaliki, Ebonyi State, Nigeria

Abstract

***Context*:** Antenatal care is of paramount importance in sustainable reduction of maternal and perinatal morbidity and mortality rates. Service purchase cost and care providers' attitude among others have been cited as major reasons for poor utilization of antenatal care services in resource scarce communities. In a free antenatal care setting, clients' satisfaction becomes a major determinant of antenatal care service uptake.

Objective: To assess client satisfaction in a tertiary health institution in a low resource setting offering free antenatal care services

Study Design and Subjects: Investigators administered exit interviews using semi-structured questionnaires on randomly selected antenatal clinic attendees who consented over a 4-month period.

***Main Outcome Measure**:* Clients' satisfaction with prenatal clinic care services

Results: Eight hundred women participated in the study. Even though majority (75.5%) was satisfied with the services at the center, a lot also (66%) complained of lack of feedback from the providers. Delay in service delivery, lack of privacy and the rowdy nature of the clinic were the recurring reasons for dissatisfaction in 24.5% of the clients.

Conclusion: Improvement in numerical strength and attitude of the manpower in tertiary health institutions, coupled with improvement in infrastructure are desirable in improving client satisfaction and hence increase uptake of services in a free antenatal care settings.

Key Words: Antenatal Care, Feedback, Free Care, Low Resource, Satisfaction.

Introduction

Maternal mortality is a major public health concern in Nigeria. Estimated lifetime risk of maternal death is high[1]. The maternal mortality ratio (MMR) has been rising since the 1987 Safe Motherhood Initiative (SMI) conference in Kenya instead of abating as would have been expected from the effects of the initiative, especially in the rural areas where more Nigerians dwell [2]. Umeora *et al* [2] recorded an MMR of 2659 per 100,000 live births in a rural community in Ebonyi State, Southeast Nigeria. The unbooked mothers accounted for almost 75% of the deaths. The major causes of maternal death remained the same as obtained globally but complications of obstructed labour made greater contribution in the rural population.

Quality antenatal care prevents majority of maternal and perinatal morbidity and mortality [3]. Care providers screen expectant mothers for risk factors, identify, manage and prevent pregnancy complications. The current antenatal clinic policy in Nigeria derives from the Western programme and involves many visits. In developing countries, these visits are irregular, poorly organized and characterized by poor feedback to the clients [4]. Utilization of available prenatal care facilities and hospital delivery rates under skilled attendants are poor [5]. These are worse in the rural communities where health facilities and personnel are sparse. Illiteracy and poverty prevalent in the areas impact negatively on the health seeking behaviour. The traditional birth attendants (TBAs) readily provide affordable services and enjoy high volume of patronage from antenatal mothers with whom they share cultural and traditional affiliations. On the other hand, high cost of medical services, transportation difficulties, poor quality service and negative providers' attitude among others mitigate clients' uptake of orthodox prenatal services.

Budgetary allocation to health in Nigeria is far below the World Health Organization's recommended average, but the prime motivation to reduce the scary mortality figures in Ebonyi State prompted the Government to introduce free maternal health policy in 2001[6]. More pregnant women assessed prenatal services and MMR declined from 3,725/100,000 live births in 2000 to 1,323 in 2002[7]. Disturbingly, there is a current decline in antenatal clinic registration at the State's teaching hospital. Where free maternal health care obtains in a low resource setting, clients' assessment of care delivery becomes a major determinant of service uptake. This study evaluated clients' satisfaction in a Nigerian teaching hospital where prenatal and maternity care services are free.

Correspondence: Dr. Mrs. Uzoma M Agwu, P.O.Box 980, Abakaliki. Ebonyi State 480001, Nigeria
E mail: vehgorsafeway@yahoo.com

Material and Methods

Study Background

Ebonyi State of Nigeria comprises 13 administrative units (local government areas), 11 of which are rural. Her population of over 2 million is mainly agrarian, with high poverty and low literacy rates. Maternal health indices are poor. The introduction of free maternal health care in 2001 led to an astronomical increase in the uptake of antenatal and maternity services. The State's teaching hospital serves not only as a major referral centre but also a primary point of health care delivery for the State and her neighbours. The Obstetrics & Gynaecology unit has seven consultant Obstetrician/Gynecologists and fifteen residents at different grades of training. At each point, about 50% of the residents are out of the department on rotational postings through allied departments. Approximately 150 expectant women book for antenatal services every Wednesday. Routine antenatal clinics are held every day of the week but for Wednesdays. The nurse records the client's blood pressure, measures her weight and height and conducts urinalysis (dipstix) before she is sent to the doctor for consultation. The doctors see ***all*** the antenatal clients. Medical students and residents are taught on clients during their visits.

Study Design

This was a cross sectional study that spanned 16 weeks: June 6 2005 to September 23 2005. The Hospital Committee on Ethics and Research approved the study. The principal investigators recruited and trained medical House Officers as research assistants. The investigators and selected assistants administered an exit interview using a semi-structured questionnaire to recruited clients who consented to participate in the study. Clients who were to be admitted into the antenatal ward after consultation were excluded from the study. Information was obtained on their socio demographic characteristics and their assessment of the prenatal visit and care obtained. Data were analyzed using the SPSS software package version 10.

Results

During the study period, 1984 clients booked for antenatal visits. We interviewed eight hundred (800) respondents, 320 (40.8%) of whom were between 25 and 29 years old. Teenagers accounted for 7.1% and those 35 years and above 8.0%. There were 164 nulliparas and 124 grandmultiparas among the respondents. Many belonged to the lower socio economic classes IV and V (22.5% and 36.5% respectively.) Forty-five of the clients were in the upper socio-economic stratum (Table 1).

The level of feedback to the antenatal clinic attendees from the doctors was evaluated in Table 2. Two hundred and fifty two (34%) of the respondents had some form of feedback, 66% did not. In more than half of the cases, the clients were only informed of their next appointment. The doctors counseled only 22.9% of the respondents and told 37.1% and 11.4% of the respondents of their clinical states and those of their babies respectively.

The general level of satisfaction among the population studied was 75.5%. However, the level of satisfaction varied according to their social classes. Only 24.2% of those in classes I and II were satisfied while 87.6% of those in classes III, IV and V were satisfied. One hundred and ninety six (24.5%) of the respondents were dissatisfied with the level of care they obtained. The reasons for the dissatisfaction as shown in Table 3, ranged from the organization and content of the clinic to the clinic staff disposition towards them. Majority of the respondents complained that they stayed too long in the hospital (83.2%), or that the clinic started late (59.2%). A hundred and two clients were dissatisfied with the rowdy nature of the clinics while eighty-five did not like the attitude of the nursing staff. Other reasons brought up were: the doctor saw me in a haste (18.9%); the clinic was not private enough (29.6%) and my problems were not attended to (12.2%).

Table 1: Socio-Biological Variables of the Respondents

N= 800

Parameter	Number	%
Age (years)		
≤19	56	7.1
20 -24	145	18.5
25 -29	320	40.8
30 -34	200	25.5
≥35	63	8.0
Not known	16	
Parity		
0	164	20.5
1-2	357	44.6
3-4	155	19.4
≥5	124	15.5
Educational Status		
No formal	61	7.6
Primary	273	34.1
Secondary	266	33.3
Post secondary	200	25.0
Social Status		
I	45	5.6
II	108	13.5
III	175	21.9
IV	180	22.5
V	292	36.5

Table 2: Content of Doctors Feedback to Clients
N= 252

Content of Feedback	Number	%
Were you told of your clinical state?	93	37.1
Were you informed of the clinical state of your baby?	28	11.4
Did you receive any counseling?	57	22.9
Were you informed of your next appointment	129	51.4

Table 3: Reasons for Dissatisfaction With Antenatal Visit
N=196

Reasons	Number	%
The doctor saw me in a haste	37	18.9
My problem was not attended to	24	12.2
I stayed too long in the hospital	163	83.2
The clinic was not started on time	116	59.2
The clinic was too rowdy	102	52.0
The clinic was not private enough	58	29.6
The nurses attitude was poor	85	43.4
There were too many investigations	4	2.0

Discussion

This study revealed that little attention is actually paid the expectant mother and her fetus in a free maternal health care setting. As much as, 65% of the respondents left the clinic without feedback. Only 57 clients received formal counselling during their visits. It was not surprising therefore, that the level of dissatisfaction was high among clients of high social standing. In a previous study, this category of clients preferred prenatal care in non-public hospitals where services were personalized and friendly[8]. The expectant mothers in this study belonged mainly to the lower rungs of the social strata. Majority of them, 87.3% were satisfied by the services offered despite care providers' inadequacy. This category of mothers, more concerned about cost, are satisfied whenever services are free. Uzochukwu *et al*[9] earlier reported a 95.5% general satisfaction in a program where drugs were available and affordable. The poor attention to clients in government hospitals is made worse when the number of antenatal clinic attendees is high. The traditional antenatal clinic program patterned after the western model involves multiple visits and increases clients' traffic with a resultant poor output.

Introduction of free maternal health services in a low resource setting, results in a rise in the number of antenatal clinic attendees. This number may overwhelm the limited staff strength of the care facility. In our center, an average of 69 clients are seen in a Consultant Obstetrician's antenatal clinic on clinic days. The consultant combines patient's care with teaching and training of medical students and residents alike. He might also delegate patients' care to the residents. The nursing staff is stretched. Such a setting does not guarantee optimum care and confidentiality. Some of our respondents complained of these. The lack of privacy may also hinder the clients from recounting all their clinical complaints especially in front of the medical students. The doctor does therefore not treat such problems.

The strength of this study drew from its design; exit interviews capture authentic respondents' feelings and perception. It therefore assessed more correctly clinic contents and organization without bias from the clinicians who were blinded to the study. However, the lack of systematic randomization in patients' recruitment might have introduced some elements of bias, but this might not have affected the overall power of the study. This study also only assessed self-selected respondents who attended the prenatal clinics at the study center. Many other pregnant women who live within reach of the hospital do not uptake these free services; this is a research question yet unanswered. A community-based study will be proper for this.

The introduction of free prenatal services should be matched with equally well organized services and motivated staff to ensure optimum care delivery. Policy makers therefore should recognize that it takes more to sustain the initial gains of such policies. Regular auditing and monitoring are essential.

Conclusion

Free maternal care in a low resource setting encouraged uptake of antenatal services and majority of clients especially in the low socio economic classes are satisfied with care delivery despite shortcomings in content and organization. In such situations, health workers see far more women in the prenatal period than any other period. It therefore affords an opportunity to reach out to a large population of females, provide quality antenatal services and address other health related issues like family planning, immunization, child health, nutrition and sexually transmitted diseases[4]. This opportunity is lost when the number of clients overwhelms the obstetric staff. There is need therefore, to address the quality and content of prenatal care in government health facilities. We support the introduction of midwife-led care units for management of low-risk women as earlier advocated by Gharoro[10] in Benin City. This will enable the doctors spend quality time with the patient with complications. Improvement in staff strength and motivation will create a more enabling environment to enhance more user-friendly antenatal services.

References

1. Ebeigbe PN. The Safe Motherhood Initiative. In: Okpere EE (ed) *Clinical Obstetrics*. Revised edition, Benin City, Uniben Press 2004; 387-8.
2. Umeora OUJ, Ejikeme BN, Egwuatu VE. Contribution of ruptured uterus to maternal mortality in rural southeastern Nigeria. *Trop J Obstet Gynaecol*, 2005; 22(2): 184-8.
3. Okpere EE. Maternal Mortality. In: Okpere EE (ed) *Clinical Obstetrics.* Revised edition, Benin City, Uniben Press 2004; 389-397.
4. Carroli G, Rooney C, Villar J. How effective is antenatal care in preventing maternal mortality and serious morbidity? An overview of the evidence. *Paed and Perinat Epidemiol,* 2001; 15(suppl.1):1-42.
5. Kabir M, Iliyasu Z, Sani AA. Determinants of utilization of antenatal care services in Kumbotso village Northern Nigeria. *Trop Doctor,* 2005; 35(2):110-111.
6. Egwuatu VE. Reflections on Maternal Mortality in Nigeria: The fifth Okoronkwo Kesandu Ogan Memorial Oration. *Trop J Obstet Gynaecol,* 2003; 20 (1):76-82.
7. Umeora OUJ, Esike COU, Egwuatu VE. Maternal Mortality in rural Nigeria. *Int J Gynecol Obstet,* 2005; 88(2): 321-322.
8. Belizan JM, Farnor U, Carroli G, Al-Mazrou Y. Antenatal care in developing countries. *Paed Perinat Epidemiol,* 1998; 12(suppl.2):1-3.
9. Uzochukwu BS, Onwujekwe OE, Akpala CO. Did the Bamako initiative improve the utilization of maternal and child health-care services in Nigeria? A case study of Oji River local government area in southeast Nigeria. *J Health and Population in developing countries,* 2004; 9:1-18.
10. Gharoro EP, Igbafe AA. Shared antenatal care to increase utilization of maternity services. *Int J Gynecol Obstet,* 2000; 69(2):155-7