Chapter – II

Review of Literature
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This chapter gives a broad view of the research already conducted in the area of maternity health services. The approaches of various researchers towards various facets and their implications are also discussed. This chapter throws light into an area of research which has not been discovered much in our region.

Maternal health is the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality.

Prenatal/Antenatal care can include education, health promotion, screening and other interventions among women of reproductive age to reduce risk factors that might affect future pregnancies. The goal of prenatal care is to detect any potential complications of pregnancy early, to prevent them if possible, and to direct the woman to appropriate specialist medical services as appropriate. Prenatal care generally consists of: monthly visits to the doctors during the first two trimesters (from week 1–28), fortnightly visits to doctor from 28th week to 36th week of pregnancy and weekly visits to doctor after 36th week till delivery. Physical examinations to identify complications in pregnancy if any, are a routine of prenatal/antenatal visits. These tests consist of i) Collection of patient’s medical history ii) Checking blood pressure & height and weight iii)undergoing
blood and urine tests iv) Fetal heart rate monitoring and discussion with caregiver.
Ultrasound scans are most commonly performed during the second trimester at approximately week 20 to check for multiple fetuses, assess possible risks to the mother and to check for fetal malformation. They are generally ordered whenever an abnormality is suspected or along a schedule of seven weeks to confirm pregnancy or determine due date, at 13–14 weeks, 18–20 weeks and after 34 weeks evaluate size, verify fetal position. Postnatal care issues include recovery from childbirth, concerns about newborn care, and nutrition. (WHO, maternal health).

**MATERNITY SERVICES**

Kenney AM, (1986) reports that the federal and state governments spend almost $1.2 billion annually for maternity care (including prenatal, postpartum and newborn care); the average expenditure per patient is $2,200. Tennessee reports the highest expenditure per patient ($3,500) and Louisiana the lowest ($1,300). Medicaid pays for about 10 percent of the nation's maternity care bill, although Medicaid subsidizes deliveries for 15 percent of all women who give birth. They do not include Medicaid expenditures for neonatal intensive care. Increased Medicaid payments for maternity care, including prenatal care, could have a positive impact on health outcomes for low-income mothers and their babies, and could reduce the necessity for massive and expensive medical treatment for newborns.
S.W. Lowe, (1987) investigates the outcome of labour of 185 low-risk pregnancies at an isolated general practitioner maternity unit was compared with that for 185 comparable low-risk pregnancies at a specialist maternity hospital. No difference was found in mode of delivery although significantly more women in the general practice group received analgesia beyond nitrous oxide. There was a significantly higher level of intervention in labour in the maternity hospital group in the form of fetal monitoring and augmentation of labour. The results suggest that where considerations for selection of low-risk pregnancy permit, the general practice maternity unit can provide a distinctive style of intrapartum care with minimum intervention.

Otolorin EO et al, (1988) discusses the prevalence of high-risk pregnancies at the tertiary level hospital was higher than that of the secondary level hospital. Consequently, the cesarean section rate was higher. Similarly, the maternal mortality and perinatal mortality were significantly higher than at 2.0 per 1000 and 9.8 per 1000, respectively.

Factors affecting the outcome of maternity care. 1. Relationship between staffing and perinatal deaths at the hospital of birth.

J Stilwell, (1988) investigate the relationship between resources (such as staff and equipment) and the outcomes of births at maternity units. Considerable variation in medical and nursing staffing levels in the units in the study was observed. After taking account of differences in very low weight births at each unit, the level of paediatric staffing at a maternity unit is a significant factor in
explaining differences in "in house" mortality. There was no identifiable relationship between staff categories other than paediatricians and the rate of perinatal death at the hospital of delivery.

Fauveau V et al, (1991) has proposed various community-based interventions to improve maternity care, but hardly any studies have reported the effect of these measures on maternal mortality. The efficacy of a maternity-care programme to reduce maternal mortality has been evaluated. The effect of the programme was evaluated by comparison of direct obstetric maternal mortality ratios between the programme area and a neighbouring control area without midwives. It was suggested that maternal survival can be improved by the posting of midwives at village level, if they are given proper training, means, supervision, and back-up.

P A Buescher et al, (1991) reports that care coordination is an important component of the enhanced prenatal care services provided under the recent expansions of the Medicaid program. Among women on Medicaid who did not receive maternity care coordination services, the low birth weight rate was 21% higher, the very low birth weight rate was 62% higher, and the infant mortality rate was 23% higher than among women on Medicaid who did receive such services. He suggests that maternity care coordination can be effective in reducing low birth weight, infant mortality, and newborn medical care costs among babies born to women in poverty.
Lorraine V. Klerman, (1992) discusses about the barriers to maternity services found in America and suitable suggestions. Offering several services in one place at one time (co-location) can also reduce travel-related barriers. Sometimes it is more effective to serve patients within the framework of their cultural beliefs than to try to change them or to ignore them. Another personal barrier is inadequate information about the need for care. Lack of motivation, depression, geographical barriers are the common reasons for seeking prenatal care late or holding negative attitude towards prenatal care.

Midmer DK. (1992), identifies that the focus has shifted from technology orientation to personalization, from birth as a biomedical event to birth as a normal developmental task. Emotional and psychosocial needs of the childbearing family are given more importance by theses family centered maternity care centres. A woman-centered childbirth model that shifts the emphasis back onto the mother is viewed as the key principal in childbirth and grants her the mandate to personalize her birth to suit both her needs and the needs of her family.

L F Smith, (1996)argued that maternity care provision by general practitioners is a central and essential part of British general practice. Specifically, it is shown how general practitioners can help to achieve the objectives of the report, and have a future role. It is suggested that all general practitioners who wish maternity care to remain an essential part of general practice need to argue the case with providers and purchasers. If not, then it is quite likely that general practitioners will be increasingly excluded as the commissioning and contracting
mechanisms become more effective with midwives providing low-risk care and consultant obstetricians high-risk care.

Marjorie Tew., (1998) shares his views about confinement in hospital is safer for certain types of patient, where the risks are high, it must also be safer for cases where the risks are less”. The shift to hospital birth has been one of the great sociological changes in the industrialized world in the past 50 years.

Singh M, Paul VK, (1997) the health pyramid does not function effectively because of limited resources, communication delays, a lack of commitment on the part of health professionals, and, above all, a lack of managerial skills, supervision, and political will. The allocation of financial resources for the delivery of health care continues to be meager. Nevertheless, in spite of obvious constraints, there has been laudable progress in reducing post-neonatal mortality in recent years. Indeed, the focus has shifted to the young infants and the perinates. India is on the threshold of an extraordinary improvement in the status of its neonatal-perinatal health.

Syed Saad Andaleeb, (2000) has analysed the quality of services provided by public and private hospitals in Bangladesh. The quality of hospital services would be contingent on the incentive structure under which these institutions operate. Since private hospitals are not subsidized and depend on income from clients they would be more motivated than public hospitals to provide quality services to patients to meet their needs more effectively and efficiently. Patient perceptions of service quality and key demographic characteristics were also used
to predict choice of public or private hospitals. It is proposed that four other incentives be considered to promote higher quality in hospitals in Bangladesh.

G.S. Lule et al, (2000) reveals that the antenatal attendance and place of delivery of women in Chilomoni health centre catchment area and how they perceived the quality of health care provided at the health centre. It was found that few women use Chilomoni health centre for antenatal services and still fewer use it for delivery. Reasons for not using the health centre included refusal by the family members and the poor facilities at the health centre. We recommend that the facilities at Chilomoni health centre be improved immediately.

Rebecca Sutha, (2001), explore how physician scarcity as well as the growing presence of registered midwives in Ontario, affects women's experiences of having children in rural parts of Ontario. The study reveals the importance and limitations of rural areas as a determinant of health, notions of expectations, satisfaction and informed choice in a rural context. Finally, features of a maternity care system designed with the needs of rural women are outlined.

Mwaniki PK et al, (2002) reveals that utilisation of health facilities for maternity services is significantly influenced by number of children and distance to health facility. Mothers living less than 5 km to a health facility utilised the services better than those living 5 km and beyond. Coverage for antenatal services was high among mothers during their last pregnancy. Among the reasons given by the mothers regarding dissatisfaction with the services offered included shortage
of drugs and essential supplies, lack of commitment by staff, poor quality of food and lack of cleanliness in the health facilities.

Helen Stapleton et al, (2002) examines the use of evidence based leaflets on informed choice in maternity services. Health professionals were positive about the leaflets and their potential to assist women in making informed choices, but competing demands within the clinical environment undermined their effective use. Time pressures limited discussion, and choice was often not available in practice. Women's trust in health professionals ensured their compliance with professionally defined choices, and only rarely were they observed asking questions or making alternative requests. The visibility and potential of the leaflets as evidence based decision aids was greatly reduced.

Carlos Manuel Valente Quiterio Simão, (2001) observes that waves of technology incorporation and scientific discovers, have driven the health sector from reliance on direct communication and physician experience, to a higher reliance on technology and community information. Providers gained access to larger market, patients could obtain local treatment, advice or other form of care, without expensive and time demanding trips to specialized centres, etc. the study focuses on the change of business relations among health sector players on the introduction of internet services. It was analyses that internet would enable information access, improving consumers’ knowledge and leading to better informed health decisions. This empowerment of the consumer, plus Internet disintermediation characteristics, should attract players, and increase market
competitiveness leading to new services, higher efficiency and easier access to care also reducing health expenditure, shifting it from treatment to prevention.

Peltier et al, (2002) focuses on the patient-provider relationship in obstetrics services. Healthcare providers need to understand what women and their families are looking for in the birthing experience and how these needs change as they move from pre-delivery services to labor-oriented services to post-delivery services. The author feels that the role caregivers play at different points in the birthing experience should be better defined. By gaining a better understanding of how patient-provider relationships evolve throughout the birthing experience, healthcare providers can better design the quality of their obstetrics services, and increase loyalty. It is noted that research in obstetrics care has shown an over-reliance on static measures of relationship strength.

Shariff, (2002) discuss the issues associated with the demand and supply of the five measures of maternity care-antenatal care, blood pressure check up, place of delivery, use of trained help at the time of delivery and postnatal care. Analysis shows that education and information variables significantly increase the utilisation rates for prenatal, child delivery and postnatal health care. Women with primary education are more likely to use maternal health services as compared to illiterate women, even after controlling for income and health care supply factors.

Peter Lachman and David Vickers (2004), assesses the opportunity for service developments that allow the holistic needs of children and pregnant
mothers to be met. Key to this is the recognition that children and young people are different and individuals in their own right, with specific requirements which can be met only by reorganisation of service delivery. This requires a change in how health professionals and managers view maternal and child health and a reassessment of how parents, children, and young people participate in and are consulted in planning services.

Margaret Maimbolwa, (2004) describes the prevalent maternity care routines during normal child birth in Zambian maternities and the views of staff, newly delivered mothers and social support women (relatives, friends) on providing extra social support to laboring women. It also measures the effects of extra social support to primiparous women during labour, on labour outcomes and mother’s early child birth experiences.

Ndola Prata et al, (2004) examines the costs of maternal health care in Tanzania, and how much can we expect households to contribute to these expenses. He estimates current spending on maternal health care by different socio-economic groups and its share in relation to total household expenditures and the effect of the prices paid for maternal health care on the likelihood of using antenatal and safe delivery services, controlling for relevant socio-economic and demographic factors.

Claudia von Both et al, (2006) reports that Antenatal care (ANC) is a widely used strategy to improve the health of pregnant women and to encourage skilled care during childbirth. She identifies the time health workers currently
spend on providing ANC services and compare it to the requirements anticipated for the new ANC model in order to identify the implications of focused ANC on health care providers' workload. The average time health workers currently spend for providing ANC service to a first visit client was found to be 15 minutes; the provision of ANC according to the focused ANC model was assessed to be 46 minutes.

Sonalde Desai et al., (2006) There is great regional variation on utilization of maternal health care services across India. He argues that the observed regional differences in India reflect two major dimensions affecting maternity care utilization: (1) Marriage and kinship patterns which determine the extent to which households are willing to invest in women’s health; and (2) Characteristics of the state and civil society which determine the extent to which households are willing to trust medical systems.

Barbara A. Hotelling, (2007) reports that every woman should have the opportunity to have a healthy and joyous birth experience and to give birth as she wishes in an environment in which she feels nurtured and secure and in which her emotional well being, privacy and personal preferences are respected. She should have access to the full range of options for pregnancy, birth, and nurturing her baby, receive accurate and up-to- date information about the benefits and risks of all procedure, drugs and tests and be allowed the rights of informed choices about what is best for her and her baby based on her individual values and beliefs. Go to:
Shah IH, Say L., (2007) reveals that maternal mortality continues to be the major cause of death among women of reproductive age in many countries. Maternal deaths and mortality ratios were highest in sub-Saharan Africa and southeast Asia and low in east Asia and Latin America/Caribbean. Only 61% of women who delivered in a health facility in 30 developing countries received post-partum care, and far fewer who gave birth at home. Countries with maternal mortality ratios of 750+ per 100,000 live births shared problems of high fertility and unplanned pregnancies, poor health infrastructure with limited resources and low availability of health personnel. The task ahead is enormous.

Department of Health, (2007) defines ‘Woman-centred care’ as the term used to describe a philosophy of maternity care that gives priority to the wishes and needs of the user, and emphasises the importance of informed choice, continuity of care, user involvement, clinical effectiveness, responsiveness and accessibility. Rouselle F. Lavado, (2007) analyses the primary health care utilization in Philippines. It concludes that most of the budgeted health expenditures is allocated to curative care and a very small amount is transferred to preventive care. There is inequality in utilization of health care services across economic classes and regions. The improvements shown in the national health care utilization reflects the participation of the rich and the poor remain to be marginalized. The study mainly calculates inequalities in maternal and child care utilization services.
Meredith J McIntyre et al, (2008) revealed the consumer influence advocating a move away from obstetric-led maternity care for all pregnant women appears to be synergistic with the ethos of corporate governance and a neoliberal approach to maternity service policy. The silent voice of one consumer group (women happy with their obstetric-led care) in the consultation process has inadvertently contributed to a consensus of opinion in support of the reforms in the absence of the counter viewpoint.

Helen Magee, Janet Askham, (2008) has made an attempt to obtain the views of women with recent birth experiences about the safety of the maternity care they received, to inform the King’s Fund inquiry into the safety of maternity services in England. The key objectives of the study were to provide an opportunity for women to identify their own areas of concern around safety, and possible solutions to these and to explore in more detail the extent to which women are aware of and have concerns about factors related to safety (such as communication and quality of working relationships between staff).

Anuja Jayaraman, S, (2008) examines the factors affecting maternal health care seeking behavior in Rwanda. It provides insight that progress towards increasing the share of assisted deliveries has been slow. There has been no significant increase in the proportion of women seeking antenatal care. This could partially explain why a large proportion of women continue to deliver at home without professional assistance.
Evans, Rebecca Jane, (2009) identifies the prominent policy influences on rural maternity care to understand the lived experiences of residents who provide or access this care in rural north Queensland. It was clear that rural communities still valued local maternity services, especially birthing workforce insufficiencies remained the biggest threat to the sustainability of rural maternity units. Despite the considerable policy attention that has been paid to rectifying the misdistribution of medical practitioners, recruitment and retention difficulties still caused major problems for all the maternity units. The quality of care experienced by rural residents was profoundly affected by the downgrading of rural maternity services in a number of ways. Most obviously, the loss of services caused less equitable geographic access to care. This led to the introduction of more carers and facilities.

John Fry, (1984) has analysed that maternity services have changed in quality and quantity. Standards of care as shown in infant and maternal mortality rates have improved greatly. Birth rates have fallen markedly.

Maggie Redshaw and Katriina Heikkila, (2010) have identified that a large proportion of women indicated that their pregnancy was planned. Contact with a health professional about maternity care had taken place for almost all women by the end of the twelfth week of pregnancy. The booking appointment had taken place for nearly two-thirds of women by 10 weeks and almost all by 18 weeks’ gestation. There was some regional variation in the health professional first seen, the timing of first contact and of the booking appointment. The median number of
antenatal checks was 9 for women who had previously given birth and 10 for women having their first baby.

Alex Smith et al, (2010) attempts to define a future role for General Practitioners in pre-conception, antenatal and postnatal care and discuss the merits of shared care between GPs and midwives. They have summarized the current role of General Practitioners play in maternity services and what current guidance says about the role of the General Practitioners in maternity care. We conclude with a discussion of the potential role General Practitioners could play in maternity care.

Priya Anant et al, (2012) have identified maternal and child health care as a priority area and extends support to creative people and effective institutions committed to reducing maternal and child morbidity and mortality.

Sanjay K. Mohanty, (2012) discusses the inequalities in the utilization of maternal health care services is often confined to only the economic domain. Individuals and families living in acute poverty may simultaneously experience multiple dimensions of deprivation, which together may obstruct their access to basic health services. He emphasizes the importance to examine the linkages between multiple deprivations and maternal health care.

Mohammad Masudul Alam et al, (2012) analyses that the performance-based incentive introduced at the institutional level increased the overall quality of care after the interventions with the simultaneous increase in the quantity of antenatal, postnatal and institutional delivery at the facilities. Incentive payments to management, services, administrative and support staff based on their level of
efforts contributed to ensure teamwork, motivation and performance level as a way to improve outcomes.

Eric Arthur, (2012) investigates the effect of wealth on maternal health care utilization in Ghana. The results have revealed that wealth still has a significant influence on adequate use of Antenatal care. Education, age, number of living children, transportation and health insurance are other factors that were found to influence the use of Antenatal care in Ghana. There also exist considerable variations in the use of Antenatal care in the geographical regions and between the rural and urban dwellers. It is recommended that to improve the use of Antenatal care and hence maternal health care utilization, some means of support is provided especially to women within the lowest wealth quintiles, like the provision and availability of recommended medication at the health center; Secondly, women should be encouraged to pursue education to at least the secondary level since this improves their use of maternal health services.

Gina M A Higginbottom et al (2012), identifies specific crucial points in care delivery, providing tailored solutions for policy and practice changes. The study reveals the experiences of immigrant women in Canada accessing maternity-care services and focuses on accessibility and acceptability as an important dimension of access to maternity-care services, as perceived and experienced by immigrant women and birth and postnatal outcomes.

Thi Hai Ha Hoang, (2012) identify the needs of women in maternity care in rural areas, examines the current available maternity health services in rural
Tasmania and identifies the gaps between the needs and services. The research indicates a set of unmet maternity needs of women in rural Tasmania namely access needs, safety needs, needs for small rural birthing services, information and support needs, and needs for quality services.

Edwin Poots (2012) A Strategy for Maternity Care in Northern Ireland explains the aim of this Maternity Strategy is to provide high-quality, safe, sustainable and appropriate maternity services to ensure the best outcome for women and babies in Northern Ireland. In doing so it is recognised that all health and social care staff and members of the public must work together if health and social care maternity outcomes are to be improved, not just for mother and baby, but for both parents and the wider family. This is because clinical treatment, emotional care and social factors are inextricably linked during a woman’s pregnancy.

Singh PK et al, (2012) documents several socioeconomic and cultural factors affecting the utilization of maternal healthcare services among rural adolescent women in India. He has insisted that the ongoing healthcare programs should start targeting household with married adolescent women belonging to poor and specific sub-groups of the population in rural areas to address the unmet need for maternal healthcare service utilization.

Raghvendra Narayan, (2012) reveals the number, disease pattern and outcome of patients admitted to a neonatal intensive care unit (NICU) at a high altitude having catchment areas of patients at about the same level. It was found
that the most common cause of death was prematurity followed by birth asphyxia. Study showed relatively increased incidence of neonatal jaundice and decreased neonatal infections at high altitude.

Lesley Page, (2013) discusses the importance of the midwife mother relationship, as well as the purpose of this relationship which is central to maternity care - “caring for the mother and providing a safe space in which she can develop confidence in her own ability to give birth and mother her baby”. Giving mothers confidence in birth and mothering is crucial to modern maternity care, fundamental to our work, the work of all who provide maternity care, but that requires midwifery rooted in the community, built on a relationship with women.

Pandhye RP et al, (2013) reveals that there are differences in percentage receiving postnatal care across rural-urban areas, caste groups and household asset index based groups. Place of delivery, type of health facility and maternal age also contributed to access to postnatal care.

Sheth J K et al, (2013) analyses that minimum three antenatal visits were done by 61.3 per cent with government hospitals. Total 86.3 per cent of them were properly vaccinated for Tetanus Toxoid. Institutional deliveries were 94.3 per cent and 96.2 per cent of the deliveries were conducted by skilled birth attendant. Postnatal visits were done in 48.6 per cent of women.

India need focused programs for rural, uneducated, poor adolescent women so that they can avail themselves of measures to delay child bearing, and for better antenatal consultation and delivery care in case of pregnancy. This study strongly advocates the promotion of a comprehensive ‘adolescent scheme’ along the lines of ‘Continuum of Maternal, Newborn and Child health Care’ to address the unmet need of reproductive and maternal healthcare services among adolescent women in India.

Priyanka Dixit et al., (2013) aims to examine the net impact of Antenatal care visits on subsequent utilization of child immunization after removing the presence of selection bias. Nationwide data from India’s latest National Family Health Survey conducted during 2005–06 is used for the study. The analysis has been carried out in the two separate models, in the first model 1–2 Antenatal care visit and in the second model three or more Antenatal care visits has been compared with no visit. This also indicates that antenatal clinics are the conventional platforms for educating pregnant women on the benefits of child immunization.

I.L. Nwaeze, (2013) evaluated clients’ perception of antenatal care quality at the University College Hospital (UCH), Ibadan and determined levels of client satisfaction. There is a high overall level of satisfaction with antenatal services among pregnant women. Policy makers and health providers should however address improvement of amenities, reduction of waiting time and ensure that health interventions are available for all clients.
SERVICE QUALITY IN MATERNITY SERVICES

The quality of health service refers to a health service that meets the needs and wishes of patients and provides them gently in time. The various dimensions of quality in maternity services as viewed by the researcher indicate:

**Tangibles:** The appearance of touchable material objects by the patient such as medical tools and equipment, hospital appearance and exterior workers appearance and so on.

**Reliability:** The extent of reliance on the service provider's ability to deliver service accurately and as promised

**Responsiveness:** The desire level of providing service to the patient with the necessary speed and on-demand

**Assurance:** Knowledge and politeness of service providers and their ability to promote an atmosphere of trust and safety to the patient

**Empathy:** Personal care and attention provided by the hospital to the patient

**Satisfaction:** If the patient being pleasant or non pleasant after receiving the health service. The previous studies which relate to this area are discussed as under:

Emin Babakus and W Glynn Mangold,(1991) evaluates a comprehensive service quality measurement scale (SERVQUAL) for its potential usefulness in a hospital service environment. Active participation by hospital management helped to address practical and user-related aspects of the assessment. The completed expectations and perceptions scales met various criteria for reliability and validity.
Suggestions are provided for the managerial use of the scale, and a number of future research issues are identified.

Donald J. Shemwell & Ugur Yavas, (1999) develops and tests a model of service quality specific for hospitals domain. The research focused more on technical quality than on functional quality. It is designed for managers to extract maximum amount of – and usefulness of information. The author has identified three sets of attributes which dominate customer choice decisions, they are search, experience and credence.


Connor et al, (2000) assesses how well physicians, health administrators, patient-contact employees, and especially medical and nursing students understand patient expectations for service quality as measured by the SERVQUAL scale. Using a cross-sectional research design and discriminant analysis, it was found that health administrators were most likely to accurately estimate the service
expectations of patients, while medical and nursing students were most likely to underestimate them.

Fogarty, G., et al., (2000) reports the performance component of the Service Quality scale (SERVQUAL), has been shown to measure five underlying dimensions corresponding to Tangibles, Reliability, Responsiveness, Assurance, and Empathy (Parasuraman, Zeithaml, & Berry, 1988). Exploratory and confirmatory factor analytic techniques were used to explore the dimensionality of the scale. Rasch analysis was employed to gain insights into the behaviour of the items.

Victor Sower et al., (2001) creates a model of hospital quality to include the health care customers perspective in the definition of quality. The study examines the theoretical dimensions of service quality validated by health care providers and customers. The Key Quality Characteristics Assessment for Hospitals scale, which uses gap analysis to determine the allocation of resources for quality improvement was developed. It identifies quality over time and keeps track of the areas within the specific hospital which requires improvement.

NSW Health, (2003) have focused on the need to provide continuity of care and to increase birthing choices for women. In particular, these reports have identified the need for greater access to primary care services for women with low risk pregnancies. In several states there is evidence of reorganization of maternity services to achieve this. Impetus for movement in this direction is being provided
by the growing commitment to evidence based, consumer-focused models of public sector health care, as well as changes in the maternity workforce.

M. Sadiq Sohail, (2003) examines and measures the quality of services provided by private hospitals in Malaysia. Empirical research was used to determine patients’ expectations and perceptions of the quality of service, and a comprehensive scale adapted from SERVQUAL is empirically evaluated for its usefulness in the Malaysian hospital environment. Results based on testing the mean differences between expectations and perception indicate that patients’ perceived value of the services exceed expectations for all the variables measured.

Majd Abd Al and Rhman Fareed Al Adham, (2004) investigates the possibility of applying quality management approaches in health care system through the identification of the level of services in Nablus hospitals and to search for possible factors affecting the level of offered services. The study also aims at finding out to what extent these hospitals implement the criteria and the standards of quality management. A direct relationship between overall hospital care processes and patient satisfaction, where patient satisfaction is directly related to attitudes and perception of employees as they in turn related to the hospital services is found. The results also showed that total quality management criteria are not considered as hospital criteria’s. In conclusion a proposed model for the improvement of the existing system was suggested.

Dat van Duong et al, (2004) examine the feasibility, reliability and validity of a 20-item scale for measuring perceived quality of maternity services provided
at commune health centres in rural Vietnam. Except for two items: ‘good clinical examination’ and ‘adequacy of health workers for women’s health’, the scale exhibited good agreement. Respondents were positive on items related to the dimensions ‘interpersonal aspects of care’ and ‘access to services’, but negative on the dimensions ‘health care delivery’ and ‘health facility’. The maternity status of clients was found to influence the perceived quality of maternity services.

M. Tauqeer Mustafa Choudhry, (2005) find out different aspects, perspectives and necessities of a quality maternity care department and then to analyze the interventions implemented in different countries to improve quality of maternity care and how has this improvement in quality affected maternal mortality. He has concluded that criterion-based clinical audit was proposed to improve the quality of maternal health services in Pakistan.

Tracey S. Dagger et al, (2007) empirically validated a multidimensional hierarchical scale for ensuring health service quality and investigated the scale’s ability to predict important service outcomes, namely, service satisfaction and behavioral intentions. The research identified nine sub dimensions driving four primary dimensions, which in turn were found to drive service quality perceptions. The primary dimensions were interpersonal quality, technical quality, environment quality, and administrative quality. The sub dimensions were interaction, relationship, outcome, expertise, atmosphere, tangibles, timeliness, operation, and support. The findings also support the hypothesis that service quality has a
significant impact on service satisfaction and behavioral intentions and that service quality mediates the relationship between the dimensions and intentions.

Wan Zahari et al, (2008) measure Service Quality in local authorities through development of instrument of FM-SERVQUAL. Basically, Service Quality is an abstract and elusive phenomenon due to its characteristics; intangibility, heterogeneity and inseparability between process and output. These characteristics causes Service Quality standard difficult to measure and evaluate. In evaluating service quality, FM-SERVQUAL instrument has been developed based on Integrated Facility Management Framework which involves the measurement of 40 elements of components of human capital, premises management, technology and ICT and working processes. This study involves Johor Bahru City Council as a case study. Two phases of data collection is carried out. In the first phase, 100 respondents were involved while in the second phase, 191 respondents were involved. From the analysis, it showed that, five (5) elements in management of technology and ICT and six (6) elements of property management were below the Service Quality level. Meanwhile, most of the elements of other services were at minimum quality level. Therefore, the SERVQUAL instrument under the Integrated Facility Management Framework, which was developed through an empirical basis, is able to measure Service Quality in such environment. Besides as an effective diagnostic tool in identifying a lacking quality element of services, Facility Management -SERVQUAL also
serves as an essential gauge in policy formulation and future planning of an organization.

Rishard M.H.N & Kodithuvakku S.S., (2008) analyses the extent to which government hospitals meet the expectations of the internal and external customers. Poor service quality was evident through the high service quality gaps that prevailed in the relation to the patients, doctors and nurses which also differed among different divisions of the same hospital. The main factors affecting the service quality of the studied hospital was found to be the negative attitude of the service providing staff and the inadequate training and resources.

Hardeep Chahal, (2008) observes that in order to sustain patient loyalty, quality of interpersonal experiences with the staff, operational quality of hospital operations and overall satisfaction and quality of the healthcare services, are to be understood in-depth in both public as well as private organisations. The outcomes of service quality (customer relationship management and loyalty) are most significant performance measurement tools in the present competitive market. The researcher makes an effort in this regard to identify the factors in sustaining customer longevity. Till today few studies in the developing settings were conducted to understand the types of relationship that exists between patient-loyalty and service quality. This study analyses the suitability of customer loyalty concept in the government hospitals through using a case study of one of the biggest hospitals operating in India.
Healthcare Commission Maternity Review (2008) focused on the entire maternity pathway from the start of pregnancy through to postnatal transfer of care by a midwife to the health visiting services. It emphasized that the trusts should monitor the pathway of care from first contact with the maternity services to the time of transfer to the health visiting service, and ensure that care complies with guidance for antenatal, intrapartum, mental health and postnatal care. They should ensure that there are sufficient numbers of appropriately qualified staff available to provide a high level of care, regular and effective mechanisms for gathering and acting on the views of women using their services, and should ensure that they are represented in the process for planning and monitoring the quality and safety of service provided.

Ioannis E. Chaniotakis, Constantine Lymperopoulos, (2009) reports the effect of service quality (SQ) dimensions on satisfaction and word of mouth (WOM) for maternities in Greece. in addition to “satisfaction”, the only service quality dimension that directly affects WOM, is “empathy”. In addition, “empathy” affects “responsiveness”, “assurance” and “tangibles” which in turn have only an indirect effect to WOM through “satisfaction”.

Mário Lino Raposo, (2009) reports the assessment of patients’ satisfaction levels, and the knowledge of what factors influence satisfaction are very important for healthcare managers as it influences healthcare results and healthcare institutions financial results. The objective of this research is to analyse patients’ satisfaction levels in a set of four Portuguese primary Healthcare Centres, through
the estimation of a satisfaction index, which simultaneously explains which dimensions of healthcare quality influence that satisfaction the most. For that, a conceptual model of patients’ satisfaction in primary healthcare was tested using data from a sample of 414 patients. Partial Least Squares path modelling (PLS) was the technique chosen to evaluate the proposed model. The results show that patients’ satisfaction is 60.887 in a scale from 1 to 100, revealing only a medium level of satisfaction. It is also possible to conclude that the most important positive effects on satisfaction are the ones linked to the patient/doctor relationship, the quality of facilities and the interaction with administrative staff, by this order.

Laohasirichaikul et al, (2010) investigates the effects and the relative importance of the four perceived service quality dimensions such as doctor concern, staff concern, convenience of the care process and tangibles on corporate image, customer satisfaction, and customer loyalty. The findings indicate that the four dimensions significantly affect corporate image, customer satisfaction, and customer loyalty. More specifically, the doctor concern dimension is the most important factor affecting customer satisfaction and customer loyalty. The tangibles dimension is the most important factor affecting corporate image.

Eleni Klameria, (2010) analyses the dimensions of the quality of health care services which are appreciated by customers using the SERVQUAL scale and the analysis of the relationship between the productivity of the Greek hospitals and patients satisfaction. The findings of the study reveal that the patients demand improved health care services and most patients tend to spread comments on
hospitalization (positive or negative). Quality systems could be the first step in implementing gradually Total Quality Management in public hospitals and hospital managers should consider patients as their external clients of a company called hospital. There is an old fashioned and therefore, superannuated management in Greek hospitals.

Holder M, Berndt A., (2011) reports the effect of changes in servicescape on the service quality perceptions of maternity ward patients in a private hospital. The changes in servicescape which took place in the experimental context resulted in a significant change in service quality perceptions among the experimental group. This change was not seen in all service quality dimensions, however, with statistical significance seen only in the tangible, reliability and responsiveness dimensions.

Dr Markanday Ahuja et al, (2011) explores the relationship between hospital quality management and service quality performance for a sample of patients of eye care hospitals in Haryana. SERVQUAL model has been adopted to encompass various aspects of service quality. The study has been undertaken to demonstrate the Gaps for measuring patient’s perceptions-expectation of eye care services quality in GOVT/NGO’s eye hospitals in Haryana. The purpose of the research paper is to provide review of the SERVQUAL research in measurement of eye care service quality, to obtain information about quality parameters of services provided by GOVT/NGO’s eye hospitals in Haryana & to find out as to how much these parameters rate are as per the expectations of the patients.
J K Sharma and Ritu Narang, (2011) assesses the perception of patients towards quality of healthcare services in rural areas of seven districts of Uttar Pradesh based on the scale developed by Haddad et al (1988) after making adjustment for Indian culture and language. 500 patients were contacted at the healthcare centres. The findings illustrated some interesting differences in user perception regarding service quality and how they varied between different healthcare centres and according to the demographic status of patients. It was observed that ‘Healthcare delivery’ and ‘financial and physical access to care’ significantly impacted the perception among men while among women it was ‘healthcare delivery’ and ‘health personnel conduct and drug availability’. With improved income and education, the expectations of the respondents also increased. It was not merely the financial and physical access that was important but the manner of delivery, the availability of various facilities and the interpersonal and diagnostic aspect of care as well that mattered to the people with enhanced economic earnings. What was most astonishing was the finding that the overall quality of healthcare services is perceived to be higher in Primary Healthcare Centres than in Community Healthcare Centres (CHCs). Inadequate availability of doctors and medical equipments, poor clinical examination and poor quality of drugs were the important drawbacks reported at CHCs. The current study demonstrates that the instrument employed was reliable and possessed the power to discern differences in the opinion of people on the basis of demographic factors and point out the quality differences in different healthcare centres.
Syed Muhammad Irfan et al, (2011) evaluates the service quality delivered by the private hospitals in Pakistan based on patient perception. Results show that in private hospitals doctors are genuinely concerned for their patients, doctors and nurses have attentions to care their patients and private hospitals are putting their maximum efforts in order to provide comforts to their patients. These variables are representing the first construct empathy and all of these variables have a positive impact on service quality.

Kyei et al, (2012) reveals that prenatal care is one of the recommended interventions to reduce maternal and neonatal mortality. In most Sub-Saharan African countries, high rates of prenatal care coverage coexist with high maternal and neonatal mortality. This disconnect has fueled calls to focus on the quality of prenatal care services. However, little conceptual or empirical work exists on the measurement of prenatal care quality at health facilities in low-income countries. They developed a classification tool and assessed the level of prenatal care service provision at health facilities in Zambia on a national scale and compared this to the quality of prenatal care received by expectant mothers.

Ni Wayan Karthi Sutharjana, (2013) highlights that improved quality of services driven by organizational citizenship behavior automatically will improve patient satisfaction and create patient loyalty. High loyalty will lead to changes in market share and profit for the company which provides service. He examines the role of organizational citizenship behavior in improving service quality, patient satisfaction and patient loyalty. Survey is carried out to women who have
delivered in Maternity Hospitals in Denpasar. The results showed that organizational citizenship behavior behaviors can indeed improve the service quality significantly; nevertheless it has not been able to directly and significantly improve patient loyalty. Other than that, service quality and patient satisfaction are perfectly capable in mediating the effect of organizational citizenship behavior on patient loyalty.

PATIENT SATISFACTION

An outpatient is a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment. An inpatient is "admitted" to the hospital and stays overnight or for an indeterminate time, usually several days or weeks. Treatment provided in this fashion is called inpatient care. Patients' satisfaction with an encounter with health care service is mainly dependent on the duration and efficiency of care, and how empathetic and communicable the health care providers are. It is favoured by a good doctor-patient relationship. Also, patients who are well informed of the necessary procedures in a clinical encounter, and the time taken to respond to the health needs make the inpatients generally more satisfied even if there is a longer waiting time. Previous studies which have focused on patient satisfaction on maternity care are presented below:

Séguin L et al, (1989) reveals a better understanding of how women's satisfaction with maternity care is affected. Five dimensions to women's
satisfaction were identified: (a) the delivery itself, (b) medical care, (c) nursing care, (d) information received and participation in the decision-making process, and (e) physical aspects of the labor and delivery rooms. Items relative to the delivery process such as pain intensity, complications, and length of labor were the most important for the delivery experience itself. Participation in the decision-making process was the first component of satisfaction with medical care. Information received appeared to be the major component of their satisfaction with nursing care. The physical environment did not affect women's satisfaction with obstetric care.

G. M. Naidu et al., (1996) reveals that relationship marketing has been gaining momentum as business entities realize that short-term sales has several pitfalls for building customer loyalty and continued patronage. Development and implementation of customer retention programs, partnering with customers, suppliers, and competitors, and other relationship marketing practices have become a way of life in the 1990s. Although the objectives for developing partnerships differ, the primary focus is to meet or exceed customer expectations in service quality, and delivery. Hospital systems that are engaged in relationship marketing have superior performance in such areas as, occupancy rates and better cash flows. Relationship marketing programs with customers seem to be the most effective followed by partnering programs with providers.

Jun et al., (1998) observes that the identification and measurement of service quality are critical factors that are responsible for customer satisfaction.
This article identifies 11 attributes that define quality of care and patient satisfaction and reveals various gaps among the patient, physician, and administrator groups in the perceived importance of those dimensions. Managerial implications for patient-focused health care are discussed.

Michael K. Brady et al, (2002) identifies that performance is the only measurement of service quality and clarifies the relationship between service quality and satisfaction. He also identifies the effects of service quality and satisfaction on consumers’ purchase intentions.

Proefschrift, (2003) analyzes (i) the quality of care from the users’ perspective, to measure user satisfaction of the health care system and its professionals, (ii) to describe the opinions of patients concerning the health care reforms in their country, and to find out peoples priorities regarding the quality aspects of health care and their experiences with health care providers. Opinions on changes describe how people think about issues such as information, accessibility and quality in 2000 as compared to 10 years before. Satisfaction with health care indicates how people appreciate the services as they are actually delivered. Satisfaction does not guarantee that the service is delivering quality. Expectations reveal what patients consider as important to receive. Expectations and actual experiences indicate the quality of the service as per his study.

Crow. R et al, (2003) identify the determinants of satisfaction with healthcare in different settings and summarise the results of studies that investigated methodological issues. He concludes that there is a need to explore
how different types of illnesses and health outcomes affect evaluations. With respect to the role of expectations, research is needed to classify different types of expectations and explore how consumers operationalise these in evaluations. The relationship between socio demographic factors and expectations should also be studied.

Hemant Kassean, (2004) examines the predictors and level of patients’ satisfaction across the regional hospitals of Mauritius. The various dimensions that were used to measure satisfaction were: admission to hospital, attitude to medical staff, attitude to nursing staff, ward/hospital environment, patients' amenities, discharge planning and coordination. The highest predictor was the “Perceptions of ward/hospital environment” when compared with the “Perception of medical staff and ‘Perception of nursing staff’ : “Patients’ perceptions of ward/hospital environment”, and “Patients’ perceptions of medical and nursing staff” were found to be good predictors of patients’ satisfaction in the survey.

Neuneung Ratna Hayati, (2004) analyze the gap between perceptions and expectations of the customer (patient), concerning with the service at Hospital “X”. The satisfaction level is evaluated based on the different between those two points. There are five dimensions in service quality (servqual), they are tangible, reliability, responsiveness, empathy, and assurance (Parasuraman, Zeithaml, &Berry, 1985). General purpose of this research to know some factors that impact patient satisfaction to Hospital “X” in Bandung, West Java. The purpose are (1) to describe applied of service quality (servqual) dimension in Hospital Business (2)
to know service quality (servqual) dimension that make patient satisfaction, and
(3) to know service quality (servqual) dimension that dominant impact patient
satisfaction in Hospital “X”. The research methodology was carried out in a
survey cross-sectional applied to 78 respondents. The data obtained was analyzed
by using reliability method, correlation and regression. Result of research showed
that hospital service attributes have positive impact and significant to build
customer (patient) satisfaction. The result of this research expected to give more
knowledge about the importance of service quality (servqual), so that it can be a
suggestion substance for management in evaluate their service.

Yıldız Z, Erdoğan S, (2004) reveals that patient satisfaction is an
important measure of service quality in health care systems. Patients’ perceptions
about health care systems seem to have been largely ignored by health care
managers in developing countries. The aim of this study is to develop a reliable
and valid instrument to measure patient satisfaction in Turkey. A questionnaire
was developed and a total of 1100 patients in 31 different hospitals were
interviewed. Factor analysis was utilized to determine the factor structure. The
instrument of the patient satisfaction developed in this study provides insights to
the researches who study the improvement of patient satisfaction with service
quality of hospitals, practitioners, and the decision makers.

Kjersti Helene Hermes (2005) reveals that hospitals’ readmission rates have
a negative and significant effect on inpatients’ experiences. Patients admitted to
hospitals with low readmission rates are more content with the care, treatment, and
information they receive from hospital personnel. They are also more content with hospital facilities and sanitary conditions and organization of hospital staff. Patients’ impression of hospitals’ facilities and sanitary conditions was better at hospitals with longer waiting time. Patients’ age, health status, number of previous admissions, and education level significantly affected their satisfaction with hospital services.

Havva Çaha, (2006) observes the health reforms realized in Turkey over the course of last several years. The patients, who have social security, have started to benefit from private hospitals. How they are satisfied from the services given by private hospitals thus becomes an important issue. It is evident that more than half of private hospitals along the country are found in Istanbul. This leads, eventually, to a high level of competition among private hospitals in the level of Istanbul. It is a matter of fact that the customer satisfaction plays important role in the competition among private hospitals more than ever before in this city. Considering that reality this study emphasizes on the consumer satisfaction in the private hospitals found in Istanbul. Based upon a survey this study uses a dynamic model in determining the quality of hospital and the consumer satisfaction.

Birna Abdosh, (2006) observes that the quality of care from the patient's perspective reveals important information about the quality of care afforded to patients and it also makes the health service more responsive to clients - an area which currently being emphasized by WHO. Satisfaction with health care was
found to have a significant association with waiting time, the availability of drugs, the payment status of the respondent and the address of the patient.

Bunthuwun Laohasirichaikul et al (2006), investigate the effects and the relative importance of the four perceived service quality dimensions on corporate image, customer satisfaction, and customer loyalty. To obtain results, factor analysis and multiple regression techniques are applied to data collected from 500 Thai outpatients of the five largest private hospitals in Bangkok. The findings indicate that the four dimensions significantly affect corporate image, customer satisfaction, and customer loyalty. More specifically, the doctor concern dimension is the most important factor affecting customer satisfaction and customer loyalty. The tangibles dimension is the most important factor affecting corporate image.

Kenneth Randall Russ, (2006) A psycho-social model of consumer expectation formation in a health care services context was developed and tested. The research identified that the uncertainty of a health service encounter may cause certain consumer segments to choose coping strategies and expectation processes based on their locus of control orientation from along a continuum ranging from approach-active to avoidance-passive. High internal locus of control was associated with greater amounts of internal search, the formation of more accurate process expectations, and higher service quality expectations. External locus of control was associated with greater amounts of external information search with medical professionals (powerful others) and the formation of higher service
quality expectations. The linkage of external locus of control to social support was not supported. However, social support was associated with higher levels of bolstering—an affect based coping strategy in which consumers minimize the risks of a chosen alternative and maximize the risks of non-chosen health service alternative. Seventy percent of the variance in the model was explained by the structural model. The model provides a useful basis for segmentation in health care services to improve consumer satisfaction based on designing integrated marketing communications and service offerings which meet unique psycho-social needs and consumer expectations.

Jackie L.M. Tam, (2007) investigates empirically the impact of improvement inservice-delivery quality on customer satisfaction and repeated patronage, in the context of health services. The results suggest that using patient feedback as an input for quality improvement improves performance. The number of patient visits increased at a higher rate than the size of the target population. This suggests that quality medical encounters improve patient satisfaction, which in turn encourages patients to revisit the same provider in the belief that they will receive high standards of care. This is particularly relevant for services that are subject to user evaluation on the basis of credence attributes which suggest that the greater the need for information, knowledge and expertise in making choices, the greater the consumer’s propensity to engage in relational behaviour. Patient satisfaction is one of the key performance indicators in the health care industry. It
should be monitored regularly, and incorporated into planning and quality improvement programmes.

Syed Saad Andaleeb et al., (2007) analyses that in developing countries such as Bangladesh, few studies have sought patients’ views on satisfaction with services, and there is little effort to involve them in measuring satisfaction or defining health service standards. Consequences of patient dissatisfaction can include patients not following treatment regimen, failing to pursue follow-up care and, in extreme cases, resorting to negative word-of-mouth that dissuades others from seeking health care from the system. Service orientation of doctors was found to be the strongest factor influencing patient satisfaction in hospitals. Service orientation of nurses is an important factor for ensuring patient satisfaction in Bangladesh, but the dearth of nurses is a continuing problem. Foreign hospitals are rated highest on all service dimensions. Unless this perception is matched by local hospitals, foreign exchange losses can be substantial as patients seek care abroad.

Syed Andaleeb, (2008) assesses the links between service quality and patient satisfaction in the context of health services delivered to children in a developing country. With the growing importance of patients’ voice in the healthcare environment, it is important to assess the factors that are best able to explain patient satisfaction to influence the art and science of patient care and health service delivery. Medical care for children in Bangladesh may be improved further by instituting behavior change among the doctors, nurses, and the support
staff. Bringing about such change requires proper attention to hiring, training, empowering, evaluating and rewarding the service providers. Changes in attitudes, as well as practices, in these higher tiers of the system are also essential for the healthcare system to respond optimally and provide the needed services to the suffering children. Publicly available ratings via customers’ voice can create social pressures and can be an important behavior change tool to make healthcare providers respond appropriately; otherwise the children will remain neglected by a seemingly impervious and monolithic healthcare system.

Ma´rio Lino Raposo et al, (2009) analyse the patients’ satisfaction levels in a set of four Portuguese primary Healthcare Centres, through the estimation of a satisfaction index, which simultaneously explains which dimensions of healthcare quality influence that satisfaction the most. For that, a conceptual model of patients’ satisfaction in primary healthcare was tested using data from a sample of 414 patients. The results showed only a medium level of satisfaction. It also concludes that the most important positive effects on satisfaction are the ones linked to the patient/doctor relationship, the quality of facilities and the interaction with administrative staff, by this order.

Edward et al, (2009) investigates the overall level of satisfaction associated with the choice of a health care provider. Parents whose children (aged-under five) fell sick four weeks prior to the survey and had sought intervention within 2 days were asked their overall level of satisfaction with health care providers. Using the ordered logit model the study confirms the notion in Ghana and elsewhere that
private health care is associated with higher levels of satisfaction or quality. Control variables that were found to be statistically significant were gender of the child, maternal age and education, distance and waiting time among others.

Anna Maria Murante, (2010) reports that two different groups of statistically significant predictors of inpatient satisfaction are identified: (i) age, education, health status, residence, admission mode, ward, continuity of care (patient characteristics) and (ii) hospital size and percentage of discharges against the medical advice. An interesting result is that patients are less satisfied when hospitalized in hospitals with a higher percentage of voluntary discharges. Moreover, it is observed that hospital setting and clinical needs generally slightly influences the patient experience in order to provide patient centered hospital services. In fact, it is observed that depending on whether the patient is hospitalized in a medical, surgical or obstetrical, gynecological and pediatric ward, the factors affecting the satisfaction can change.
End notes:


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