Author's response to reviews

Title: Women's Satisfaction with Intrapartum Care in St Paul's Hospital Millennium Medical College Addis Ababa Ethiopia: A Cross Sectional Study

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Abstract

1. Giving the cut point (4.20) in the abstract is a little confusing without full explanation of what the Likert scale questions looked like. I might suggest removing this from the abstract.

The cutoff point > 4.20 stated in the abstract is removed.

2. AOR needs a definition with its first use.

AOR definition (Adjusted Odds Ratio) is written with its first use in the abstract.

3. The results highlighted in the abstract should be re-considered and perhaps replaced with others. The finding that all separated women were dissatisfied is based on an extremely small amount of women, as was the government employee finding.

The result on the abstract is reconsidered and replaced with others. The variable all separated women is excluded and replaced by (married women, house wife and primary education).

4. The authors state that "only" 24.4% of women with secondary education were satisfied, however this is somewhat misleading because satisfaction was actually higher among those with secondary education than those with lower educational attainment.
We substitute it with the following statement, “among women who attained primary education 81.3% were not satisfied”.

5. In the last sentence of the results section, the authors state that time after admission and short length of stay were positively associated with satisfaction - this should be re-phrased. They were associated, but not all variables listed were in a positive direction.

The statement rephrased as time after admission and short length of stay were found to be significantly associated with intrapartum care women satisfaction.

Background

6. It would be helpful to present information - if the authors have it - on current repeat utilization of delivery services. This would better frame the issues - are women currently not returning based on lack of satisfaction in this setting?

Even though we lack evidences on the number of Ethiopian women’s repeat utilization of delivery services and not returning to delivery service because of lack of satisfaction, we add the following related information on the background of the manuscript.

Women’s experiences with health care providers and facilities influenced their care seeking decisions (20). A study conducted on “why women prefer home births in Ethiopia” indicated that, the main reason women reported were poor quality of care and previous negative experience with health facilities (21).

Methods

7. There is a reference (22) given in the power calculation section. There is no reference 22 in the reference list.

It was written by mistake and is corrected by reference 19.

8. It would be helpful to understand where the 61.9% satisfaction estimate given in the power section came from.

It was taken from a study conducted on mothers’ satisfaction with hospital delivery service in Amhara region Ethiopia, which is in reference 19.

9. In line 37, page 5 the authors refer to inclusion criteria. Were there other inclusion criteria other than those given in Line 9 (just having given birth after admission to the maternity ward?)

This was the only inclusion criteria.
10. It would be helpful to see more detail about the process of adaptation of the questionnaire. Who were the 'group' who reviewed the instrument (what experience/qualification did they have?). What specific modifications were made to the survey instrument?

A group of health professionals (obstetrics and gynecologist, midwife, nurse and public health) who have previous experience in research were discussed in detail on the survey instrument to relate with the local context and make it better understandable to the respondents.

Specific modification like, changing the sentence which describes about Doctor and midwife, with “health care provider” in the delivery room as other professionals like nurses in our country are competent and accredited to provide delivery service to laboring mother.

11. What does "after discharge while being in the ward" (line 6, page 6) mean in terms of the timing of the questionnaire administration?

The questionnaire was administered after the physician has wrote a discharge summary, but before the client has leave the maternity ward while the discharge process like hospital stay and service fee is processed by her relatives.

12. What was the rationale for using a mean +1SD cutoff for dichotomizing satisfaction? Is this a standard approach? How was the cutpoint of >4.20 then operationalized? Did participants have to get 4.2 or higher on all questions? Or was it a mean of at least 4.20 across all questions? I would like to see some evidence that this is a valid approach to dichotomizing satisfaction.

Satisfaction is assessed using 14 likert scale questions (Chronbach's alpha of 0.835) measuring women satisfaction with 5 items related to interpersonal care (Chronbach's alpha of 0.911) by the health care provider, 4 items related to information received and involvement in decision making (Chronbach's alpha of 0.681) and 5 items related to physical birth environment (Chronbach's alpha of 0.678). Participants were asked to rate their satisfaction with intrapartum care on a five point likert scale of 1 strongly disagree to 5 strongly agree. The cut off point for satisfaction was adopted from a study conducted in Jordan (15) and calculated using the total mean score plus one standard deviation. The Cut-off point for this study was 4.20 (Over all mean (3.61) + standard deviation (0.59)). A women scored a mean score of greater or equal to 4.20 in the 14 scale likert question was consider as satisfied and a mean score less than 4.20 considered as not satisfied.

13. Was there any testing of the construct validity of the sub-scales described in lines 51-57 (page 6) completed? i.e. was exploratory factor analysis completed to ensure the validity of these subscales for this specific population? Reporting the Chronbach's alpha within each subscale would be helpful to answer this question.

The overall and subscale Chronbach's alpha value is stated on the above paragraph and on the revised manuscript.

Results
14. In Table 1 some clearer definitions of categories are needed. Specifically - what does private mean for occupation? Does no formal education always result in someone being illiterate?

In our case “Private” means women of nongovernmental organization employee and “Illiterate “means those who cannot read and write. Both of them are written on the operational definition of the manuscript as the space is not enough to write them on the table.

15. In Table 1 some of the sub-categories are very small, for example 8 women were separated and 2 divorced. What was the rationale for not collapsing these women into the single category?

In our case divorced means they are legally separated and they don’t have any support from their partner, they might discourage in which, will have impact in their satisfaction. Whereas, separated women means those who are not divorced but they are separated from their partner for some time because of work place or education, but they have good communication and support which may have positive outcome for their satisfaction. That is why we decided to consider them separately.

16. The numbers in each group do not always add to the sample size reported in the methods. Were women excluded only if they were missing satisfaction measures but allowed to be missing some of the demographic information?

It was by mistake and corrected.

17. Significance of the difference between groups in terms of satisfaction could be given in the text (lines 7-15; page 9) and table 2 using chi-square analyses.

We did not incorporate the chi-square analyses to avoid redundancy since it conveys the same kinds of information as of the simple logistic regression results (table 3).

18. On page 10 (line 26) the authors state "Variables with a small number of success (<10) in each category were not considered for analysis" - having low sample size in a group does not reflect the "success" of a question. Perhaps this could be re-phrased?

We are trying to rephrase the statement as “Considering the rule of thumb for logistic regression Variables with a small number of success (<10) in each category were not included in the model”.

19. On page 10 (line 37) the authors indicate that the multiple logistic regression can be found in Table 3 - this should be changed to table 4.

It was misplaced and is corrected.

20. In Table 3 factors need much better definition. It is unclear what "Seek to Talk" means and what "Expected Labor" means. Does "Number of Delivery" mean parity? What do "Time to see Professional" and "Length of Time" mean? The definitions of each of these should be made very clear so that the table may stand alone.
Each of them corrected as follows on the revised manuscript.

“Seek to talk” means “Seek to talk professionals”

“Expected labor” means “Labor as expected”

“Number of delivery” means “Parity”

"Time to see professional” means the “length of time (hour) taken to be seen by health professional” after arrival in the hospital.

“Length of Stay” means the “overall length of stay (hr) in the hospital for delivery service”.

21. On page 13 (lines 59-61) the units for time of admission should be clearly stated. What did a 1 unit increase actually mean in terms of minutes? Same question for length of stay in the hospital (line 4, page 14).

It is in terms of hours and is rephrased on the revised manuscript.

Discussion

22. Line 35, page 14: the authors describe a prior study conducted in Ethiopia in which satisfaction was 61.9%. The authors should reflect more in the discussion about the source of the difference between this finding and theirs. Was it a different setting, different study population?

This might be because of different study population background as our study was done in Addis Ababa, the capital city of Ethiopia and their study was performed in three regional referral hospitals where most women from the rural area are utilized the service whom their knowledge about quality of care might be low and considering the care given to them as (standard quality care) or might be because of a real difference in quality of services provided.

23. The authors also describe other Ethiopian studies (line 54-57, reference 10) how was this study new/different compared to those previously conducted. What does this study add?

Two of the studies (24, 25) were conducted in regional health institutions, where most of the women are from rural settings. The other study (10) conducted in Mahetem Ghandi memorial hospital found in Addis Ababa, Ethiopia, where, the women are from urban setting (the capital city). But, our study setting SPHMMC is the second largest referral hospital in the country with catchment areas from rural settings as well. Therefore, our study has the chance to compare women from regions (more of rural setting) with women from the capital city (urban setting) who received the service in same health facility.

24. What is a business score card (line 20, page 15) and how would it help increase satisfaction/decrease waiting time/length of hospital stay?
The word business was written by mistake and corrected by balanced.

Balanced score card is a strategic planning and management system which is used for profit and nonprofit organizations including health care systems performance measurement worldwide. It enables the organizations to clarify their vision and strategy and translate them into action. Ministry of health in Ethiopia has a national performance monitoring and improvement manual which outlined each indicator thoroughly and specified precise definitions and data sources which can improve quality of service and client satisfaction. One of them is reduction in outpatient waiting time and a reduction in average length of stay in the hospital.

25. In general - what are the authors’ recommendations for improving satisfaction with care? What areas need additional research/attention?

This study strongly suggested that the Ethiopian government should put effort to expand access to services by improving infrastructure and trained human resource to facility based care. The facility based care must be harmonized to ensure that the care provided to the delivering mother should be client centered easily accessible and high quality.

St. Paul’s Hospital Millennium Medical College should also work hard to increase women’s levels of satisfaction as it is one of the measures of quality care for delivery service, especially improvement should be done to the availability of bed for child birth and health. In addition, further research should be done at a community level to address women who did not come to health facilities and to see the problem from the health care providers’ perspective.

Additional corrections

Specific areas of confusion in the Methods include:

- It seemed that the authors triangulated the methodology with qualitative information from patients.

It is not triangulated, it is a quantitative study. Efforts also made to avoid such confusions.

More details about measurement and instrumentation: i.e. the 14 Likert Scale questions and the rationale for collapsing the outcome satisfaction variable into the binary of Satisfied vs. Not Satisfied.

It is written clearly earlier on comment number 12 and the revised manuscript.

- More details about the decision to use Nurses as data collectors.

As nurses are more familiar with the terminology specially related to patient care, we recruited nurses from other hospitals (who are not affiliated with the study hospital) for data collection to prevent bias.
More details about instrumentation: was a questionnaire or interview used to collect the data? What is the context of this study?

We used structured questionnaire which was administered by data collectors with casual dress.

More details about the timing of data collection and bias: how soon after delivery? Were participants compensated for their time and effort?

Unless there is complication or have caesarean section, usually delivered women are waiting for six hours after delivery and will be discharged. The data was collected after the physician has wrote a discharge summary, but before the client has leave the maternity ward in the separate room while the discharge process like hospital stay and service fee is processed by her relatives. The participants were not compensated for their time and effort except that the data collectors thank them for their cooperation. To control bias with respect to the health care providers, the data collectors (Nurses) were recruited from another facilities.

More details and explanation of the "3 dimension of intrapartum care sub-scale": i.e. sociometric, psychometric rationale and implications.

The "three dimension of intrapartum care sub-scale" are the satisfaction variables which are grouped in to three categories: Interpersonal care (with five questions), Information provision & decision making (with four questions), and hospital physical environment (with five questions) a total of 14 questions used to measure satisfaction in this study. Even though the way of analysis can be different from literature to literature, they are important questions to assess the satisfaction level of women with the service provided and the quality of service.

With a careful rewrite that expands the discussion of methods with specific details and rationale, and rerunning the analysis with a poly-chotomous vs. dichotomous satisfaction variable

We accept the comment and will consider it for the next research.

Please note that all manuscripts must contain all the following sections under the heading 'Declarations'. The Declarations should follow the Conclusions section, and be before the References.

We included all sections of the declaration as requested.

A careful rewrite with attention to grammar, spelling and punctuation indicated of technical writing: consistent spacing, capitalization (i.e. World Health Organization- WHO), paragraph consistency in terms of tense, theme and topic, clear thesis statements, subject verb agreement, avoid the passive voice, etc

We edited according to the comment given.