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Client Satisfaction with Maternal and Neonatal Care: A Qualitative Assessment of Partnership Defined Quality Process (PDQ) in a Peri-Urban Setting in KwaZulu-Natal, South Africa

Thoko Ndaba[1*], Myra Taylor[1], Musawenkosi Mabaso[2]

[1]*Department of Health Research, University of KwaZulu-Natal, Durban, South Africa*

[2]*Department of Health Research, Human Sciences Research Council, Durban, South Africa*

ABSTRACT

Background: In South Africa, increasing attention has been paid to measure structural and process quality of Primary Health Care (PHC), but there has been a paucity of process-based measures of health care quality developed to assess utilization or performance improvement. This paper explores client satisfaction on maternal and neonatal care following implementation of a Partnership Defined Quality process (PDQ) in a peri-urban setting in KwaZulu-Natal, South Africa.

Methods: This was a qualitative study that used a purposive sampling technique to select 80 pregnant women from three primary health care catchment areas (n=80). The interviews were audio-recorded, translated and transcribed verbatim from the local language to English. Thematic analysis was used and the results presented in quotes in accordance with the themes that emerged.

Results: Mothers needed a welcoming environment at antenatal care consultation rooms as well as delivery rooms. They emphasized caring through a dedicated health team, which is keen, supportive, committed to do their work and prepared to listen to the maternal and neonatal challenges that mothers may present with at health care facilities. They highlighted a need for quality maternal, child and neonatal service backed up by credibly qualified staff coupled with professionalism.

Conclusion: Pregnant mothers should be attending clinics that provide quality maternal, neonatal and child health care services that function optimally at all times. It is important that clinics have an operational protocol that clearly directs norms and standards for quality delivery of health care services. Quality Improvement (QI) teams working together with the community and health care intend to continue to monitor and evaluate QI processes.

Keywords: Primary health care; Client satisfaction; Maternal; Neonatal; Partnership

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Corresponding author: Thoko Ndaba, Department of Health Research, University of KwaZulu-Natal, Durban, South Africa; E-mail: ndabathoko@gmail.com

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INTRODUCTION

In South Africa, the government has committed itself to providing quality healthcare programmes closer to communities though the Primary Health Care (PHC) re-engineering strategy. This health care reform includes strengthening primary care towards creating an integrated health service delivery system by bridging the gap between health care facilities and communities. Decreasing maternal and child mortality through delivery of quality health care is one of the cornerstones of PHC re-engineering.

Consequently, increasing attention has been paid to measure the structural and process quality of PHC in South Africa, but there is a paucity of process-based measures of health care quality. Quality of care is a dominant concept in quality assurance and quality improvement programs in the healthcare sector. The quality of healthcare can be measured by observing its structure, processes and outcomes. Process-based measures of health care quality are developed mainly to assess utilization or performance improvement [1].

PHC that adheres to protocols and puts clients first may result in less waiting time, more adherence to follow-up appointments and more co-operation by all parties involved. This partnership and commitment may contribute to reducing maternal and neonatal mortalities and promote healthier communities. Among other issues this entails relieving tensions, mistrust and even conflicts and including improving client satisfaction. Client satisfaction is an important measure of evaluating the quality of the healthcare services and contributes to health service improvements by assisting health program managers to develop appropriate strategies.

Recently, Partnership Defined Quality (PDQ) was implemented as part of improving the partnership between the community and PHC facilities in an impoverished area in KwaZulu-Natal, South Africa in order to address the suspicion and mistrust between community care givers, facility staff and community. This is a collaborative process towards improving the quality and accessibility of health services, with active community involvement in defining, implementing and monitoring the quality of improvement process. The PDQ process involved engaging communities and health providers in four phases: Phase 1 (planning, designing and building support), phase 2 (exploring quality), phase 3 (bridging the gap) and phase 4 (working in partnerships).

This paper explores client satisfaction on maternal and neonatal care following implementation of the Partnership Defined Quality process (PDQ) in a peri-urban setting in KwaZulu-Natal, South Africa.

MATERIALS AND METHODS

Study Area

The area is in Umlazi a peri-urban settlement with a population of approximately over 1 million people located approximately 17 kilometres South of Durban's central business district in the KwaZulu-Natal province of South Africa. The area forms part of eThekwini Municipality. The area is characterized by severe housing shortages, major informal settlements, overcrowding high levels of unemployment and little economic development [2].

Study Design and Data Collection

The study adopted a qualitative approach and purposefully recruited 80 pregnant women, 18 years and older in their 28th trimester and above. Others were recruited during clinic visits with their neonates. The recruitments were conducted in the catchment areas of three Primary Healthcare Clinics (PHCs) where Partnership Defined Quality (PDQ) was applied to improve quality and accessibility of primary health care in order to improve maternal and neonatal care in the selected areas. These selected PHC facilities have a very high workload with an average catchment population per clinic greater than 60,000.

Key informant interviews with open-ended questionnaires were conducted six months after the implementation of PDQ in the selected catchment areas. The PDQ process involved engaging communities and health providers in four phases: Baby phase 1 (Planning, designing and building support), phase 2 (exploring quality), phase 3 (bridging the gap) and phase 4 (working in partnerships). This was aimed at creating deep dialogue and collective action for the improved quality of health services for mothers and their babies [3].

Written consent was obtained from participants in all the meetings. Informed consent was sought from respondents before including them in the study. Respondents were also assured of confidentiality and the anonymity of information.

Analysis

The interviews were audio-recorded in the local language (IsiZulu) and transcribed from the local language and translated into English. The transcripts were coded manually for patterns and emerging themes and the codes generated were then named and reviewed. A peer debriefing process was involved in the coding development process to minimize the possibility of researcher bias in the development of the codes. The results are presented in the form of emerging themes and direct quotes from the respondents [4].

RESULTS

Sociodemographic Characteristics

Out of 80 participants, the majority was between 21 and 42 years of age, single and although employed, this employment was mainly casual labour (**Table 1**). Most respondents were in 28-40 weeks trimester.

Table 1: Socio-demographic profile of study participants in selected catchment areas served by three primary health care.

Catchment areas	Number recruited	Age range	Single	Married	Employed	Unemployed
Clinic A	21	21-42	21	0	21	0
Clinic B	29	21-42	24	5	10	19
Clinic C	30	20-39	29	1	29	0

Emerging Themes

Three major themes emerged from the analysis, which had both positive and negative attributes. The themes were: (a) Welcoming environment (b) professionalism and caring, (c) quality and standard of services [5].

Welcoming Environment

Most women felt that following the PDQ process they could feel the change welcoming nature of the clinic environment, which made it easy for them to access services without fear. One woman mention that "I was very uncomfortable on arrival because I thought I was going to be scolded by the nurses but they did not" (women 20 years old). Another woman stated that, "my expectation was that they will scold me for falling pregnant when I am on ARV's but that was not the case" (woman 29 years old). Another 29 year old woman also shared a similar view, "The clinic staff welcomed me well. I expected to be scolded by nurses as I was pregnant being HIV positive".

One woman re-iterated this point mentioned that, "I had a warm welcome, greeted, asked to join the morning prayer and singing with the nurses" (women 28 years old). In another FGD a 37 year old woman also shared the same experience, "warm welcome greeted and asked how the baby was doing". A 28 year old woman although in agreement felt slightly differently, "the whole service is good and unexpected behaviour from staff mostly happens due to some negative provocation from pregnant mothers, especially those that default on scheduled follow up visits. This annoys nurses very much and end up shouting at defaulters" [6].

A 31 years old woman narrated one such instance, "I wish your study had been done here before, as in my previous attendance with my previous pregnancy the nurse who was here at that time scolded me, asking why was I not taking my treatment and telling me that I may not deliver at this clinic. I was so emotionally hurt, I was going through severe pain and she seemed not to understand. I am seeing a change now the nurses are welcoming and communicating so well". Highlighting the improvement in the selected catchment area that had undergone the PDQ process. One woman stated, "this particular clinic works comparatively better than others in the area" (woman 32 years old) [7].

Professionalism and Caring

They highlighted a need for quality maternal, child and neonatal services backed up by credibly qualified staff coupled with professionalism, especially when dealing with HIV positive women. Hinting at the improvement in the level of professionalism one woman mention that "the care is good because the nurses look professional in their performance and have a very strict manager so they work well" (32 years old women). Another woman stated that on arrival "I was taken around the ANC area as well as the labour ward as my plan was to deliver at this clinic" (woman 37 years old). A 25 year old women said that, "communication was of a caring nature and accommodating, they further asked if I have understood all what I need to do for the unborn baby".

The views were generally positive. In one FGD a woman concurred, "I was given good care and even referred to the nearest hospital as the baby was a breech and thought the delivery might complicate" (woman 30 years old). One woman was very specific and reported that "they gave all medicines for example calcium, iron, ferrous sulphate and treatment for the infection" (woman 32 years old). Another 32 year old woman stated that "all treatment given was explained how it should be taken". In another FGD, a 26-year-old woman mentioned that, "the overall care was satisfactory as all processes were explained to me" [8].

Support for HIV Positive Women

One woman also stated that, "I was treated well; the staff was pleasant, we prayed together in the morning as they pray before they start their work. I thought they were going to scold me because of being pregnant when I knew that I was HIV positive but did not instead advised me how to take care of my pregnancy since I am positive by adhering to scheduled visits and treatment" (woman 36 years old). In support of this view a 29 year old woman mentioned that, "the care provided was good except for the long queues and I thought they were going to scold me because of being pregnant when I knew that I was HIV positive but did not, but advised me how to take care of my pregnancy since I am positive".

Quality and Standard of Services

While there was general agreement about improvement in the environment and quality of treatment and care. There were still issues of concern about the quality of certain services, especially with regards to ambulance service, overcrowding and duration of waiting, insufficient midwives and availability of medicines.

Ambulance Service

For example, with regards to ambulance service one woman said "the ambulance was called and took long to come and

arrived when I had already delivered. It however took me to hospital for stitches and for baby's immunization" (woman 25 years old). In another FGD a similar experience was shared "I delivered at home because I did not have money for transport after waiting for an ambulance that never came" (woman 32 years old) [9].

Another woman agreed, "Ambulance delays are frequent-when I went into labour at home and was bleeding heavily, I called an ambulance and there was no show of it so I ended up calling a metered taxi. On arrival at the hospital, I was assisted quickly and the bleeding arrested, drips were put up and was discharged home the following day with my baby" (woman 32 years old). A 39 year old woman stated that, "When I got into labour I called for an ambulance and it never came and also did not get a car to get me to the health facility, I eventually lost my baby".

Overcrowding and Duration of Waiting

There were also complains about overcrowding and the waiting period. One woman affirmed that, "the standard of care is good but the waiting period is too long, because whether you come early morning or not it does not make any difference" (woman 20 years old). Another woman concurred, "I waited in the long queue for hours before I was attended to" (woman 25 years old) [10].

Insufficient Midwives

In support of this view a 31 year old woman mentioned that when she visited the CHC "there was shortage of midwives to attend to long queues". Another woman explained, "the waiting list for doing ultrasound is so long that the clinic sometimes refers pregnant mothers to go to a private facility which is expensive and some women cannot afford" (woman 34 years old). A 26 year old woman stated that, "overcrowding, long queues and shortage of staff make nurses to be irritable and as pregnant mothers we get very reluctant to ask them questions relating to what I experience with the pregnancy". Another woman stated, "I delivered at home because clinics and hospitals are sometimes very crowded with less nurses to take care of everybody who is in labour" (woman 32 years old).

Availability of Medication

There were also issues about availability of medicines in some facilities. One woman explained "sometimes the clinic does not have all medicines and we are advised to go and buy from the chemists or come back another day" (woman 28 years old). A 27 year old woman agreed that "on discharge there are sometimes no medicines given for cord care the nurses tell you to go and buy it from the chemist".

In another FGD one woman shared her experience, "There had been a change of tablets from calcium and iron tablets and I got given yellow tablets with no explanation as to why and as a result I do not take them" (woman 19 years old). Another woman explained, "when I started at the clinic I was not given my TB treatment and was only given on my sixth visit and when I asked the nurses they said they also do not know why I have not been given and they started giving me. I was very unhappy about this answer" (woman 28 years old).

DISCUSSION

Client satisfaction is an important indicator of health care quality and can assist in providing data for health officials to use in improving and maintaining quality care standards. It may also assist in changing health systems' policy to improve better management and care towards achieving better maternal and child health outcomes. The study findings highlight the importance and implications of a welcoming clinic environment, professionalism, care and treatment as well as quality and standard of services. There was palpable cooperation and a healthy partnership after the PDQ process.

A welcoming health facility environment made clients feel accepted, cared for and respected. The anxiety that goes along with the fear of the unknown regarding the care that was to be received was thus minimized. There was immediately a feeling of calmness. The high level of hygiene observed was highly reassuring to users of the service, as a high standard of cleanliness in keeping with well-run primary health care clinics that adhere to principles of quality care. Evidence show that one of the most satisfactory domains related to the quality of health care include the surrounding environment of the health care facility, that is, physical environment, cleanliness and the behavior of health personnel toward clients. As observed in the current study a better physical environment at the health facility yielded greater patient satisfaction environment and this led to a positive perception towards the healthcare providers [11].

The findings also showed that even though sometimes the health facilities were busy with long queues, the clients experienced an acceptable standard of professionalism, treatment and care. The health facility staff were willing to listen to maternal challenges that the clients faced and wanted to discuss and receive advice and counsel where necessary. There was privacy in the consultation rooms. Clients experienced healthy and valuable communication at all levels and their fear and uncertainty was quelled. There was a clear indication that the shortage of medication has serious implications for mothers if PHC facility repeatedly have stock outs, but fortunately this rarely happened and most of the time stocks were thus available and if not at the time, a plan was immediately actioned to get a clinic driver to fetch supplies from a sister PHC facility. In line with current findings, other studies have observed that in addition to physical environment, the level of dissatisfaction is influenced by the characteristics of medical professionalism. That is, the degree of attention paid by the medical staff, the communication procedures and treatments applied and the promptness to the requests of patients.

Not with-standing a well coming clinic environment, professionalism, care and treatment led to a positive perception towards the healthcare providers. Pregnant women pre and post-delivery were very vocal about the

shortage of medicines, shortage of staff, lack of privacy in consultation rooms, staff attitudes, long tea and lunch breaks, long meetings, lack of environmental safety and hygiene, long waiting times, long queues, overcrowding, lack of turnaround time by ambulance service and uncomfortable waiting areas especially on very cold and rainy days. Evidence shows that if client level of satisfaction on quality of service does not meet the defined standards, clients tend to seek health care somewhere else. The results of the study provide valuable information for improved health care delivery towards better maternal and child health outcomes.

Essentially, the implementation of the PDQ process and its Quality Improvement (QI) teams created a platform for everybody to voice how they perceived a quality run clinic, as well as what they observed as improper for a clinic to be doing if delivering a good service to its community. This process highlighted a need to work in partnership with other stakeholders in the community that had an interest in health matters, including health professionals and those that were interested in home deliveries. There was great sympathy from the community for the overworked nurses. They were encouraged to continue working while the department of health was tackling the challenge.

This study has some limitations that need to be taken into account when interpreting the findings. Qualitative methods in general and focus groups in particular do not allow for generalizing the findings obtained to larger populations, as the participants are not meant to be a representative sample. Respondents may feel peer pressure to give similar answers to the moderator's questions. The moderator's skill in phrasing questions along with the setting can affect responses and influence the results. However, given their qualitative nature, focus groups allow for a more in-depth understanding of issues under investigation beyond the facts and numbers. In addition, this study was implemented by the paper's first author, who has experience in working with communities and is a skilled group facilitator, with an understanding of the problems experienced by the local health system and an appreciation of the strengths of the PDQ process [12].

CONCLUSION

The current study found that client satisfaction was a useful tool to measure the quality and performance of PHC services following implementation of the PDQ process in the selected catchment areas. The results revealed that quality of care according to the perspective of pregnant women pre and post-delivery included the suitability and privacy of environment where clients are welcomed and seen. How communication takes place (high level of listening skills); where waiting times before being seen by a midwife or doctor are not unreasonably long; where medicines and ambulance are readily available; where demonstration of work ethic and professionalism is practiced. The findings also highlighted the importance of the PQD process in ensuring that PHC facilities work closely with communities in forging strong partnerships for delivery of quality services towards better maternal and child health outcomes.

ETHICAL CONSIDERATION

This work was approved by the Biomedical Research Committee (BREC) of the discipline of public health, school of nursing and public health medicine, university of KwaZulu-Natal (BREC REF NO: BF081/17).

AVAILABILITY OF DATA AND MATERIALS

The data are being used for the PhD student for the thesis and are a property of the University of KwaZulu-Natal and are not, therefore, available to the public.

AUTHOR'S CONTRIBUTIONS

TN was involved conceptualising the study, conducting field work, analysing the data and drafting the manuscript. MT and MM assessed the findings, edited and reviewed the manuscript for significant intellectual input. All authors reviewed and approved the final draft.

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COMPETING AND CONFLICTING INTERESTS

The authors declare that they have no competing interests.

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