Examining Women’s Perceptions of Maternity Care in the public and private sectors of National Guard Hospitals in Saudi Arabia: A Qualitative Study

Background:

Patient satisfaction is considered one proxy for quality of care provided by both doctors and hospitals (Prakash, 2010). Due to multiple components that encompass satisfaction (i.e. care experience, patient engagement, perceptions, and preferences), defining and assessing it can be associated with numerous challenges (13). One definition of patient satisfaction is “a measure of the extent to which a patient is content with the health care which they received from their health care provider” (Farley, 2014). There are three major determinants of satisfaction: patient’s expectation, patient’s characteristics, and patients’ psychological determination (Sitzia & Wood, 1997). Donabedian believes in integrating patients in the care experience and measuring their satisfaction can contribute to quality assurance in a significant way (Donabedian, 1992).

Assessing patient satisfaction is very important, because it represents the patient’s perspective on “the timely, efficient, and patient-centered delivery of quality health care” (Alabri, 2014). Specifically, it provides a benchmark for hospitals to document, monitor, and manage their performance. This helps them make strategic decisions about what to improve. Also, knowing what aspects of care patients value and their expectations helps doctors customize treatment for patients and engage them in their care process (Alabri, 2014).

In order to assess the satisfaction of patients in general, more specifically women seeking maternity care, we should measure both physical and psychological care. Improving women’s satisfaction might increase service utilization in the short term but will lead to better long term outcomes. Understanding what constitutes satisfaction will help policy makers know what services to improve and how to ultimately provide lasting benefits to women’s health. (Tayelgan, 2011).

For decades, women’s voices in the Middle East have been coerced into silence and their points of view have not been considered. In Saudi Arabia, a simple decision, like having an epidural, for example, is made by male guardians rather than women in labor. This is due to respect for Saudi Arabian custom, where males are placed in positions of authority and given the autonomy to make decisions on behalf of women, not because of any political law (Al-Amoudi, 2012 ). Considering women’s perspectives is important because it helps health care providers understand what is important to women, and empowers women to more actively engage into their care. Since Saudi women lives in such society, it is important to explore what women need, how far they know about their rights, and how much they are willing to be engaged to their health care process. More deeply understanding women’s needs when it comes to their health also aligns with the Saudi vision of 2030. The vision of 2030 supports the independence of women in many aspects. Since 2017, women have gained back many rights that were taken from them for decades. A women activist movement “Women’s Health empowerment program, which was founded in 2016, started to educate women, physicians, and medical students about women’s rights in hospitals (Al-Amoudi, 2012). Furthermore, there is an app that Saudi women can download "know your right" which help women to learn about their rights in all aspects of life and health rights in particular. In addition, the Ministry of health runs educational campaigns throughout the year to educate women about their rights (Fiske, 2017). This is not only important for women but for society as a whole, because when women more actively engage in their own care it can lead to better outcomes (Al-Amoudi, 2012). For that, study will assess also how much women know about their rights and how much they want to contribute to their health process.
Involving women in decisions about what kind of care they prefer is one of the key findings in the article “Maternity Satisfaction Studies and Their Limitations: What Is, Must Still Be Best”, in which Dr. Teijlingen and others outline how important it is to increase women’s satisfaction. (2002). Aligned with this study, Dr. Brown and others found out that involving women in the decision-making process, in intra-partum and antenatal stages increases women’s satisfaction (1994).

Based on the Middle East literature review that was searches up to March 2018, women who delivered in the private hospitals usually have higher satisfaction than those who deliver in public hospitals. We want to see if this is the case here in both hospitals that are famous for their high quality of care compared to other governmental hospitals. This study should fill the gap in the Saudi literature because it focuses on comparing satisfaction of women giving birth in public versus private hospitals. In general, there is a lack of comparative studies that measure satisfaction between these two hospital sectors in Saudi Arabia and across the entire Middle East. Most of the existing research studies related to maternity care focus on improving the process of giving birth in order to improve clinical outcomes (Jahlan, 2016). At this time, there is no comparative study that examines women’s satisfaction with their care in the public and private sectors of hospitals in Saudi Arabia. Furthermore, this study assesses and measures how much women know about their health rights and how much they are willing to contribute to decisions made about their health. In addition, this study will assess the concept of patient and family centered care. Patient-centered care is a relatively new concept being applied worldwide, therefore, this study would be the first to assess what women know and understand about this type of care in Saudi Arabia. Furthermore, there is a recent focus on family-centered care in maternity care in western literature (Aaron, 2016). In the western countries, policy makers are trying to involve fathers into the care plan so they can decide with the mothers what the best options are for their child during the birth process. In Saudi Arabia, given its cultural history and respect for male authority, we to explore what conditions exist in order to implement policies that allow women to participate more actively with fathers regarding what the best birth options are for their child. Health care providers should be interested in these findings because it has been shown that patient and family centered care can lead to better outcomes for mother and baby (Aaron, 2016).

10. **Objectives of the Study:**

10.1 **Aim of the Study:**

The objectives of this study are:

1.) To compare how satisfied mothers are with the care provided to them in the public and in the private sectors of each hospital

2.) To examine the perceptions of women regarding patient-centered kind of care in public and private sectors of each hospital

3.) To assess the willingness of these women to engage in decisions related to their care process and to know mothers’ goals and priorities as it relates to their maternity care.

10.2 **Specific Objectives:**

**Specific Objective 1:**
To compare satisfaction of mothers regarding their experiences during giving birth in private versus public sections in two National Guard hospitals.

**Specific Objective 2**
- **a:** To assess how far women know about patient-centered care
- **b:** Compare women’s perceptions what constitutes patient-centered care and shared decision making between private versus public sectors of the hospitals.
Specific Objective 3
a: To understand the roles and desired level of the mothers to participate and engage in patient centered care by being involved in decisions related to their delivery and follow-up care
b. To examine how their goals, values, and priorities can be integrated into the maternity care.

11. Materials and Methods:

This study is a qualitative study that applies a grounded theory approach. Eligible patients will be recruited in their patients’ rooms after delivery to participate in semi-structure one-to-one interviews. Discharged patients who want to participate into the study will be reached via phone on their convenience. Nurses will distribute recruitment flyers (see Appendix A for sample) to all eligible patients. The main researcher and the co-investigators will work with the clinical partner, Dr. Shams, to determine patients that meet inclusion/exclusion criteria, and assessing the good health. Those who agree to participate will be interviewed in their rooms. The contact information will be provided in the flyers so discharged patients will be able to be reached via phone or the co-investigators can meet them in an affiliated clinic in the hospital. All interviews will be recorded and an Arabic transcription will be done using a secured app (Transcribe) and then translated into English for analysis.

Recorded interviews will be stored on an Olympus recorder. They will be transferred to a secure computer and turned into an MP4 for transcription. No identifying information about the patient will be recorded in the interview. The interviews will be transcribed into a PDF for coding and theming by the co-investigators. The transcriptions will be backed up on a thumb drive which will be kept in a locked location with the primary investigator. Transcriptions will be viewed by approved co-investigators on the project and kept only for the study purposes.

A grounded theory approach will be used to analyze the transcriptions (Bernard, 2011). Investigators will independently and follow steps of: familiarization with transcripts, coding, developing a working analysis, creating the application of a working analytical framework, charting data into a matrix, and lastly, interpretation (Gale, 2013). Co-investigators will apply an inductive analysis technique wherein the raw data will be reviewed to identify patterns, ideas, or key themes that emerge (Thomas, 2006). Investigators also will use the ‘constant comparison’ technique to review data to ensure that the full breadth of concepts emerge from the raw data. Investigators will review each unit of data several times to allow for meaningful concepts to emerge and to make connections between those concepts. Data will be continually compared and reviewed until we reach saturation, wherein no new themes or ideas appear to emerge from the data.

Coding is the process for categorizing the data into meaningful categories. Initially, three investigators will use open coding techniques to generate an initial list of emergent ideas or ‘codes’. To ensure inter-rate reliability, they will co-code five interviews independently. After independent review, the three individuals will compare their coding schemes, discuss discrepancies, and reach consensus on a coding scheme. Codes will be synthesized into a list or ‘code book’ that will outline each code and its description. Following the initial open coding process, we will move to selective coding wherein remaining interviews will be categorized based on the established categories outlined in the codebook. The selective coding process will generate themes to illustrate and explain the observations in the study. Finally, themes will be summarized, identifying any emergent concepts that may be developed into a theoretical model for future study.

The theoretical model will allow co-investigators to describe commonalities, patterns, and major themes that emerge from the transcripts. We will compare the findings within and across both hospitals. Pending approval of the National Guard Institutional Review Board, the data collection process will start in July 2018 and run through December 2018 or until the 80 participant sample size is reached.
11.1 Study Area/Setting:

King Abdulaziz medical city (KAMC) in Jeddah and in Riyadh. Both the public and the private sections of each hospitals will be covered.

11.2 Study Subjects:

**Inclusion criteria:**
1. Women who are adults (>18)
2. Gave birth to a healthy child. The child should be there second or subsequent birth.
3. Able and willing to provide informed consent for participation.
4. In a good status of health (physically and mentally).

**Exclusion criteria:**
1. Unable or unwilling to provide informed consent for participation.
2. Not in good health status (physically and mentally).
3. Patients who gave birth outside the delivery room.

11.3 Study Design:

Cross-sectional qualitative study.

11.4 Sample Size:

It is anticipated that a total of 80 participants (20 participants for each section (public and private) across both hospitals (Jeddah and Riyadh). In the National Guard hospital in Jeddah, we anticipate collecting data from a maximum of 20 mothers from the private section and a maximum of 20 mothers from the public section. The number of participants will be interviewed in the hospital in Riyadh. 80 total participants will ensure that saturation of important themes across each aim is reached and no new information emerges from the participants.

11.5 Sampling Technique:

Semi-structured based on the eligibility and what fits the inclusion criteria.

11.6 Data Collection methods, instruments used, measurements.

Eligible patients will be recruited in their patients' rooms after delivery to participate in semi-structure one-to-one interviews. Discharged patients who want to participate into the study will be reached via phone on their convenience. Nurses will distribute recruitment flyers to all eligible patients. The main researcher and the co-investigators will be working with the clinical partner, Dr. Shams, to determine patients that meet inclusion/exclusion criteria, and assessing the good health. Those who agree to participate will be interviewed in their rooms. The contact information will be provided in the flyers so discharged patients will be able to be reached via phone or the co-investigators can meet them in an affiliated clinic in the hospital. All interviews will be recorded and an Arabic transcription will be done using a secured app (Transcribe) and then translated into English for analysis.

11.7 Data Management and Analysis Plan:

Recorded interviews will be stored on an Olympus recorder. They will be transferred to a secure computer and turned into an MP4 for transcription. No identifying information about the patient will be recorded in the interview. The interviews will be transcribed into a PDF for coding and theming by the co-investigators. The transcriptions will be backed up on a thumb drive which will be kept in a locked location with the primary investigator. Transcriptions will be viewed by approved co-investigators on the project and kept only for the study purposes. Vivo qualitative software will be used for analysis.
A grounded theory approach will be used to analyze the transcriptions (Bernard, 2011). Investigators will independently and follow steps of: familiarization with transcripts, coding, developing a working analysis, creating the application of a working analytical framework, charting data into a matrix, and lastly, interpretation (Gale, 2013). Co-investigators will apply an inductive analysis technique wherein the raw data will be reviewed to identify patterns, ideas, or key themes that emerge (Thomas, 2006). Investigators also will use the ‘constant comparison’ technique to review data to ensure that the full breadth of concepts emerge from the raw data. Investigators will review each unit of data several times to allow for meaningful concepts to emerge and to make connections between those concepts. Data will be continually compared and reviewed until we reach saturation, wherein no new themes or ideas appear to emerge from the data.

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12. Bibliographic References:


13. **Ethical Considerations:**

Data confidentiality is of utmost concern. Transcripts generated from interviews will be confidential and only members of the research team will have access to them. In addition, participants will never be personally identified in any presentation of this data. Both hard and soft copies will be saved in a secure locations within NGHA premises in which only research member team will have an access.