

Research Article

Experiences of Facility-Based Delivery Services among Women of Reproductive Age in Unguja Island, Zanzibar: A Qualitative Study

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Background: Progress towards the 2030 targets for ending preventable maternal and newborn deaths depends on the quality of care during delivery period. Zanzibar, as in the context of low-income countries, contributes to high maternal mortality due to obstetric complications. Considering that maternal deaths occur in a world where 80% of all births are attended by a skilled health attendant, there is a need for further exploration on the way services are delivered in the healthcare facilities in order to inform on the implementation strategy for universal coverage for health-facility delivery.

Methods: Descriptive exploratory study was conducted using a qualitative approach to explore experiences of facility-based delivery services among women of reproductive age in Zanzibar. Ten focused group discussions were carried out from the community. Data were analysed using thematic analysis approach.

Results: The study found that women's experience encountered during delivery in health facilities varied widely; from very satisfactory to the most challenging delivery experiences. Important to women were the level of customer care they received, space and privacy assigned to them, confidentiality and availability and use of essential medical equipments and supplies required for maternal and neonatal care services in these healthcare facilities during delivery. Based on their perceived level of satisfaction for services they received, clients were the most important influencers on the facility based delivery seeking behavior to other pregnant women in the community.

Conclusions: Healthcare facility services need to be improved by providing equipment and supplies in order to increase women's satisfaction on the services received during facility deliveries for pregnant women. Furthermore, the attitude of healthcare providers to their clients should be positive during the provision of delivery services as this will encourage more women in facility deliveries.

Keywords: Experiences; Challenges; Facility-delivery services; Unguja Island; Zanzibar

Introduction

Improving maternal and newborn health has been an important global priority to avert maternal and/or newborn morbidity and mortality [1–3]. Approximately 830 preventable maternal deaths happen every day in the world due to pregnancy and childbirth with 99% of them occurring in developing countries [4]. The situation is serious in Zanzibar whereby 307 deaths are estimated to occur in every 100,000 live births [5]. In order to end these preventable maternal deaths, a call to successfully implement the Sustainable Development Goals (SDGs) has been made, with a target of reducing global maternal mortality to less than 70 deaths per 100,000 live births by 2030 [6]. Today, the deaths are still occurring in a world where approximately 80% of all births are attended by a skilled health attendant [7]. Considering the main emphasis of SDGs is on universal access to delivery services in health facilities and that the deliveries

are assisted by a trained healthcare provider [8], there is a need for further exploration on the way services are delivered in the healthcare facilities in order to inform on the implementation strategy for universal coverage for health-facility delivery.

Zanzibar has made efforts to increase births at healthcare facilities. However, the goal may not be realized if women do not consider giving birth at a healthcare facility as a “positive experience” based on their previous experiences for services they have received [7]. A fulfilling experience on women's delivery services is mainly a result of quality of services received which in Zanzibar, as in the context of Sub-Saharan countries, is a huge challenge [9–11]. Little evidence exists about women's opinions on the quality of delivery services (demand side) they receive at healthcare facilities. However, the general quality of basic maternal care at Zanzibar's health facilities (supply side) have been reported to be a challenge [11,12]. Fakhir et

al. assessed the status of maternal and newborn health services in 79 out of 224 health facilities in Zanzibar and reported a huge shortage of staff, compounded by few facilities capable to provide basic and comprehensive emergency obstetric and neonatal care (EmONC) [12]. Quality of services is poor in primary healthcare facilities, which are the majority and assist about 40% of all deliveries [11]. The performance of the health sector in Zanzibar remains unsatisfactory even though geographical coverage of the health facilities is considered equitably distributed to all regions and districts, and easily accessible to 95% of the population [13]. Blending the evidences for both demand and supply sides that influence facility-based deliveries is important in understanding a holistic nature of the challenges facing the health system in Zanzibar; further adding to the literature on the women's experiences in using healthcare facilities for delivery.

Progress towards the 2030 SDG targets for ending preventable maternal and newborn deaths depends on improvement of quality of care during birth such that the care is responsive to clients' demand. There is limited documented evidence, if any, of women's experiences on maternal healthcare services at health facilities in Unguja Island. Understanding women's perceptions on the services delivered through exploration of their experiences in care is important in strengthening national health systems which are key in achieving universal health coverage. Such experiences are crucial in addressing specific health system bottlenecks that negatively influence the health-seeking behavior of women during pregnancy, labour and birth [1]. The study aimed to explore women's experiences on facility-based delivery services among women of reproductive age in Unguja Island, Zanzibar.

Materials and Methods

Setting

The study was conducted in Unguja Island, Zanzibar between March and April 2016. Unguja Island is one of the two Islands in Zanzibar; the other being Pemba. The islands are situated off the eastern coast of Tanzania Mainland with an area of 2,654 sq. km. Unguja Island covers an area of about 1,464 sq.km. [14]. It has three administrative regions, which are further subdivided into six districts; North A, North B, West, Urban, Central and South. Each district is further subdivided into smaller administrative units known as "Shehias" [15].

According to the 2012 Census, the total population of Unguja was 896,721, mostly concentrated in the Zanzibar Urban and West districts [16]. Zanzibar has the overall fertility rate of 5.1 children per woman [17]. In 2012, it was estimated that Zanzibar had 339,007 women of childbearing age (15 - 49 years) [16].

Study design

This study employed descriptive exploratory design using qualitative approach.

Sampling and Study participants

Three districts (Urban, West, and North B districts) out of six, were purposively selected because they are highly populated with good coverage of the facilities providing maternal and newborn healthcare services [5]. Simple random sampling was used to select ten shehias from the selected districts. With the assistance of local government leaders and community health workers in the ten

shehias, the research team identified all women of childbearing age (15-49 years) who had delivered at healthcare facilities in the past years prior to data collection. These were eligible for the focus group discussions (FGDs). Women were identified by using a record book from the shehia's office which has a list of all shehia's residents. From each shehia, 10-12 women were purposively recruited for the study. With the help of local leaders, the research team identified the venue and suitable time for the meetings. A prior meeting was arranged to meet the selected women so as to provide information about the study, why they have been selected, and how the results will be used.

Data collection

Ten FGDs were conducted using an interview guide with semi-structured questions. The guide was in Swahili language. The guide comprised of two main question areas: 1) experiences of women at healthcare facilities during delivery 2) challenges of facility-based delivery services.

Before beginning the discussions, all study participants were informed about the aim and importance of the study. All FGDs were recorded using digital voice recorders. Participants were asked for their consent to be recorded. Verbal consent was requested from all the participants and confidentiality was assured by excluding their names as identification in the collected information. Each FGD lasted for about 45 to 60 minutes and was moderated by the principal investigator (PI) and a note taker; a nurse with experience in qualitative research.

Data analysis

All FGDs were transcribed and translated into English, and were analyzed using thematic analysis approach. The discussion scripts were read several times to get familiar with the context of the data. After familiarization, a preliminary coding structure was agreed upon by two coders and a codebook was created and additional codes which emerged during coding process were added concurrently following consensus by both coders. Saturation was achieved when no more codes emerged from the data. The PI always checked for accuracy during the coding process to ensure that the meaning of units, codes and categories was congruent to emerging patterns. Discrepancies were resolved and agreed upon through discussion until consensus was reached. After completion of the coding process, major issues were highlighted, appropriate themes searched for categorization and the emerging themes were defined and named.

Ethical consideration

This study was approved by the Kilimanjaro Christian Medical University College Research and Ethical Review Committee (certificate number 677). Approval to conduct the study was also granted by the Zanzibar Medical Research Council. Permission to involve the community was sought from the respective shehia leaders. A verbal consent was requested from each study participant whereby a consent form was given to each participant to sign to confirm her willingness to participate in the study.

Results

Social demographic characteristics of the study participants

A total of one hundred and eight women of childbearing age

Table 1: Socio-demographic and reproductive characteristics of women in Unguja Island, Zanzibar (n = 108).

Characteristic	Number (%)
Age (years)	
Less than 25	39 (36.1)
25 - 34	45 (41.7)
Older than 34	24 (22.2)
Marital status	
Single	3 (2.8)
Married	99 (91.7)
Widowed	6 (5.6)
Educational level	
Non-literate	4 (3.7)
Completed primary	15 (13.9)
Completed secondary	89 (82.4)
Occupation	
Government employee	3 (2.8)
Private employee	8 (7.4)
Farming	12 (11.1)
Housewife	85 (78.7)
Parity	
1	37 (34.3)
2 – 4	54 (50.0)
5+	17 (15.7)
District of residence	
Urban	32 (29.6)
West	31 (28.7)
North B	45 (41.7)

from the three districts participated in the study. The mean age was 29 years (range, 19-46 years). More than one-third (42%) of the study participants were in the age range of 25-34 years. Majority (92%) of the women were married and about 82% had completed secondary education. Nearly two-thirds (66%) were multiparous, and 79% were housewives. Only few study participants (10%) were employed in the formal sector. Farming was the main source of livelihood of most of the participants though reported by less than a quarter (11%) of the study participants (Table 1).

Experiences of women on maternal healthcare services at healthcare facilities

This section describes women experiences on delivery services at healthcare facilities. Their experiences have been categorized into two: best practices and challenges.

Best practices of delivery services influenced positively healthcare facility use

During discussions, women were asked to explain their experiences of antenatal and delivery care services which they received at their respective health facilities in order to determine their perceptions based on challenges which they faced. This entailed their experiences during delivery services.

In this regard, majority (60%) of the participants acknowledged that, maternal healthcare services were fairly good while other participants faced some challenges when receiving these services. One of the participants narrated her experience that, she received good services both at the antenatal clinic and during delivery. When asked what she meant by “good service”, this 45-year old mother of gravida 7 para 6, with primary level education said:

“Frankly speaking, for me maternity services were good. When I went for checkup during antenatal care, I was received well by healthcare providers, particularly the nurses. Their attitudes were good towards me throughout the process. I was examined accordingly beyond my expectations.” [FGD3, P5]

To this participant, as it was also elaborated by others, customer care was a key aspect of care that cements relationship between the healthcare provider and the client. This bond created through the process of care was reported to influence positively on women to seek healthcare. It was described by these participants that the strong bond created to one participant sparks waves of information-sharing among other women, which in turn facilitates a better way of advocating the use of services through satisfied clients, as narrated below:

“I have an experience of delivery at the hospital for my five children. My opinion matters a lot to other women who are about to go through the process of delivery. Usually, it is women’s expectations that healthcare providers should continue attending other pregnant women as they attended me. Things that demotivate pregnant women to seek healthcare services include being rude when communicating and insulting them. I say this because pregnant woman need to be received well from the first booking during pregnancy up to delivery.” [FGD6, P4]

Most participants went a step further by indicating that good customer care, coupled with availability of medical supplies and medicines at a health facility that provide services to pregnant women, is a “perfect recipe for better services” to them. With their experience in accessing pregnancy-related health services, pregnant women provide the community with up-to-date status of this recipe, influencing the healthcare-seeking behavior of other pregnant women in their areas. One participant aged 29 years, a housewife who is a mother of 4 children narrated her experience:

I visited one of the facilities as a response for abdominal pain during pregnancy ...I was checked and found to have no problem. I have not faced any problem, like being harassed by healthcare providers. Doctors and nurses were available; examination gloves and urine checkup were free of charge.” [FGD 6, P3]

Commenting on changes in healthcare service delivery, which was not positively communicated to the community, one participant narrated:

“It is very unfortunate in these recent days there are no doctors or nurses for maternal services, particularly at our facility. Pregnant women who attended the facility were told to go to another facility because the facility carried out only hospital attendant. That means, the health facility no longer provided maternal services including deliveries.” [FGD1, P9]

She continued as follows:

"This is bothersome because we had been used to that facility for maternal services including deliveries, but nowadays maternal health services are provided there. This brings distress to pregnant women resulting to many women deciding to deliver at home." [FGD1, P9]

Challenges of healthcare facilities

Interviews with participants provided insights of challenges experienced when accessing maternal healthcare services at healthcare facilities and these influenced their health-seeking behavior for facility delivery. Challenges described ranged from lack of adequate space to shortage of required medical supplies and commodities.

Space is a primary problem: Space was reported by most women to be a big problem, especially in facilities located in urban areas of Zanzibar. Sensitization done to motivate women to have births attended by a trained health provider has motivated women to deliver at healthcare facilities. This, in turn, challenges the available infrastructure and availability of space to accommodate pregnant women. In one busy delivery facility, it was reported to have so many women who needed delivery services, compelling the health providers to allocate a single bed to more than one woman in labor. In such event, women have questioned infection-prevention strategies and are afraid that clients succumb to cross-infections from other women occupying the same bed. Describing the actual situation at the facility, a young mother of two children who happened to deliver at the facility two years prior to this interview narrated that:

"I went to the hospital for delivery during my first pregnancy as I had been advised by many people, but the problem at the hospital was that there were many people. A bed was shared by two people; how could you deliver while everyone has her own labor pain? Think of that bed, is it an advocated environment that a pregnant woman can deliver safely? No place to sit or give birth, the bed was sometimes wet and at the same time you are in labor pain." [FGD2, P10]

Noting in a very disappointing voice she continued;

"For that case I better deliver at home. I don't want to get cross-infections and bring them at my home. The only solution is to provide more space, bring more qualified nurses and specialists in delivery centers." [FGD2, P10]

In a number of other health care facilities, availability of adequate maternity beds was a problem. Participants cited a number of health facilities where the number of beds did not tally with the number of clients admitted for delivery in maternity wards, presenting the same picture of co-occupancy of a single bed.

Privacy: The challenge with space is reported to accompany one main consequence - privacy. Participants described that many women occupied the same room, necessitating healthcare providers to examine women with little or no privacy. Having many women in the same room also necessitated a good number of health providers supporting these women to enter the room more frequently. One participant who had been attended at the facility narrated her story and decided never to go again for delivery during her subsequent pregnancies as follows:

"Myself, I don't want to deliver at the hospital because the first time

I gave birth at that hospital, it was not good to me. I didn't like the way the place was open. There were other patients, nurses and doctors in the labour ward. Similarly, women case histories and clinical examination of pregnancy took place in the midst of other patients. So everyone could see you or hear everything about you. That is very bad because delivering women need adequate privacy." [FGD10, P3]

During group discussions, women were strongly attached to privacy while noting that privacy was neither usually ensured nor given any serious importance in maternity wards. This made women remain naked during physical examinations, often palpated in open doors or curtains, which made it easy for other patients or healthcare workers to see them. Several participants said this was a big concern because it failed them to fulfill their delivery requirements and rights by preserving bodily sanctity. These limitations imposed by healthcare facility environments constitute an important factor negatively affecting maternal healthcare-seeking behavior.

Equipment and supplies: Some participants agreed that equipment and supplies are available in some of the healthcare facilities and maternity wards. Although delivery- and all pregnant-related services should be provided for free, unavailability of supplies in some facilities necessitated women coming for the services to incur costs for buying supplies from private pharmacies and shops. Women postulated that such variation in the availability of supplies is a function of facility management. The way these facilities are managed influences a lot on the level of availability of supplies and customer care. Giving an example of a health facility with good maternal services, one participant said:

"Recently I took my sister-in-law to a nearby hospital for delivery. She was well received and attended. We were never told to buy anything pertaining to her delivery. She was supplied with everything necessary during delivery and she delivered safely. The mother was even given free sweaters for her baby, something which is unusual in most of the hospitals." [FGD10, P8]

She continued:

"They provided good services and attended us well. If drugs and other services were available, they gave us free of charge and if not available they told us to contribute; that means we had to pay for. For example, we were contributing Tsh. 1,000/- for the haemoglobin level and urine for albumin checkup." [FGD10, P8]

On the contrary, another woman narrated that:

"For our clinic, when you are attending antenatal care clinic you have to pay Tsh. 3,000/- for registration once, and at every other visit you have to pay 1,500/- for the Hb and urine investigation. If you do not have money to pay, they tell you to go back home to find the money first before receiving services. Also, we are paying 500/- shillings for the ANC card." [FGD4, P11]

Attitude of healthcare providers: Problems on the negative attitude of healthcare workers towards their clients, especially doctors and nurses, were mentioned by most of the participants in the FGDs. Participants detailed that the negative attitude of healthcare providers was expressed in the way they rendered their customer care services to clients. However, a number of healthcare workers were reported to lack basics of good communication skills. They didn't empower

women to exercise their own right to deliver but rather dictated to them. One participant described the situation of the maternity ward based on her experience:

"Services are not for free; we are buying gloves, mackintosh for delivery, so there nothing for free; it is only money. Doctors and nurses are mistreating us, using awful language. We just go to the clinic because we have no other alternatives. Sometimes people think it is better to deliver at home rather than at the hospital due to the abusive language which nurses and doctors use to us." [FGD5, P3]

Another participant also expressed her experience:

"Maternity ward is like a military base; you receive commands only, no polite language is heard there." [FGD10, P6]

Seeking alternative delivery services: Due to prevailing health facility-related challenges, some women preferred to use delivery services from traditional birth attendants, which are available in the community. Traditional birth attendants were described to be usually elderly women, respected by the community, with experience in providing delivery services at home and receiving in-kind payment or, in rare instances, cash for remuneration. The traditional birth attendants do capitalize in good customer care and their vast experience in delivering women. They are therefore described to be "popular" in the community irrespective of the fact that the health system does not allow them to provide such services but rather are required to be referral agents to healthcare. One participant suggested that the government should strengthen their role in providing delivery services, noting that these women are experienced in delivery service provision and know what it takes to do so:

"I think one of the good things that may be done about safe maternal care is to sensitize and train more village women to become traditional birth attendants who will serve and help in conducting safe deliveries in the community. The elderly people who used to serve us have now grown old. The newly trained traditional birth attendants will deliver a woman properly in their homes more than young midwives in facilities because traditional birth attendants have even been pregnant themselves." [FGD4, P11]

Discussion

This study explored the women's experiences on MNCH care services in the health facilities during pregnancy, delivery and postnatal services in Unguja island, Zanzibar. The study has documented how women's encounters during use of health services influences their health-seeking behavior and the use of services during pregnancy, delivery, and postnatal services. Some women acknowledged that their experience in utilizing maternal services were fairly good; were well received by healthcare providers and were provided with the required services. This influenced positively their seeking behavior for healthcare [18,19] However, some women experienced some challenges during utilization of the services.

In this study, women shared the challenges experienced when accessing maternal healthcare at healthcare facilities and these influenced their health-seeking behavior in healthcare-facility delivery. Availability of enough maternity beds was a problem, whereby the number of beds did not match the number of clients admitted for delivery in the maternity wards. Lack of enough space

has been reported by most women to be a big problem, whereby a single bed did at times accommodate more than one woman in labor, especially in facilities located in urban areas of Zanzibar. Similarly, a study done in Ghana reported that inadequate ward space for delivery and resting is a challenge [20]. The in-patient wards for delivery are too small to accommodate a large number of pregnant women who come to deliver. Sometimes, pregnant women have to lie on the bare floor due to the fact that the delivery beds are not enough. This might be due to sensitization done to motivate women to have births attended by a skilled health provider which, in turn, challenges the available infrastructure and availability of enough space to accommodate pregnant women.

Shortage of medical supplies and required commodities challenged women's expectations when attending for maternal and child health services. In many health facilities, essential equipment and commodities were either not available, not in working order or not enough for the needs of the facility. This was often mentioned by women as the biggest challenge limiting accessing maternal and newborn care [21]. The quality of care during childbirth in health facilities is reflected by the availability of essential equipment, supplies and commodities that would aid the provision of quality services when used by human resources with the knowledge, skills and capacity to deal with pregnancy and childbirth [22–24]. Women frequently reported facing the unavailability of drugs at the facilities. Women reported that the lack of drugs and equipment was accentuated in lower-level facilities. This collaborates with the finding from other studies in Zanzibar that indicated the pronounced low quality of services in primary health care facilities than secondary and tertiary facilities [11,12]. Women recognized this as a major problem, and were aware of its negative impact on service quality [25].

Our finding also revealed that, privacy was not usually ensured in maternity wards. This made women remain fearful of other patients or healthcare workers to see and/or hear them during physical examination. Women were strongly attached to privacy. The main challenge with space is the fact that it accompany with lack of privacy. Participants described that many women occupied the same room, necessitating health care providers to examine women with little or no privacy at all. These limitations imposed by hospital environments constitute an important factor negatively affecting maternal healthcare-seeking behavior. Privacy is a key requirement of women utilizing maternal care services, for physical examinations as well as the delivery process itself. A sense of shame is also attached to the process of physical examination and also procedures like perineal shaving, thereby increasing women's discomfort and diminishing their satisfaction levels [26]. Inadequate privacy during antenatal checkup and counseling is associated with women's poor perception of services [27,28]. Maintenance of privacy via a separate room or screen for examination or delivery was a significant determinant of satisfaction with maternal health services in Bangladesh and India [29,30]. Lack of confidentiality during checkups and deliveries, on the other hand, caused dissatisfaction with services in Malawi, Cuba and Nigeria [31–33].

Many of health facilities were reported to be hit with severe shortage of staff in all sections, limiting their capacity to deliver required maternal healthcare services. Unavailability of required number of staff is further affected by the shortage of equipment and

supplies. The lack of equipment endangers both the midwives and their patients [34]. This experience of shortage of staff is not only in the area of the study but it is almost the same in Ghana [35]. Ganle et al. stated that health systems and maternity healthcare facilities in Ghana are still chronically under-resourced, especially doctors and nurses, which makes them incapable of effectively providing an acceptable minimum quality of care in the event of serious obstetric complications [35]. Ghana study also revealed that there is always absence of a midwife, coupled with the incompetence of existing available nursing staff to manage deliveries. This is a major factor impeding access to skilled care in many health centres in the Ghana.

Our findings reported that women experience poor attitude of healthcare providers when attending for healthcare services at facilities. Women expressed that, some healthcare providers use harsh and abusive language. Women expected health workers to be friendly in providing care and not to be rude or shout at them. Healthcare providers do not empower women to exercise their own right to deliver but rather dictate to them. Many studies reported negative attitude of healthcare providers on healthcare delivery [36–39]. Women described childbirth experiences with verbal abuse from the health workers, including insults, yelling, discussing the woman's intimate life, blaming, judgmental and accusatory comments, and threatening to throw a woman out of the health facility [36–38]. Negative attitude towards their clients might be due to being overworked and overstretched by too many clients. This possibly leads to healthcare workers being physically and mentally tired, which is further challenged with lack of enough medicines and medical supplies.

This study found that, some women preferred to continue using the delivery services of traditional birth attendants which are “unskilled” but available in the community as an alternative way to stay away from the existing healthcare facility-related challenges. The traditional birth attendants do capitalize in good customer care and stand for the community trust from their vast experience in conducting delivery services to women. Concurrent with another study, women reported “shared experiences” that their friends may not go to the hospital for childbirth in future after feeling neglected and abandoned during their previous childbirth [36]. This neglect seems to occur when providers engage in other activities or if they take a break to relax. In both scenarios, the provider is not present when the woman needs them. Such scenarios have consequences that lead to babies' neglect or even death [36]. Another study reported that, women feared mistreatment during facility-based childbirth to the extent that they sometimes avoided attending the facility altogether [37,40]. Women believed that they would be better supported during a home birth, and that they will be mistreated if they deliver at the hospital [37].

Conclusion

The study has shown that some women experiences fairly good maternal healthcare services in healthcare facilities during pregnancy, childbirth and postnatal period. However, majority of women encountered some challenges during utilization of the services as a result of shortage of space, medical equipment, commodities, human resources and negative attitude from healthcare providers. To realize the SDG, there is a strong need for the Ministry of Health

to strengthen the health system so that the healthcare facilities are equipped with adequate equipment and supplies in order to provide quality healthcare for the maternal and newborn health. Furthermore, attitude of healthcare providers need to be revitalized to positively empower women to receive services and ultimately encourage them to deliver at the health facility.

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