PERSPECTIVES OF WOMEN ON THE MEANING OF QUALITY CARE DURING CHILDBIRTH IN HOSPITAL. A STUDY BASED AT MOI TEACHING AND REFERRAL HOSPITAL

BY

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DECLARATION

Declaration by Candidate

This thesis is my original work and has not been presented for a degree in any other university. No part of this thesis may be reproduced without prior written permission of the author and or Moi University.

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DEDICATION

This study is dedicated to all women and men within childbearing age.

ABSTRACT

Introduction: Women have different perspectives of the meaning of quality care during childbirth in hospital. Women will tend to avoid hospital birth if the care provided does not meet these perspectives. The researcher sought to determine what women consider quality care during childbirth in the hospital.

Study setting: The study was carried out in the postnatal section of Riley mother-baby hospital of Moi Teaching and Referral Hospital, Eldoret Kenya.

Purpose: To explore and describe the perspectives of women on the meaning of quality care during childbirth in hospital.

Methods: A qualitative method using exploratory descriptive design was applied. In-depth interviews were used in collecting data from 14 mothers who had hospital birth. The interviews were audio recorded and field notes taken.

Data analysis Audio recorded data was transcribed into Ms Word. Analytic triangulation was done using NVIVO 8 software and Tesch's method of qualitative analysis. The interviews were read; emerging ideas were identified, and then grouped into subthemes, which were further categorized to generate themes.

Results: presence of caregiver, less frequent examinations, promptness, warmth, pain relief, cleanliness and nutritional care emerged as subthemes and were categorized under the theme of caring. Information and positive relationship emerged as themes that define quality. Clear instructions and frequent information on progress of labour emerged as subthemes defining information as a theme. Attention to individual needs, understanding the mother and a friendly attitude of the care provider emerged as subthemes that were further categorized under the theme of positive relationship.

Conclusion: Quality care during childbirth in hospital is determined by the caring aspects, information given to the mothers and the degree of positive relationship between the caregiver and the mother.

Recommendation: Individual perspectives of quality care for every mother in labour should be considered when providing care to meet the needs of the client.

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ACRONYMS

ANA	American Nursing Association
CBS	Central Beaureau of statistics
MTRH	Moi Teaching and Referral Hospital
FGD	Focus group Discussion
IREC	Institutional research and Ethics committee
RMBH	Riley Mother and Baby Hospital

DEFINITION OF KEY CONCEPTS

Quality care: Care that meets acceptable technical standards as well as the needs and expectations of users and communities. (Hulton, Matthews & Stones, 2007). In this study, quality care was construed to mean care preferred by women during childbirth.

Perspectives: Refers to ones opinion or attitude towards something (Oxford student's Dictionary of English, 2001:477). In this study, perspectives was construed to mean opinions of the women.

Childbirth: This is also called labour, birth, *partus* or parturition. It is the culmination of a human pregnancy or gestation period with the delivery of one or more newborn infants from a woman's uterus . In this study, childbirth implies first, second, third and fourth stages of labour.

Women: This refers to female adult human beings . In this study, women refer to females who have undergone childbirth.

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND

Quality in the health care setting refers to meeting the needs and expectations of clients [the customers of health care] with minimum effort, rework and waste (Bernick, Godfrey and Roessner, 1990). Quality of care is a multifaceted concept that involves both the consumer and the service provider. The quality of care during childbirth has been defined primarily from the service providers' point of view. According to Bennet and Tibbits (1989: 11), achievement of quality is essentially a human accomplishment and it is the quality of people –more than the advancement in technology –that gives the health care institution its reputation for excellence as perceived by consumers of health care services. Improving supplies in our institutions may not necessarily translate to quality care as seen by mothers who are our target customers in hospitals. Similarly, quality of care has various social, economic and demographic determinants that play part in its description by the consumer. Leininger (as quoted in Van der Wal 2004: 235) emphasizes the need of considering the cultural aspects of quality. Leininger (2004) further focuses on the question of beneficence which considers who is supposed to decide what is best for the patient. In most cases, the patient has not been considered when determining what is best for them. The subjective description of quality by the clients can provide important input that can help the service provider understand and establish acceptable standards of services (Andaleeb, 2001:1359)

Quality of care is a function of care rendered and the care received, the interface between provider and patient, between health services and the community (De Kock and Van der Walt (2004:3-1). This means that the context of the need for the care

interventions must be evaluated if it is meeting these qualities i.e. providing a link between the care provider and the patient. This can only be possible if the clients come to the health care providers for service. Quality of midwifery care is not a simple homogenous variable but a complex construct incorporating values, beliefs and attitudes involved in the health care interaction(De Kock, and Van der Walt 2004: 3-1). Both the perspectives and providers' needs to be accounted for when quality of maternity services is defined. Quality care therefore could mean the care that meets acceptable technical standards as well as the needs and expectations of users and communities.

In most health care facilities providing childbirth services, there seems to be a gap between care given and the client expectations. This is evidenced in a study done by Hulton, Matthews & Stones (2007). Findings provide evidence that quality is far from optimal in both public and private facilities. Problems identified included a lack of essential drugs, women left unsupported, evidence of physical and verbal abuse, and births occurring in hospitals without a health professional in attendance. The paper concludes that while many governments have explicit targets to increase institutional deliveries, many do not have explicit targets or even a commitment to assess and improve the quality of institutional services for childbirth. This problem is accentuated through lack of focus on the perspectives of the clients when defining quality or making quality improvement strategies.

According to Hulton, Matthews & Stones (2007) as quoted in De Kock et al (2004: 3-2), the recognition that the quality of services has an impact on the use of services has given a strong incentive to improve quality of midwifery care with the goal of

greater acceptance and more substantial use thereof. This greater acceptance does not compare well with Kenya's situation whereby home deliveries by unskilled attendants are as high as sixty percent (CBS, 2003). This is quite an alarming rate especially when we need to ensure skilled attendants for every delivery as an indicator for health during childbirth.

1.2 STATEMENT OF THE PROBLEM

Current definition and provision of quality care has greatly focused on service providers as opposed to consumers. In provision of maternity services, women are the consumers of the service. As consumers, they contribute heavily to the definition of quality with their values and expectations (Donabedian, 1980:26). Considering the views of consumers will determine heavily whether they use the services or not. The uptake of hospital childbirth in Kenya has been as low as 40% (CBS, 2004).Therefore the majority of mothers give birth at home assisted by traditional birth attendants (28%), relatives or self (22%) (CBS, 2004). These alternatives are associated with high maternal mortality rates. Since it is the patients' expectations of the service that make them choose a particular care provider (Parsley and Corrigan 1999:124), it may imply therefore that most of the women's' expectations are not being met in the hospitals. The study identified quality of care from the consumers' perspective so as to meet their expectations in the hospital, hence reduce maternal and neonatal mortality which currently stands at 414 per 10,000 live births and 33 per 1,000 live births respectively in Kenya (CBS, 2004:237).

1.3 THE PURPOSE OF THE STUDY

The purpose of the study was to explore what women in postnatal ward perceive as quality care during childbirth in hospital.

1.4. OBJECTIVES OF THE STUDY

- To describe the perception of postnatal mothers on quality of care during childbirth in hospital
- To describe factors that hinder the achievement of perceived quality care during childbirth in hospital.

1.5. SIGNIFICANCE OF THE STUDY

The study identified the factors considered by the mothers as quality care during childbirth which if provided may contribute to the provision of quality care at birth. Consideration of the subjective information of mothers on quality care may enhance maternal satisfaction with care during childbirth. The women's perspectives of quality care were evaluated against the evidence-based practices of care during childbirth. The findings sensitize midwives and other health workers on the needs of women during labour and how best to address hence reduce maternal and neonatal morbidity and mortality (CBS, 2004: 134)

CHAPTER TWO: LITERATURE REVIEW

The literature review under this study was covered under the following headings: Quality and quality care, women's perspectives of quality in midwifery care, advantages of exploring client perceptions of quality care and determinants of women's choice of health care services.

2.1. Definition of quality and quality care

Quality in the health care setting refers to meeting the needs and expectations of clients [the customers of health care] with minimum effort, rework and waste (Bernick, Godfrey and Roessner, 1990). In midwifery, practice women experiencing childbirth are referred to as clients. Quality is a broad concept whose definition must consider the consumer and the provider of services. Both parties (consumer and the provider) are involved in the outcomes that will be used to evaluate the kind of care that is being provided. The consumer in the field of health care is the client or patient. The definition of this concept therefore will be incomplete without addressing the perspectives of the client/patient. Quality care can be equated to client- centered care which is defined as an approach to providing services that embraces a philosophy of respect for, and partnership with, people receiving services (Law et. al. 1995 as cited in Witte, Schoot and Proot. 2006: 68).

The subjective description of whether a specific health care service is of quality depends on the expectations of the client. Various central values have been identified as underlying client expectations (Witte et al, 2006: 62-68). These include autonomy, which is the ability to be who one is, and self-determination. Continuity of life, comprehensiveness, uniqueness and fairness are also determinants of quality care

during childbirth. However, all these factors seem to be centered to one aspect of uniqueness of an individual patient. Therefore evaluating the expectations of the clients to be able to provide care, which is acceptable to them, is necessary.

The medical models of care ignore the comprehensive view of quality care. The focus of the medical models is on individual and his or her symptoms, while ignoring wider familial, social and economic issues. This focus makes both a consensus and a solution to the problem difficult to achieve (Helman, 2000:103). By not viewing the client as a whole, the health care system may miss the goal of achieving client satisfaction. This is why Helman further notes that medical models and lay models may differ greatly in how they represent illness especially…appropriate treatment. Thus the doctor who concentrates on diagnosing and treating physical dysfunction may not take emotional states such as quilt or fear on the patient's part into account.

In addition, Helman (2000: 106-107), suggests strategies to deal with the doctor patient relationship. These include understanding illness, improving communication, increasing reflexivity, treating illness and disease, respecting diversity and assessing the role of context. Emphasis is put on considering illness separate from disease... The illness aspect is comprehensive and holistic and considers the preferences and perceptions of the clients.

Witte et al (2005: 62) identifies central values underlying client satisfaction. These include autonomy, continuity of life, uniqueness, comprehensiveness, fairness, equality, partnership and interdependence. The aspect of autonomy focuses on having the possibility of being who you are and self-determination while uniqueness refers to

the understanding of the client as an individual human being with individual demands. Holistic approach is met by the values considered by Witte.

In summary, quality care is refers to care that considers biological, psychological and social factors of the client. Provision of holistic maternity care may improve the perception of women on the meaning of quality of services provided in the hospitals.

2.2 Women's perspectives of quality in midwifery care

The underlying philosophy of much current service provision is that pregnant women should be at the center of midwifery care decisions and service planning, and that health professionals should work with women towards achieving this objective (Proctor, 1998: 85). Service providers need to understand the perspectives of quality in midwifery care in hospital to provide quality care as perceived by women. In studies by Duong, Binns, Lee and Hipgrave 2004:447-452; Proctor, 1998:85;Haddad, Potvin, Robergea, Pineault and Remondina, 2000: 21–29, clients identified various aspects of what they consider as quality care. Despite these studies being carried in different settings [developed and developing countries], the themes of quality care were similar. Focusing on women during childbirth, Proctor (1998: 85) identified the following ten dimensions of perspectives of quality care as mentioned by women in the United Kingdom: Continuity of caregiver, environment to include physical surroundings and tangible aspects of care, information to include the nature of information given to women, Access to include location and convenience of the service. Others are Care and treatment; specific comments relating to aspects of care and treatment, Relationship to include features of the staff-patient relationship, outcome to include desired outcome of pregnancy and of the service. In addition, staff attributes to include personal and professional attributes of staff, choice to include

involvement in care decisions, choices about the care or service, control to include feelings of confidence, empowerment and control over care.

A study by Duong et al (2004:447-452) was done in Vietnam, a developing country similar to Kenya. Themes of quality care were categorized as health care setting, Health facility, Interpersonal aspects of care and access to services. In-depth discussions of these themes are similar to some those identified by Proctor (1998: 85) in United Kingdom. In conclusion, the themes of quality care as summarized by the study by Proctor (1998: 85) may form a guide to elicit women's perspectives of quality care during childbirth in hospital. However, in this study the researcher intends to elicit the women's dimension of quality care from their (women) own perspective.

2.3. Advantages of exploring client perceptions of quality care

Measuring client perceptions of quality care has various advantages. Haddad et al, (2000: 21-29) observes that patients constitute an essential and even exclusive source of information about accessibility or effectiveness of care measurement of patient's perceptions. Further, the patient's opinion directly influences his or her compliance with treatment, continuity and patient–physician relationship. Extent of compliance to treatment, care and the relationship built between the care provider and the client influence the perception of quality care. Finally, exploring patient perceptions of quality care constitutes a positive approach to the evaluation of quality, in contrast to

negative approaches that focus on the measurement of inadequate processes or undesired outcomes.

Haddad et al (2000) further notes that assessment of patient perceptions offers several practical advantages since it can be measured rapidly following the delivery of care; it is inexpensive; it does not depend on the quality of data found in medical records**.** In the provision of good quality maternity care for women, Wickham (2006:45) concludes that women are the only people who can tell us whether we are succeeding or not. This study therefore, is rooted on the advantages as noted above and seeks to explore them for the benefit of childbearing women in the setting of the study.

2.4. Determinants of women's choice of health care services

For every step in seeking health care, there are factors that will determine the decision of the type of care sought. Women seeking childbirth are not an exception in this trend. Their use of health services is greatly influenced by their expectations of those services and whether those expectations are met (Mwaniki, Kabiru, Mbugua 2002:184-187). As an attempt is made to improve accessibility of mothers to skilled attendants, its important to explore their expectation since this influence the use of the services. However, it is worthwhile appreciating that patients [mothers] are also different from one another in type and stage of illness and in the demographic and social characteristics that influence the course of health-seeking behavior and its response to care (Donabedian 1980: 24). When the judgment of quality therefore takes into account the mothers' wishes, expectations, values, opinions then one can refer to personalized and individualized definition of quality care. Exploration of variations in expectations in respect to specific characteristics is paramount in helping midwives to provide quality care during childbirth.

In Kenya, many women would rather deliver their babies at home, with no assistance, no drugs, and no medical equipment, than deliver in a public or private hospital (Amanda: 2008: online). Some expectant women would decide not to seek reproductive health care services, thereby increasing their risk of complications during childbirth and creating a higher maternal mortality and child death rate in the country.

Amanda (2008: online) further notes the negative attitude towards seeking medical help in a hospital is not based on ignorance, lack of information or traditional values, rather it has to do with the way these women have been treated in the past. Through this study, the women will share their positive and negative experiences during childbirth.

The ultimate aim of considering quality of care from the mothers' perspective is to enhance understanding of needs; expectations of mothers to skilled attendants, which can help mothers to utilize hospital services, hence reduce maternal and neonatal morbidity and mortality. If pregnant women get simple, basic, cheap but quality antenatal and maternity care, pregnancy and birth can be much safer thus reducing maternal morbidity and mortality (Mwaniki et al 2002: 184-187).

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

In the preceding chapter, the researcher explored the literature as it relates to quality care during childbirth in hospital. In this chapter, the researcher will describe and clarify the study design and methods. The research design, research methods, data collection and analysis, trustworthiness of findings and ethical considerations will be described.

3.2 Research design

A research design is a plan or blueprint of how one intends to conduct the research study (Babbie and Mouton 2003: 74). The design gives a basis and framework upon which the methods will be implemented during the research process. There are two main research designs i.e. qualitative and quantitative research designs. According to Burns & Grove (2005: 23), these designs complement each other because they generate different kinds of knowledge that are useful in nursing practice. The different kinds of information are generated by the inductive and deductive approaches used in data collection. However, the problem area to be studied determines the type of research to conduct and the predominant design one applies in a study. Burns and Grove (2001:26-27) and Maxwell (1996:17) said the strengths of qualitative research are primarily from its inductive approach, its focus on specific situations or people, emphasis on words rather than numbers, and methods of giving meaning to the whole (holistic). The problem area in this study related to exploring perspectives of women on the meaning of quality care during childbirth in hospital. Therefore, qualitative method was used because the researcher aimed at describing and promoting understanding and interpreting the world from the perspective of the insider (Burns

and Grove, 2005: 23, Babbie & Mouton 2003:78). The perspective of quality of care from women's perspective can be examined from an insider's view on this phenomenon. The purpose of this study was to explore and describe the perspectives of women on the meaning of quality care during childbirth in hospital. Therefore the researcher employed the exploratory descriptive design.

3.2.1 Justification for Qualitative method

A subjective phenomenon like perspectives is best studied qualitatively because the method inductively explores words rather than counting numbers. This design gives a way to gain insights through discovering meanings (Burns and Grove: 2005: 52). According to Streubert and Carpenter (2003), qualitative research is an accepted, meaningful and important methodological approach to the development of a substantive body of nursing [and midwifery] knowledge.

Qualitative researchers emphasize significant characteristics in their research: a belief in multiple realities, a commitment to identifying an approach to understanding that supports the phenomenon studied, a commitment to the participants viewpoint, the conduct of inquiry in a way that limits disruption of the natural context of the phenomena of interest, acknowledged participation of the researcher in the research process and the reporting of data in a literary style rich with participant commentaries (Streubert and Carpenter, 2003: 16; Babbie and Mouton: 2003:270).

3.2.2 Study site

The study was carried out in Riley Mother Baby Hospital (RMBH) of Moi Teaching and Referral Hospital being second largest referral hospital in Kenya. The hospital is

located in Eldoret municipality of Western region of Kenya in Eldoret town, in the greater Uasin Gishu district, North of Rift Valley province and is about 320km North West of Nairobi. The hospital is located along the Nandi Road, East of Eldoret town. The setting at RMBH is in a way that there are six cubicles with six beds each. Two cubicles have been set aside for women who experience normal labor. The study therefore targeted women in the two cubicles with a total of twelve beds.

3.2.3 Unit of analysis

Unit of analysis refers to the type of unit the researcher uses when measuring variables. Common units in social research are individuals (Neumann, 1997:113). Unit of analysis also refers to individuals in the broad study population who possess specific characteristics (De Vos et al., 2005: 193; Burns and Grove 2005:40; Polit and Hungler, 1991:254). In this study, the unit of analysis was all women who had a hospital birth experience and were in the postnatal ward of Moi Teaching and Referral Hospital following a normal hospital birth.

3.3. Sampling

Sampling refers to the process of selecting a portion of the population to represent the entire population (Polit and Hungler, 1991:254; Uys and Puttergill, 2003:107)). Sampling involves selecting a group of people, events, behaviors, or other elements with which to conduct a study (Burns and Grove, 2005:346). The women who met the inclusion criteria were identified using their record in the ward. They were admitted in two cubicles with a total of 12 beds numbered 24-36. When the bed capacity was exceeded, two women would share a bed. Following a normal childbirth, the mother was discharged after an average duration of 12 hours. Convenient sampling was used

to conduct the study. The mother from bed number 24 was conveniently selected and screened using inclusion criteria. Then the mother on the subsequent bed was also approached as long as she met the inclusion criteria. Every interview was transcribed and analyzed before moving on with the next interview. Twelve women were interviewed and saturation achieved.

3.3.1 Inclusion sampling criteria

Inclusion criteria are those characteristics that a subject or element must possess to be part of the target population (Burns and Grove, 2005:343). In this study, the participants were mothers who had had a normal childbirth in the hospital. They had to have been in the hospital for at least two hours following admission and prior to having a vaginal birth. Those women who met above criteria and were willing to participate in the study were approached for participation in the study.

3.3.2 Exploratory interview (Pilot study)

Pilot tests are designed to determine whether the project will work. Pilot tests are implemented in settings convenient for the researchers, and are somewhat similar to ones in which the intervention will be used (De Vos et al, 2005: 402; Polit and Hungler, 1991:62). The principal focus of a pilot study is the assessment of the adequacy of the data collection plan (Polit & Hungler, 1991:62).

In this study, a pilot study was carried out at the same study site of postnatal clinic and postnatal ward of Moi Teaching Referral hospital. The sampling and inclusion criteria were the same as for the main study. Polit and Hungler (1991:62) recommend that pilot subjects should be chosen from the same population as subjects of the study sample. The main purpose of the pilot study was to test the question: *"Could you*

please describe what you would consider quality care during childbirth in hospital right from admission to discharge" The researcher sought to know if the respondents [participants] understood the question and directions and rule out any ambiguity (Polit and Hungler, 1991:62).

The participants for the pilot study were recruited as per the procedure for the main study. During in-depth interview, the researcher interviewed the mother at the bedside and did audiotaping of the interview with her permission. Following the pilot study, the information collected was analyzed to identify any misinterpretation of the questions during interview and discussions and necessary adjustments were made on the methodology and the questions.

3.3.3 Adjustments following pilot study

The pilot study took place in the postnatal ward and postnatal clinic of Moi teaching and referral hospital.

During the in-depth interview, the researcher noted that the mothers tended to describe their experiences as they occurred in the current childbirth process rather than what their perceptions of the ideal would be. The researcher hence adjusted the question so that the focus of women would not be on the current experience but rather what they would have wished it to be like. Hence the question, *" Could you please describe what you would consider quality care during childbirth in hospital right from admission to discharge"* was adjusted to *"Could you please describe what you would consider quality care during childbirth in any hospital right from admission to discharge"*

While piloting for focus group discussions, the researcher noted that getting women at six weeks of similar planned characteristics i.e. one childbirth experience and more than one childbirth experience was a challenge. There was a waiting time of 30 minutes between one potential participant and another. This was causing a lot of delay and long waiting time for these potential participants. The intended purpose for the focus group discussion was to elicit information from women of similar parity after a six-week period of rest following childbirth. Therefore, the element of parity was to be elicited during in-depth interviews. However, the influence of immediacy of childbirth experience would be an aspect to be investigated to determine whether there is a difference in perceptions following a lapse of six weeks period.

3.4 Data collection

Data collection is the process of selecting subjects and gathering data from these subjects (Burns and Grove, 2005:430). In planning the process of data collection, the researcher needs to determine step by step how and in what sequence data will be collected from a single subject [participants] (Burns and Grove, 2005:421).

In this section, the steps followed in data collection through in-depth interviews to elicit the perspectives of women on the meaning of quality care during childbirth in hospital will be described.

3.4.1 Research technique

Qualitative research is conducted to describe and promote understanding of human experiences such as caring and comfort (Parsley and Corrigan, 1999). Hence it will be the most appropriate approach so as to elicit how the mothers perceive the phenomena of quality care. This study explored the women's perceptions focusing on the area of

quality care during childbirth in hospital setting. In this study, mothers who had had hospital births were the target group of interest since they had insight into the care they received during childbirth in this setting. Hence, they gave a description of what they considered quality care during childbirth in hospital.

3.4.2 In-depth interview

In-depth interview is a non-directive and non-restrictive type of interview, in which the initiative is almost completely in the hands of the subject. In addition, in-depth interview involves a repeated face-to-face encounter between the interviewer and the subjects. The aim of this method is to reconstruct reality from the world of the participants through exploration and description (Berg, 2001:90-97; Cormack, 2000:20, 293; Mayan, 2001:14-15; Wilson, 1993:224). In-depth interviewing was the means by which the researcher gained access to, and subsequently sought to understand the private interpretation of quality care each mother held following experience of childbirth in hospital.

The mothers who met the inclusion criteria were given a verbal explanation of the study. The interviewer introduced himself. The study was explained to the mother verbally and a written consent was signed by the mother once she agreed to participate. Interviews were audio taped. The bedside environment was screened for privacy and distractions. The demographic data of the participant was filled in a form. The demographic information involved age, marital status, number of children, number of previous hospital births, religion, highest level of education and tribe. Then the researcher began the interview questions. The interview opening question was, ““*Could you please describe what you would consider quality care during childbirth*

in any hospital right from admission to discharge" .Each interview took an average of 30 minutes.

3.5 Data management and analysis

Data analysis is the process of bringing order, structure and meaning to the mass of collected data (De Vos et al, 2005:333). Data analysis involves coding of data, reflective remarks, marginal remarks, memoing and developing propositions (Burns and Grove, 2005:548). The ultimate purpose of data management, regardless of the type data one has, is to impose some order on a large body of information so that some general conclusions can be reached and communicated in a research report (Polit and Hungler, 1991:500). The research was conducted between January 2010 and February 2010 at Riley Mother- Baby Hospital of Moi Teaching and Referral Hospital. The researcher prepared and interview guide which was used to elicit the information from participants (Appendix 1). Following approval of the study by the IREC, the researcher planned a day to visit the study site and sought permission from the Nurse In-charge of the hospital site at Riley mother and baby hospital where the study was conducted. A brief description of the study was done to the nurse in charge of the postnatal section. The researcher was then given orientation on the layout of postnatal ward and the criteria for admitting clients in specific cubicles. The researcher noted that there were four cubicles with six beds each. Two cubicles were used for clients who had normal childbirth while the other two were used for clients who had abnormal childbirth. Therefore the cubicle with normal childbirth experience women was identified for the study as they fulfilled inclusion criteria. The researcher then set the following day to commence data collection.

On the first day of data collection the mother on the first bed was approached for participation in the study. Following explanation of the study to her, she signed consent, the bedside was screened and interview commenced.

The interview guide that was used to collect data in this study comprised of two sections (see appendix 2).The first part, section a, consisted of demographic information that described the characteristics of the respondent to facilitate understanding of their background. These demographic data was analyzed manually in a quantitative manner. The second part, section B, which was the main method of data collection, comprised of the individual in-depth interview questions that were used to guide the researcher and was analyzed qualitatively.

Demographic data was entered in section A of the interview guide then immediately followed by oral in-depth interview which was audio recorded using a digital voice recorder. Two in-depth interviews were done per day and then transcription followed immediately. The analysis began immediately after completion of the first interview. Transcription and coding were performed simultaneously with other interviews. Transcription of the interviews was accomplished using MS word and analysis followed which comprised of coding of major themes using NVIVO 8 software for qualitative research. The nodes that were coded formed the basis for further analysis into subthemes and themes respectively.

3.6. Measures to ensure trustworthiness of the results

In qualitative research, rigor [trustworthiness] is associated with openness, scrupulous adherence to philosophical perspective and thoroughness in collecting data (Burns &

Grove, 2005:55). Trustworthiness is demonstrated through researcher's attention to and confirmation of information discovery (Streubert and carpenter, 2007: 47). The main objective for rigor [trustworthiness] is to accurately represent study participants' experiences (Streubert and Carpenter, 2007:49). Lincoln (1994) in Streubert and carpenter, (2007:49), identifies the following criteria that describe operational techniques supporting the rigor [trustworthiness] of the work: credibility, dependability, confirmability and transferability. Below is the description of how the researcher achieved trustworthiness of the study.

3.6.1 Credibility

Credibility refers to conducting a research in such a manner as to ensure that the subject was accurately identified, described and that credible findings produced (De Vos, 2005:346; Streubert and Carpenter, 2007: 49).

In order to produce findings that are convincing and believable, the researcher implemented the following strategies: prolonged engagement and referential adequacy.

3.6.1.1. Prolonged engagement

Polit & Hungler (2003:313) state that prolonged engagement is the investment of sufficient time in data collection activities to gain an in-depth understanding of the culture, the language or the views of the group under study and to test for misinformation. In specific terms, prolonged engagement refers to staying in the field until data saturation occurs (Babbie & Mouton, 2003:277). The researcher spent enough time on data collection activities. Saturation was reached at the end of twelve interviews. Two additional participants were recruited to verify the findings. The

researcher recognized repetition in data and determined that addition of new participants confirmed rather than added new information.

3.6.1.2 . Referential adequacy

According to (Babbie & Mouton, 2003:277) referential adequacy refers to use of various materials to document the findings. The materials include audio or video recording. In this study the researcher used audio recording and field notes to capture adequate information relating to the interviews.

3.6.2 Dependability

Dependability is a criterion met once researchers have demonstrated the credibility of the findings (Streubert and carpenter, 2007: 49). Triangulation of methods has the potential to contribute to the dependability of findings (Sharts-Hopko, 2002). Dependability in this study was enhanced by analysis triangulation which refers to using two or more differing data analysis techniques (Burns and Grove 2005:226). The data was analyzed by Tesch's method of data analysis (see appendix 2) then by NVIVO 8 software for qualitative methods. Both methods generated similar subthemes and themes. The use of the two methods provided a means of validating the findings hence dependability.

3.6.3 Confirmability

This is a criterion that requires the researcher to illustrate as clearly as possible the evidence and thought process that led to the conclusions in a way that another individual can follow (Streubert and carpenter, 2007: 49). Confirmability asks whether the findings of the study could be confirmed by another (De Vos, 2005:347).

However, Sandelowski in Streubert and Carpenter (2007:49) argues that the researcher is the only one who has collected the data and been immersed in them who can confirm the findings. The following strategies for establishing confirmability were applied to this study: Researcher as the research tool and pilot study.

3.6.3.1. Researcher as the research tool

During the in-depth interviews, the researcher was able to bracket any preconceived ideas about the topic. For example, the notion that women would consider quality care depending on gender of the caregiver was disregarded and all women were interviewed regardless of the sex of the birth attendants.

3.6.3.2. Pilot study

The pilot study was done to test the research questions, the feasibility of the study and availability of the participants. The findings were discussed with the researcher's supervisors who confirmed that the research question and the methods would yield accurate results.

3.6.4 Transferability

Transferability refers to the probability that the study findings have meaning to others in similar situations (Streubert and Carpenter, 2007: 49). During this study, the researcher ensured transferability by the following means: purposeful sampling and thick description.

3.6.4.1 . Purposeful sampling

Purposeful sampling occurs when the researcher selects individuals for study participation based on their particular knowledge of a phenomenon for the purpose of

sharing that knowledge (Streubert and Carpenter (2007:94), In this study, the researcher intentionally selected participants from postnatal ward who had had childbirth experience in the hospital. These participants were able to provide information about what they had experienced and elicit what they would consider quality care. Participants had experience and hence perspectives of quality of what they were discussing.

3.6.4.2 . Thick description

According to Streubert and Carpenter (2003:225), transferability is established by thick description, which, when read by another researcher, can enable the findings of the research to be applied in another context. Stringer in Streubert and Carpenter (2003:225) indicates that it is the researcher's responsibility to describe as fully as possible the means for applying the information in another context. During the study the researcher used interviews and audiotape recordings, which, when they were combined during the data analysis, contained enough information to permit judgment about contextual similarities. Furthermore, a literature control which involves relevant literature citation was conducted in order to contribute to thick description.

3.7. Ethical issues

The conduct of nursing research requires not only expertise and diligence but also honesty and integrity. Conducting research ethically starts with the identification of the study topic and continues through the publication of the study (Burns & Grove, 2005:176). The conduct of this study observed ethical issues as discussed below:

3.7.1. Permission to carry out the study

Permission to carry out the study was obtained from the Institutional Research and Ethics Committee (IREC) of Moi University who reviewed and approved the study. Permission was also sought from the administration of Moi Teaching and Referral Hospital (MTRH) to carry out the study in the postnatal ward.

3.7.2. Respect for autonomy

Respect for autonomy implies that an individual has the right to decide whether or not to participate in a study, without the risk of penalty or prejudicial treatment (Brink, 2006:32). The participants who met the eligibility criteria had full explanation about the purpose of the study. After agreeing to participate, they signed a consent form that gave the details of the nature of the study. They were free to withdraw from the study without penalty.

3.7.3. Confidentiality

The process of ensuring confidentiality refers to the researcher's responsibility to prevent all data gathered during the study from being divulged or made available to any other person without the authorization of the subject (Brink, 2006:35, Burns & Grove, 2005: 188, De Vos, Strydom, Fouche, & Delport, 2005:61). In this study, the participants were informed that confidentiality would be maintained from the time of recruitment and throughout the study. The data gathered could not be linked to any participant and no name was used to identify the data. Each transcription was given a unique code that could not be linked to the participant.

3.8. Study limitations

The study represents a qualitative study in Kenya related to perspectives of women on the meaning of quality care during childbirth in Hospital; hence the research findings cannot be generalized to other populations beyond the sample.

3.9. Conclusion

The study exploring the perspectives of women on the meaning of quality care during childbirth was conducted between January 2010 and February 2010 in Riley Mother Baby Hospital. It involved use of in-depth interview of participants which helped the researcher to understand concepts, probe further to get richness of the concepts of interest. Analytic triangulation was done using NVIVO 8 software and Tesch's method of data analysis. Ideas emerged from the analysis, then further categorized into subthemes and themes. In the next chapter, the major themes as well as sub themes in each theme are presented. Qualitative approach of data presentation has been employed to summarize demographic data of the participants.

CHAPTER FOUR: RESULTS OF THE STUDY

In this chapter, presentation of the findings of the study in relation to the study aim and objectives are presented. The aim of the study was to explore and describe the perspectives of women on the meaning of quality health care during childbirth in hospital. The study was based on the following objectives:

- To describe the perception of postnatal mothers on the meaning of quality care during childbirth in hospital
- To describe factors that hinder the achievement of perceived quality care during childbirth in hospital.

The data presented in this chapter emanates from interviewer guide and is presented in two parts. The demographic information part is described in quantitative manner to summarize the characteristics of the sampled population to facilitate understanding of the respondents' background. The other part consists of responses of the participants from the individual in-depth interview questions that were used to guide the researcher. This section forms the greater part of the study since the study was qualitative in nature. The in depth interviews involved 14 mothers in postnatal ward of Riley Mother Baby Hospital of Moi teaching and Referral Hospital. Transcription of data was done into Ms Word. Data analysis was done using NVIVO 8 software for qualitative analysis and cross checked for trustworthiness using Tesch's method of qualitative analysis. Both methods generated similar subthemes and themes.

Three themes emerged from the interviews. These themes were: Caring, Information and positive Interpersonal relationship.

4.1 Demographic characteristics of the participants

Fourteen women were interviewed of which two were interviewed to confirm saturation of data. Overall the age range for the participants was 15 to 30 years. Nine of the fourteen mothers were married. Thirteen of them had one to three children. Eight had no previous experience with birth while six had a previous experience with hospital birth. All the participants were Christians. They all had formal education above primary school level and four had attained university education. Ten of the participants were from the Kalenjin community the others were from Luhya and Kikuyu communities.

4.2 Themes and Sub-themes

After analysis of data, three themes emerged as caring, information and positive interpersonal relationship. The table below presents the sub themes that emerged from each theme.

Table 1: Themes and sub themes

THEME	**SUBTHEME**
Caring	Caring by being physically present and offering prompt attentive care
	Caring by providing relief of pain and discomfort
	Caring by providing clean and warm environment
	Caring by providing nutrition
Information	Providing specific instructions
	Providing frequent information on progress
Positive Interpersonal relationship	Being understood as an individual
	Friendliness

4.2.1 Theme 1: Caring

From the findings, caring can be defined as the presence of a care giver, who provides frequent and precise information and develops a positive interpersonal relationship with the mother during labour.

Four sub themes, which relate to caring emerged from the interviews.

4.2.1.1 Sub-theme 1: Caring by being physically present and offering prompt attentive care

Presence of a caregiver was considered an aspect of quality care by the participants. A caregiver who was referred to as either a doctor or nurse was required to be constantly present or accessible during labour. The presence of a caregiver was considered critical during the experience of labour pain. One participant expressed as below:

"Sometimes you might be experiencing labour pain but there is no doctor around"

The caregiver was seen as having a monitoring role to detect any deviation from the normal process. A participant who had one previous hospital birth experience stated:

"During the labour pains, the doctor should at least be nearby to monitor any changes either positive or negative."

Regarding presence the participants expected the caregiver to demonstrate concern and keenness to the labour process. A participant who had three previous hospital births demonstrated that the caregiver should be serious with caring role during labour. The emphasis of the desired seriousness during care in labour was lauded by the following excerpt:

"The quality care that I expected was that to be attended most of the time but some

nurses were not serious during that process of labour."

The doctor/midwife attending the mother was required by the participants to be quick in responding to her needs. Mothers considered that they should be attended quickly when they called for assistance. The participants expected that upon arrival in the hospital, they should be attended to as promptly as possible as some participants said:

"I would expect to be attended to promptly as soon as I enter the hospital. This was done to me and I really appreciated"

The admission process was considered lengthy by some participants especially when they were in pain. A participant who had her first childbirth expressed herself with bitterness said:

"When I was waiting, I was in so much pain, I would be happy if the admission process were speeded up a little bit."

The prompt attendance by the midwife/doctor was associated with good outcomes of the baby. A mother who had had her first born baby said:

"I would expect them to attend to that process promptly, because at times, you may find that the midwives are not on time and maybe the outcome of the baby may not be good".

Promptness in attending the mother while in labour was associated serious attention to the laboring mother. The doctor /midwife were reported as being serious if he/she is attending to the laboring mother promptly.

"Some things also to be done are that they (care providers) are not really serious on attending to you during the birth of the baby. They are not quick."

Some participants would strive to help themselves if the midwife /doctor are not attending her. The participants expected the doctor/midwife to respond promptly to what they asked for when in labour. A participant who had three previous hospital births had the following to say:

"Some of them (doctors and midwives) are not attending to what you ask for, for example when I was almost to push the baby I told one of them to come but she refused attending to me. And I only did my own wish to see that I have achieved."

4.2.1.2 Sub-theme 2: Caring by providing relief of pain and discomfort

Pain was considered a discomfort which when controlled, quality care would be achieved. A participant who had given birth for the first time expressed thus:

"If possible when giving birth, they should give me some analgesics to relieve the pain".

However, some clients had contrary views regarding pain relieve during labour. They considered labour pain unavoidable though they expressed need for pain relief during other procedures related to childbirth like repair of episiotomy. A participant with three previous hospital birth experiences said:

"While laboring, it's a must to feel the pain, and once you deliver and you were cut(episiotomy) or had a tear they should inject you enough medicine (local anesthesia) so that at least you don't feel the pain because sometimes they stitch while you feel the pain as if there was no anesthesia".

Besides pain, discomfort during vaginal examination was cited by some participants. However, from the interview, they valued the role of the examination. The discomfort

was cited as arising from different doctors/midwives coming to examine the client at different times. The frequency of examination was considered as being too close by the participants. A participant who had her first hospital birth expressed this view by saying:

"*You find somebody doing vaginal examination then after 15 minutes someone else comes to redo it, which is wrong"*

4.2.1.3 Sub-theme 3: Caring by providing clean and warm environment

Mothers considered that during childbirth, they should be kept warm and the birth environment should be clean. Similarly, after childbirth, the baby should be kept warm and clean. Participants considered that warmth could be provided by being given clothes. The following excerpt illustrates the need for warm clothes and clean environment:

"The best thing to be done was that they attended to the baby and assisted me and cleaned me and also assisted the baby by covering with clothes. I think that was the best thing they did".

The participants found labour ward lacking in provision of warmth. A participant who had her third hospital birth expressed in the following excerpt:

"I would expect you to provide us with warm clothes because down there (in Labour ward) there is nothing warm for covering yourself".

Besides warmth, the participants considered that cleanliness should be observed during the childbirth process. The participants would consider quality care if the linen would be change as soon as it was dirty. A mother of one who had one hospital birth experience said:

"...and also the changing of linen should be done as soon as it becomes dirty and it

should be changed promptly."

A participant appreciated the fact that they were told to bath and their beddings changed. With a smile she said:

"…I see its well because (smiling) we are told to bath, beddings are changed, after bathing then you enter clean beddings."

However the participants would appreciate having a bed each. A participant who was sharing a bed with another postnatal mother expressed the following in this excerpt:

"I would expect that every client to be having their own bed for proper hygiene of the babies because they are prone to infections".

Infection prevention to the baby was the main reason cited to necessitate each client having own bed.

4.2.1.4 Sub-theme 4: Caring by providing nutrition

Mothers deemed nutrition an aspect of quality during childbirth in hospital. This was mainly for the sake of enhancing the mother to gain strength and be able to take care of the baby. This aspect was included in the verbatim below from a mother who had delivered in the hospital for the second time.

"It would be better to be given some food after the delivery process to renew ones energy"

The need for food was considered necessary especially after delivery of the baby.

"You should take care of the food and the hygiene of the baby since when the mother is not satisfied; the baby will also not be satisfied since she will not produce enough milk for the baby"

Hence, provision of food after childbirth was associated with maternal satisfaction, which translates into satisfied care of the baby. The participants associated feeding

after childbirth with good flow of milk for baby feeding.

4.2.2 Theme 2: Information

Specific instructions and frequent information on progress were aspects of quality that emerged constructing a theme on information. These sub themes shall be discussed as below:

4.2.2.1 Sub-theme 1: Specific instructions

This sub theme was brought up by the participants as an aspect of quality care during childbirth in the hospital. The participants expected information on the expectations of the care provider. The information was expected to be specific on what the mother should do during labour. However, the specific instructions were expected to focus on meeting the needs of the mother during labour. The excerpt below demonstrates the need for a link between specific instructions given to the mother and her needs.

"I would want to give me the Maybe the rules of what I am expected to do while in the hospital, and I also expect them to attend to my needs."

The other purpose of specific instructions from the midwife/doctor was to promote cooperation by the mother during labour. Such cooperation between the care provider and the mother during labour was associated with successful labour. A mother who had her first born and a first hospital birth said:

"They should tell me what I am expected to do so that I follow them and at least it will be easier for me so that I cooperate with them and everything will be good."

The specific instructions were also appreciated if they touched on care of the baby. Such instructions were considered quality care especially by first time mothers who were new with baby care. One primiparous mother expressed thus:

"Also they kept telling me what to do with my child thereafter; and showed me the place where the blood was oozing from."

4.2.2.2 Sub-theme 2: Frequent information on progress

The women would appreciate being given information on progress of labour as frequently as possible. This was associated with increasing the mother's ability to cope with labour. The following verbatim were brought up by the mothers:

"They should be telling me the progress because I can't see. They should be giving me instructions, for example when to push so that I don't hurt the baby; and when the baby is out they should tell me."

The mothers interviewed expressed need for information on subsequent care of the baby after birth. Any observation made on the baby by the midwife/doctor was expected to be reported to the mother. One postnatal mother expressed as follows:

"Also they kept telling me what to do with my child thereafter; and showed me the place where the blood was oozing from."

On the overall, the mothers valued information on what they were expected of while in the hospital. A participant demonstrated this in the following excerpt:

"I would want to be given the rules of what I am expected to do while in the hospital…"

Others would appreciate information on what was expected of them throughout the labour process. On participant who had given birth for the first time commented as:

"I would want to be told the process of labour which I was going through".

4.2.3 Theme 3: Positive interpersonal relationship

Positive interpersonal relationship between the mother and the caregiver emerged as a theme during the data analysis. This theme generated two subthemes i.e. being understood as an individual and friendliness. These subthemes shall be discussed below:

4.2.3.1 Sub-theme 1: Being understood as an individual

The mothers expressed need for individualized attention so that they are given due care and attention to their specific needs. The need for personalized care brings good relationship and generates trust between the mother and the caregiver. This subtheme is illustrated thus:

"…when I arrived, I was in pain, so I was allowed to go [to labour room] first because I was in too much pain, I like that, and it shows that you [caregiver] really care".

Individualized care was considered a dimension of quality care if the baby was cared too. The extent of attention and concern demonstrated by the caregiver added value to the quality of care delivered. One participant expressed with certainty in the following excerpt:

"I would of course like to be treated with a lot of concern and my baby should be treated well too."

Quality of care was further described as being accepted the way one was. The clients expected to check upon frequently and their individual need s addressed. A twenty six year old mother of three described her perspective of quality care as:

"[Quality care]…is to be accepted, checked, and then you are given special attention and being taken care of."

The participants considered being understood from their perspective as an aspect of quality. They would prefer the caregivers to cope with them for the behavior and character they may manifest during labour and childbirth. This was expressed in the following verbatim:

"I would expect to be understood the way I am. People are different and may behave differently during labour. They should not quarrel us but understand us the way we are because at that time you can't know what you are doing."

The participants demonstrated during the interviews that what they went through during labour needed an understanding and caring person to be near them.

4.2.3.2 Sub-theme 2: Friendliness

Friendliness was mentioned as an aspect to consider when describing quality childbirth in hospital. The women would prefer the caregivers to portray a friendly environment so as to bring the comfort of childbirth. The participants expressed themselves as follows:

"… I would consider it quality if they become friendly and not harsh to me so that I will be able to at least cope up with the pain."

The friendly environment was thought to enhance pain relief hence enable the mother cope with labour process.

A participant recalled the friendly care she had received during labour and said:

""The nurse was good and understanding. I was assisted so much, I would say that they were loving, caring they were very good in fact, they assisted me to carry the baby up to this place".

CHAPTER FIVE: DISCUSSION

This chapter presents discussion of the findings in the preceding chapter. The themes generated from the study shall be discussed and relevant literature cited to provide control of the findings.

Eleven out of the fourteen mothers interviewed had an age range of 21 to 30 years. This age range was consistent with the findings of Kenya demographic health survey of 2003, that the fertility rate of women peaks broadly at age 20 to 29 years (CBS, 2004). The ages of respondents falling within this age bracket is associated with their high fertility rate hence the likelihood of having been in the postnatal ward at the time of the study. Nine out of the participants were married while five were single. Ten of the participants were from the Kalenjin tribe. This majority could be explained by the fact that the hospital is located within the Kalenjin community.

During data analysis, three themes emerged that depict what women considered quality care during childbirth in the hospital. The themes were caring, information and good relationship. The themes will be discussed in the following section.

5.1. Caring

Attributes related to caring emerged during the study. According to Stichler and Weiss (2000), caring refers to care that relates to the total person and his/her specific needs rather than to standardize or routine care. In this study, the participants mentioned the following subthemes related to caring: Presence of the caregiver and

offering of prompt care, Relief of pain and discomfort, Nutritional care and Clean and warm environment.

The presence of the caregiver during childbirth relates to the accessibility of the mother to the caregiver at any time. During labour, the mother's experience needs to have a second person for help since they may not determine their own progress and assurance of what is happening. The presence gives them a sense of safety, confidence and relaxation (Bayes, Fenwick and Hauck, 2008).Laboring is preferred by mothers to be a social process with someone knowledgeable around, which the woman can interact with and at the same time, be informed of the progress of labour. Even in staff constrained settings, the women in labour would require the caregiver to spare time so as to attend her. Melender (2006:336) while researching on what constitutes a good childbirth it was found that as much as midwives may be busy in the labour room, the women should have their fair share of the caregivers' time. Kabakian-Khasholian, Campbell, Shediac-Rizkallah & Ghorayeb (2000:110) found out that presence of medical support was a characteristic of quality care during childbirth. Care givers' role is specified by the women. There are the elements to be done and actions to be avoided so as to enhance quality care during childbirth in the hospital. The caregiver should provide warmth, pain and discomfort relief, clean environment and food. In a study by Melender (2006:336), warmth was mentioned by women as one of the environmental factors that the women perceived as an aspect of quality care. Warmth was considered to bring home like environment in the hospital during childbirth.

Invasive interventions like vaginal examinations should be kept to a minimum. The

frequency should best be discussed by the mother so that they see the need for the examination. There is need for more interaction with the mothers during routine procedures so as to reduce the degree of discontent that mothers have during the procedures Kabakian-Khasholian, Campbell, Shediac-Rizkallah & Ghorayeb (2000:111). Pain and anxiety during labour was associated with negative birth experience by women in a study by Waldenstrom (1999:471) while researching on women's experience of labour and birth. Any interventions that may cause pain and discomfort should, if possible, be avoided so as to promote good progress of labor.

Nutritional care was considered a factor that determines quality care. Women preferred being provided with some food during and after labour. The main reason for feeding after childbirth was to enhance milk flow. In a study by Geckil, Sahin and Ege (2009:67) while investigating on traditional postpartum practices of women and infants and the factors influencing such practices it was found that most women eat a kind of dessert and drink a mixture of butter and grape molasses just after childbirth. These meals were believed to help produce energy, positively affect women's health, and be beneficial for breast milk production. Women should be provided food during labour but more so following childbirth.

5.2. Information

Information as a subtheme emerged during this study. Information entails the communication between the caregiver and the mother. The nature of communication was categorized by the participants in the form of clarity and frequency.

Clarity of information delivered to the women is essential when considering quality

care. Information gives a road map of interaction between the caregiver and the mother. There is need to give the women in labour regular communication of their progress. The information given should be clear and the caregiver should exercise a lot of patience at such time. Women's sense of the task of birth and the time it will take is connected not only to their physiological experience but also to the information they receive from their carers (Maher, 2008: 131).

The description of clarity of information should be understood from the mothers' perspective because of the alteration in the psycho-physiological function. The relevance of any communication will be determined by the temporal aspects of the birth; whether a woman is able to hear and respond; whether the information being communicated contradicts or is congruent with her physiological experience of the moment. (Maher, 2008: 131). However the mother may be very suspicious of any information that may be referring to her especially if it's not intended for her hearing. Women can rely on comments overheard or exchanged between caregivers as they labor, to work out what was happening and where they are in their own birth process (Maher, 2008: 131). Therefore, hidden communications about progress of mothers need to be avoided by the caregivers.

5.3. Positive interpersonal relationship

The participants expressed the need for positive relationship between the caregiver and the mothers during childbirth in the hospital. Mothers considered the presence of a caregiver who is friendly, understanding and offers personalized attention to their needs.

This theme evoked aspects of humanistic and holistic approaches paradigms of childbirth. According to Davis-Floyd, (2001), a humanistic model was described as one that makes care individually responsive and compassionate. Individualized and compassionate care are attributes of friendliness, which grant the laboring mother a sense of comfort and enjoyment of the process. Friendly care is associated with good labour outcomes like shortened length of labour, and enhanced mother- infant interaction (Davis-Floyd, 2001) which are preferred attributes for a good labour experience.

Women also need to be understood in their experience and not criticized since caregiver may not know what the woman is experiencing. A need exists to encourage women during childbirth to boost their self-esteem (Kabakian-Khasholian, Campbell, Shediac-Rizkallah & Ghorayeb 2000:111). The caregivers have a duty to give attention to the mothers during childbirth. This is a component of individualized care in which the mother is given due attention to her personal needs. This kind of support is associated with childbirth satisfaction (Waldenstrom, 1999). The findings further concurred with those of Stichler and Weiss (2001:62) in the study called “Through the eye of the beholder: Multiple perspectives on quality in women’s health care”. In this study, patients stated that personalized caring was critical to the achievement of quality and clients preferred staff that showed a personal interest in them. Such care that regards the mother as an individual would be appreciated by the women during labour hence bring satisfaction with care.

CHAPTER SIX: SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1. Summary

This researcher employed in-depth interviews with fourteen mothers within their 24 hours of childbirth. The interviews generated information that was analyzed leading to emergence of three themes as caring, information and good relationship. The sub-themes associated with caring were Presence of the caregiver offering prompt care, Nutritional care and Clean and warm environment.

Under information, Specificity and frequency of the information were the emerging sub themes. Positive interpersonal relationship was characterized by individuality, understanding and friendliness as components defining quality care during childbirth.

6.2. Conclusion

The study was conducted in an urban setting using an exploratory design. This design makes it impossible to generalize the findings. However, the themes generated i.e caring, information and Positive interpersonal relationship with the mothers in labour point to essential characteristics of quality care during childbirth in hospital. There is need for care providers in labour to explore what their clientele would consider quality care and focus their services towards satisfying the client.

6.3. Recommendations

- The service providers during childbirth need to consider aspects of quality from the women's perspective so as to achieve client satisfaction.
- There is need for a study to compare meaning of quality among mothers giving birth at home and in hospital settings.

- The researcher recommends a study among women in different hospital settings to check if they would have similar perspectives on the meaning of quality care during childbirth in hospital
- There is need for study to compare meaning of quality care immediately after birth and after puerperium (six weeks postpartum) to determine if time lapse had an impact on the perspectives women had regarding quality care.

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APPENDIX 1: TESCH'S METHOD FOR DATA ANALYSIS

- Get a sense of the whole. Read all of the transcriptions carefully. Write down the ideas as they come to mind.

- Pick one most interesting interview; go through it, asking yourself: what is this interview about? Do not think about the substance of the information, but rather on its underlying meaning. Write thoughts in the margin.

- After you have completed this task with other interviews, make a list of all topics. Cluster similar topics together. Form these topics into columns that might be arrayed as major topics, unique topics and leftovers.

- Now take this list and go back to your data. Abbreviate the topics as codes and write the codes next to the appropriate segment of the text.

- Find the most descriptive wording for your topics and turn them into categories. To reduce the total list of categories, group together the topics that relate to one another. Lines may be drawn between the categories to show interrelationships.

- Make a final decision on the abbreviation for each category and arrange these codes alphabetically.

- The data materials belonging to each category can then be assembled in one

place, and a preliminary analysis can be performed

- If necessary recording of the existing data will be done

APPENDIX 2: IN-DEPTH INTERVIEW GUIDE

PART A

Age_____

Parity_____

Educational level_____

Tribe_____

Religion_____

PART B

Stem question: "Could you please describe what you would consider quality care during childbirth in any hospital right from admission to discharge?

1. What would you consider the best care when being admitted in a labour room?

   Probe: Describe the kind of welcome you would appreciate most?

   Probe: What kind of information would you appreciate from those attending you?

2. What would you consider the best care during laboring process?

   Probe: What are your expectations during the laboring process?

   Probe: What would you describe as a pleasant laboring process?

3. What would you describe as the best care when the baby is just coming out of the birth canal?

   Probe: What would you expect from the midwives when your baby is just coming out?

4. Following the birth of your baby, how would you prefer to be cared for?

   Probe: Describe the activities to be done for you at this stage for you to consider it quality care.

APPENDIX 3: PERMISION TO CARRY OUT THE STUDY