



Women's perspective of maternity care in Cambodia

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ABSTRACT

Background: Consideration of the needs of pregnant women and their ability and willingness to attend maternal services and pay for them is central to the provision of accessible and acceptable maternal care. Women's satisfaction with maternal services is poorly understood in many developing countries, including Cambodia in South East Asia. The objective of this study was to investigate women's perceptions and experiences of private and public skilled birth attendants, including midwives, during childbirth in Cambodia.

Methods: A qualitative design using a naturalistic inquiry approach was undertaken to seek sensitive personal issue. Thirty individual in-depth interviews were conducted with women who had recently given birth at private and public health facilities in one province in Cambodia. Data were analysed using a thematic approach.

Findings: Women's choice of health facility was influenced by their perceptions of safety and staff attitudes. Reported barriers to the effective utilisation of public maternity services were costs associated with the birth, staff attitudes and a lack of supportive care during labour and in the postpartum period. Although private health care is more expensive than public health care, some women reported a preference for private birth attendants as they perceived them to provide safer and more supportive care in labour.

Conclusion: Women expect, but do not always receive humane, professional, supportive and respectful treatment from public skilled birth attendants. While the removal of unexpected costs and geographical barriers are important to increasing public maternity care and service utilisation, improvements in maternity services should focus on addressing provider attitudes and enhancing communication skills during labour, birth and the immediate postpartum period.

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1. Introduction

Many countries in South-East Asia have made considerable efforts towards reducing maternal mortality, a key Millennium Development Goal (MDG).¹ The maternal mortality ratio in one South East Asian country, Cambodia, has decreased from 580 per 100,000 in 1999 to 290 per 100,000 live births in 2011.² However, as current trends indicate progress is slowing with a range of uncertainty of between 180 and 480 deaths per 100,000 live births,³ it is unlikely that Cambodia will reach the United Nations 2015 MDG 5 target of a 75% reduction in maternal deaths from the level in 1990.⁴ Major causes of maternal mortality in Cambodia, as

in many resource-poor countries, are abortion-related complications, obstructed labour, haemorrhage, eclampsia and infection.⁵

A critical component of efforts to reduce maternal mortality is the availability of skilled birth attendants¹ (SBAs) who can provide emergency obstetric and newborn care and referral.² Increasing women's access to quality maternity care has become a focus of global efforts to avert death.² Whilst skilled attendance at birth is essential, barriers to the use of health facilities have been identified.¹¹ Many women in developing countries experience economic, and geographical barriers to accessing health services¹² that are complicated by service and provider quality.^{11,13} As in many developing countries, access to health care in Cambodia is constrained by poverty. Essential health services are expensive particularly in rural areas, attracting user fees and transport, food and accommodation costs.¹¹ Geographical factors including the

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¹ SBAs refer to primary and secondary midwives, primary nurse-midwife and doctor with midwifery skills.

time required to travel to facilities and transport availability are barriers affecting access.¹⁴

Another barrier to maternity care is the perceived quality of care at facilities. Skilled birth attendants (SBAs) may not provide socio-culturally appropriate and respectful care leading to poor usage as women identify services to be unsuitable or inadequate.¹⁵ Furthermore, even if women arrive at a facility in time, they experience a lack of skilled staff, impolite behaviour¹¹ and a shortage of equipment and supplies,¹⁶ all factors that affect the standard of care. Women in developing countries, like women in all settings, value access to drugs, facilities and caring staff. For example, a study in Tanzania showed that women appreciated reliable access to drugs and medical facilities and respectful staff attitudes over other features, such as type of providers (public or private), cost (formal and informal costs), distance and transport.¹⁷

Studies on access to maternity services often focus on geographical, socio-cultural and economic issues; however, there is a lack of knowledge about services from the perspective of women themselves.¹⁸ Consideration of the needs of pregnant women and their ability and willingness to access skilled birth attendants (SBA) and pay for services is central to the provision of maternal care. The objective of this study was to investigate women's perceptions and experiences of public and private birth attendants during labour, birth and the immediate postnatal period in one province in Cambodia (Table 1).

2. Methods

A qualitative design was undertaken using a naturalistic inquiry²⁵ to explore sensitive personal issues. This approach was primarily selected as it allows for the description and explanation of complex, real-world phenomena pertinent to health services research.¹⁹ It is, therefore, suitable for describing, analysing and understanding the perceptions and views underpinning women's experiences enabling the target phenomenon to

be examined without the pre-selection or manipulation of study variables and a prior commitment to any theoretical view.²⁰

Approval for this study was granted from the University of New South Wales Human Research Ethics Committee and the Cambodian Ministry of Health Ethics Committee for Health Research.

Public health facilities were purposively selected as they reflect similar levels of basic and comprehensive emergency obstetric care provision across Cambodia. Private health facilities were recruited through a mixed sampling strategy of purposive and snowballing sampling with clinics suggested by public SBAs. The province in which the study was undertaken was selected as it is known to the author who has established access to stakeholders. The province name is not disclosed due to the sensitive nature of the study and need for confidentiality.

A convenience sample of women who had recently given birth at selected health facilities were recruited.²¹ Women were approached by the SBAs on arrival who informed the women verbally and in writing about the study and sought permission. SBAs read the standardized information statement and consent form in Khmer language explaining the aim of the study, especially participants whose literacy skills were inadequate. The SBAs also asked another participant who was literate, to read the information statement and consent form until the women indicated that they understood the content. Then the consent form was obtained from study participants through signing or thumbs printing when they agreed to take part in the study.

Written informed consent (in Khmer) was obtained from 30 women. Interviews of 60–90 min were conducted in one provincial hospital, two district referral hospitals, two health centres and five private facilities. Interviews were audio-taped, transcribed verbatim and prepared for analysis using computer software.

An in-depth interview was conducted with each participant in the health facility in which they worked. The interviews consisted of a series of questions including the following. 'Tell me about your perception and experience of childbirth during labour, birth and after the birth?' 'What do you think about private and public skilled

Table 1
Details of the staff involved in the provision of maternal care in Cambodia.

Designation	Training	Role and service level	Numbers	Ratio per 10,000 population (population 2004 = 13.5 million)
Traditional birth attendant	Informal apprenticeship + NGOs and government short courses	Delivery, referral, community support, community based	Not available, but the number of births undertaken by TBAs in homes in 2011 is 198, 36 (=7% of all births) [6]	Not applicable
Primary midwife/primary nurse-midwife	9 months/1 year [7]	Antenatal and postnatal care, immunisation and intended to support secondary midwives at health centres [8]	1063 ⁹ (2004)	0.79
Secondary Midwife	3 years [7]	Antenatal care, delivery and postnatal care and referral and immunisation [8]	1756 ⁹ (2004)	1.3
Post-basic midwife/secondary midwife	3 + 1 year (3 years in nursing and 1 year in midwifery [7])	Antenatal care, delivery and postnatal care and referral and immunisation (for mothers and their infants)	Not available	Not applicable
All nursing midwifery personnel (2008)	11,736 [10]	7.9		
Doctor with midwifery skills	8 years + 6, 12 months midwifery [7]	Delivery (normal and complicated birth) and life-saving interventions (transfusion, caesarean section)	Not available	Not applicable
Obstetrician	8 years + 3 years obstetrics	Manage complicated birth and surgery at the provincial and national hospitals	Not available	Not applicable
Medical assistant	5 years [7]	Delivery and support midwives and assist doctors	1340 (2004)	1
Medical doctor	8 years [7]	General practice and support midwives (when complications occur)	2120 (2004)	1.6

birth attendants?' 'What support did you have in labour?' 'What did staff tell you to do immediately after your baby was born?' 'What do you know about other women's perception of private and public facilities? How do you think this maternity service could be improved?

Data were analysed thematically.²² Participants' responses in Khmer were translated into English and imported into the qualitative data management software NVivo version 8.²³ Analysis involved reading and rereading transcripts to develop a sense of the themes as they related to the research objectives to identify patterns and categories.²³ Each new piece of data was consistently compared with earlier data. Data were then coded into text units and grouped into categories. The categories were defined and clustered into broader themes constituting the descriptive analytic framework for analysis.²⁴ The transcriptions and findings were discussed with the participants improving the veracity of the data and discussed with the other authors to achieve consensus.

3. Findings

Thirty women (20 gave birth in five public health facilities and 10 gave birth in five private health facilities) were interviewed. All women were married with mostly primary school as their highest level of education. Most were housewives (80%), with only 20% reporting paid employment outside the home. Around 70% of women were primiparous and almost two-thirds had attended antenatal visits.

Themes emerged describing women's perceptions and experience regarding the choice and use of maternal health services at public and private health facilities. These included a safe birth; staff attitudes; support during childbirth; and associated fees.

4. Seeking a safe birth

All women reported awareness of current services offered by providers, including home birth and private clinics, health centres and hospitals. Most women were concerned about safety issues leading them to choose SBAs over traditional birth attendants (TBA).

When complications, such as bleeding or convulsions occur, TBAs cannot manage it and finally refers us to the health centre or the hospital. I would rather go to the health centre or hospital as these health facilities have a team of well-trained and competent midwives who could provide life-saving skills during childbirth (#6 & #27).

Women who gave birth at private facilities felt unsafe in the hospital and health centres due to poor midwifery care.

I found that public health service is so slow and no one is really responsible for providing continuity of care. I once was left alone without health staff in attendance. The midwives helped me only for delivery; after the birth, they disappeared. I did not feel safe at all (#5).

4.1. Staff attitudes

Staff attitudes affected the choice of health facility. All women reported that they were reluctant to use or avoided public maternal health services due to attitudes of SBAs.

Many women did not like to go to the health centre or hospital as midwives or doctors were unfriendly (#19 & #12).

Poor women have had negative experiences including impolite and rude behaviour from midwives during childbirth, which may affect our future choice of facility (#2 & #9).

Women who gave birth at private facilities were fearful of giving birth in the public facilities and described negative experiences with public midwives:

During birth, the midwives yelled at me impolitely. They said that I was not clean; my nails were very long and dirty. That's why I had a discharge and smelly odour. I was very scared and ashamed to come here. Therefore, I chose this private health facility for the second birth (#7).

Women stated that leaving home to seek facility-based care was not an easy option due to travel and food expenses and the lack of family support. However, women were prepared to travel if they felt comfortable with providers.

My house is close to the hospital and the fees here are not really expensive, but the staff are so rude. As I live close to the border, I prefer going to hospital [over the border in a neighbouring country] although I need to spend more money on transport, food and family companion because health professionals here are friendly and courteous (#18).

4.2. Support during labour and the immediate postpartum period

All women reported that self-introduction, privacy, confidentiality and an adequate explanation of all procedures by midwives during labour and birth were essential. One woman said:

I did not know who looked after me during childbirth because midwives did not tell me about their names. When I arrived at the maternity ward they asked my history, took my blood pressure and pulse, but did not tell me about this information. Then they told me to get on the table and put their hands into my vagina in front of many people. They told me that I do not need to be shy because women are all the same when giving birth. Actually, I did not want many people to see my genitalia (#20).

Women's choice of personal support throughout labour and birth was also a concern. Birth companions in labour were reportedly not permitted in public health facilities. One woman stated:

I was alone and felt frightened during my birth. Midwives did not ask me whether I wanted my mother, husband or sisters to stay with me or not. If my mother or anyone of my family had stayed with me, I would have felt much stronger and confident to give birth (#16).

Women who gave birth at private clinics expressed their satisfaction with private birth attendants:

My childbirth had been a beautiful experience as my sister and mother were present with me all the time. This was completely different from the time I had my first baby attended by a midwife at the hospital (#22).

Some women perceived that their negative experiences at public hospitals were due to socio-economic status.

As I am poor, midwives did not provide as good reassurance or support for my birth as other women. This was my observation. Midwives spoke with me only a few words and left. I could not ask them as much as I wanted. This may be because I might not be able to make extra-payment (#25 & #1).

Disrespect and physical abuse in public facilities affected choice of facility.

One midwife said that I was the most difficult woman. She slapped me. She also complained that she could not sleep the whole night because of my slow birth (#30).

Women reported that follow-up during postnatal care was difficult to access at public health facilities that were different from those at which they had given birth. One woman expressed disappointment with midwives during postnatal care.

When I gave birth at a different health facility away from my residence, midwives of this health centre are not happy and friendly when providing immunisation to my child. They did not give me any advice or tell me about the next follow-up (#26).

4.3. Perceptions of fees of birth

Fees charged at public hospitals were reportedly barriers to accessing midwives. However, the desire for a safe birth meant that these women were motivated to attend health facilities.

Financial affordability remains a major barrier for poor women to choose qualified midwives; however, many women are scared of delivering at home with untrained providers, such as a TBA who has empty hands and can only deliver a normal birth (#28, #4 & #9).

Women who gave birth at public facilities said that they chose public services as the cost of delivery is cheaper than private facilities and safe for women and their babies.

This hospital charged me only 20,000 riel (=US\$5) for the normal birth. My baby and I were healthy and safe and the fee is cheaper than the private clinics charge. Private clinics charged around 200,000–350,000 riel [\$50–\$80 US dollars] (#17).

Despite the fees being cheaper at public facilities, all women reported that there were additional costs and these fees were much higher than they expected and officially advertised.

... when we delivered our baby at the health centre, midwives charged us two to three times higher than what they declared. The charge includes fees for cleaning the labour room, birth, placenta burial, episiotomy and vacuum extraction, as well as payments in gratitude to the SBAs. We no longer believe in this health centre (#5, #6 & #11).

Another woman expressed disappointment with SBA practice felt forced to pay fees at a public hospital.

The provision of pharmaceuticals was considered part of the cost. The alleviation of pain via anaesthetics during perineal suturing would only occur if a payment was made. When midwives sutured me, they did not use pain relief medication or local anaesthetics unless I paid for that. They sutured me like an animal. The suturing was extremely painful more so than the pain in labour or pushing period (#12).

5. Discussion

Our study provides insight into women's birthing experience of public and private-based maternal care and the factors that affect their access to these services in one province in Cambodia. The choice of health facility was influenced by perceptions of safety, the attitudes of the staff, supportive care during labour and birth, and costs.

Our research shows similarities with studies in other countries concerning staff attitudes, women's birthing experiences and the uptake of maternal services.^{11,25} These studies note women's feelings of discomfort, mistrust and unwillingness to give birth in public health facilities and seek care for complications. Disrespectful SBA behaviour in childbirth can deter skilled health care usage more than other recognized deterrents such as geographic and financial barriers.²⁶

Access to, and use of, skilled birth attendants, especially midwives, is a critical component of the MDGs and an important strategy to improve maternal health. Addressing women's expectations for respectful supportive maternal care is likely to result in user satisfaction and increased use of SBAs.²⁷ Although there are a lack of studies that rigorously evaluate the impact of interventions designed to reduce discrimination and abuse or promote respectful birth care,²⁶ clinical audits and provider training may be useful strategies that could be applied in Cambodia. In Malawi, for example, a clinical audit assessed staff according to how they received women, their attitudes, respect of culture, and for women, provision and proper management of patient information, individualised care, patient waiting time, and confidentiality. Standards for woman-friendly care were achievable, acceptable to, and valued by health providers.²⁸ Other interventions have successfully addressed SBA attitudes and behaviours through education.²⁹

Health care in Cambodia is expensive and the public system is chronically underfunded. User fees were introduced in 1997 to address government funding fluctuations and regulate unofficial fees.³⁰ Informal (unofficial) and additional fees in public facilities are charged by health workers to compensate for low salaries while others seek additional income through private and dual public-private practice.³¹ Most women who gave birth in our study had to pay additional costs, creating extra financial burden and hardship. Furthermore, the dual and unregulated income supplementation practices of Cambodian government health providers may lead to a conflict of interest and distortions in health staff attitudes, productivity and performance³² and contribute to low facility-birth rates and maternal mortality in Cambodia.

The study had a number of limitations, which may affect the generalizability of the results. Firstly, conducting interviews in an area near the postnatal room or health facility might have encouraged some women to give accounts of care that may have been more positive than their actual experience. Secondly, satisfaction with staff attitudes and a successful birthing outcome were regarded as quality care which may not be an adequate benchmark because the education level of all women in this study was low. When a woman's life has been saved, they are likely to show their gratitude or pay in-kind for a safe birth that met their expectations even if those expectations are very low. Moreover, all women recognised that the researcher was a medical doctor and; women who were unhappy with services might have declined to report their negative experiences. Despite these limitations and the non-random nature of the study, it is likely that the findings are relevant to other women's experiences of public and private-based maternity care in Cambodia and in other developing countries.

6. Conclusion

Our findings suggest that expectations of safe birth, staff attitudes, provision of respectful and supportive care and affordable transparent fees have considerable impact on the choice of health facility. While the removal of financial and geographical barriers is important to increasing the utilisation of maternal health services, improvements in maternity care should focus on addressing staff attitudes and enhancing communication skills. Understanding the drivers of health seeking behaviour of women will improve maternal health and develop rational policy and delivery systems to ensure acceptable, accessible and of high quality to all women to accelerate progress towards the MDG 5 targets.

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