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Original Research

The Process of Intrapartum Care Among Skilled Birth Attendants in the Dominican Republic and Maternal Perceptions of Care During Labor and Birth: A Case Report

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Introduction: The World Health Organization calls for situation analyses of maternity settings globally to improve maternal-newborn health. This study evaluated the care processes of skilled birth attendants and women’s satisfaction with the care in a public hospital in the Dominican Republic. The purpose of the assessment was to establish a baseline to build quality improvements.

Methods: A cross-sectional, mixed-methods, observational study was conducted by an international team. Eighty-four participants were included in the Intrapartum Data Set (American College of Nurse-Midwives), and 55 participants completed the Chilean Maternal Well-Being Scale. The data set was analyzed using descriptive statistics. Three focus groups were conducted with health providers, and 4 focus groups were conducted with postpartum women. Themes were derived using content analysis.

Results: Nurses were the skilled birth attendants (SBAs) for 54% of women; 46% were attended by either obstetricians or family medicine residents. Ninety-one percent of newborns with nurse attendants had immediate skin-to-skin contact, compared to 79% of newborns with physician attendants. Newborns breastfed within the first hour of life for 67% of the dyads with nurse SBAs, whereas 24% of newborns attended by physicians did so. The well-being survey indicated most women perceived care was adequate or better, irrespective of attending provider. Nevertheless, 67% of rural women perceived care negatively. Qualitative findings indicated that some women felt neither respected nor heard.

Discussion: When nurses managed the labor and birth, their care was comparable to that of physicians. Moreover, women were more likely to receive evidence-based newborn care, including skin-to-skin contact, immediate breastfeeding, and discharge instructions. Qualitative findings highlighted the discrepancy between health care providers’ perception of the care they provided and patients’ perceptions of that care. Reflexive practice and frequent communication with patients about their experience of care should be a part of every practitioner’s toolkit, wherever that care is provided.


Keywords: Dominican Republic, global health, maternal-child health services, quality of health care

INTRODUCTION

There is currently a worldwide movement to improve the quality of maternity care. The World Health Organization (WHO) has developed a vision and a framework to structure the advancement of quality maternity care for all women. WHO calls for a baseline analysis of the quality of care in institutionalized maternity settings. Once this analysis has been conducted, crucial interventions can be identified and tested in the cycle of “plan, do, study, act,” the widely recognized process of the quality improvement cycle, described by the Institute for Healthcare Improvement.

One aspect of quality care in institutions is the skill of the health care providers who attend the births. A skilled birth attendant is defined as “an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.”

A recent series in the Lancet highlighted the importance of the midwife in the global reduction of infant mortality and the improvement of maternal health. If educated and regulated to international standards, midwives can provide 87% of the essential care needed for women and newborns, and investing in midwives can provide a 16-fold return on investment. In the region of Latin America and the Caribbean, more than 89% of births occur in institutions, and professionally educated midwives are part of almost every nation’s public-sector health care workforce. In contrast, the Dominican Republic is one country in the region where the professionally educated midwife is not a recognized cadre of health professional. In some public-sector hospitals in the Dominican Republic, it is the nurses who manage uncomplicated intrapartum care for women birthing vaginally when the obstetricians are not present, or when either the family medicine resident or obstetrician prefers the nurse to do so.

This article reports the results of a situation analysis, or baseline assessment, undertaken by midwifery and nurse researchers in 2013 in one maternity unit within a public,
A situation analysis is an essential first step in the quality improvement cycle to advance women’s and newborns’ health care in every maternity site globally.

A situation analysis conducted in the Dominican Republic revealed a discrepancy between the health care providers’ perception of the quality of care they provided and women’s perceptions of care by providers, whether the attending provider was a nurse, a family practice resident, or an obstetrician. This was true even when care was assessed as adequate or better.

Reflexive practice and frequent communication with patients about their experience of care is an important element of quality maternal-newborn care in all settings.

Background

The impetus for this study came about because to date there has been scant literature about nursing and midwifery practice in the Americas. A small group of midwives within a subcommittee for research and publication among nurses and midwives in Latin America and the Caribbean region of the Global Alliance of Nurses and Midwives sought to initiate baseline assessments of maternity practice in the Hispanophone Americas.

The first country in the region to conduct a situation analysis of the process of care and maternal well-being in labor among women attended by midwives was Chile. The Chilean midwifery faculty invited faculty from various universities in the Latin American and Caribbean countries to replicate this study, adapted to their local context. The Collaborating Center provided the research protocols and instrumentation and offered data analysis to those agreeing to participate. Midwifery or nursing faculty from Argentina, Brazil, Peru, Uruguay, and the Dominican Republic participated. There was an agreement at the outset that the Chilean researchers would report on the aggregate results of the participating countries, but researchers representing each country would report the individual results from their country. This article is the report that is specific to the situation in the Dominican Republic. Funding for the study came from the partner university in the United States.

METHODS

A mixed-methods, cross-sectional, descriptive study design was used to replicate the situation analysis carried out in Chile but was adapted to the local context of the Dominican Republic. The institutional review board of Emory University and the Ethics Committee of the Dominican hospital approved the study.

Sample

The sample was a convenience sample of women who gave birth attended by obstetricians, family practice residents, or nurses during June and July 2013. Written informed consent was obtained for a total of 87 women. Inclusion criteria included primiparous and multiparous women admitted in spontaneous labor with at least 2 to 3 cm of cervical dilatation and whose labor lasted a minimum of 3 hours. The purpose of this criterion was to ensure that women were well established in labor and that they had some experience with labor to be able to evaluate the care they received. Multiparous women were included if no more than 3 years has elapsed since their last birth. This was to ensure relatively recent memory of their previous birth experience. Another criterion of inclusion was the capacity to give and sign informed consent. Women with a clinical history of drug abuse or mental illness were excluded.

Setting

The Dominican Republic is a lower-middle-income country of approximately 10 million people in which more than 40% of the population live in poverty, and 10% of the population owns 40% of the wealth. More than 99% of women give birth in hospitals, yet maternal and newborn mortality continues to be higher than expected given the relatively well-developed roads and public health infrastructure, including secondary and tertiary hospitals that exist in the country.

Public hospitals serve the poorest people in the country. The maternity unit in the public hospital in the study was staffed by obstetrician attending physicians, family practice residents, nurses, and medical and nursing students. Obstetricians relied on the family practice residents or nurses to attend the women with uncomplicated births when they were in private practice during the day.

From 2004 to 2007, a cohort of obstetric nurses in the hospital where this study was conducted participated in a series of midwifery education trainings by means of a joint partnership with nurse-midwives from the United States. A formative evaluation found that obstetric nurses who participated in those educational conferences added specific midwifery knowledge, attitudes, and skills to their practice. Although many of the nurses who participated in that program no longer worked in labor and delivery, nonetheless most
The internal reliability (Cronbach’s alpha) was validated = and at least one of them = strongly disagree). There are 8 subscales. The subscales www.jmwh.org It was pilot tested with 6 Dominican nurses prior to = strongly agree and = published in 1996 for educational or research = the maximum possible score is 210, with an optimal score (152–172), adequate score (152–172), and minimal score (<152).

Quantitative Data Collection and Analysis

All data were collected in Spanish by the US and Dominican research team members. The 3 US researchers are fluent in Spanish. The data were translated after interpretation by the first and last authors to prepare for English language publication.

Prior to data collection, training was conducted for all the research team. Team members included 4 nurses from the Dominican labor and delivery ward, 3 Dominican community members, and 3 US researchers, one as the in-country lead and 2 as research assistants. The training included an explanation about the project, the instruments, and the research protocol and procedures. The labor process outcome data were collected using the Intrapartum Data Set, developed by the American College of Nurse-Midwives (ACNM), validated in 1991, and published in 1996 for educational or research purposes. The data were collected manually within a day from when they occurred, from the birth log book on the maternity unit, with follow-up for missing data with the personnel who were present for the birth. The research team had a 24-hour presence daily in the maternity unit to collect data. Data were collected on paper and then entered into a spreadsheet for analysis. All information was double entered by a research assistant and the in-country director. Participants with incomplete data were dropped from the study.

The other quantitative instrument was the Maternal Well-Being Scale, which was created and validated in Chile. This is a 42-item Spanish language survey instrument that is measured using a 5-point Likert scale (1 = strongly agree and 5 = strongly disagree). There are 8 subscales. The subscales encompassed respectful treatment, continuous emotional support in labor, availability of pain medication, correct medication and treatments, ability to ambulate and eat during labor, time allowed with newborn, professionalism and competence of staff, and the physical environment. Although the instrument measured perception of well-being in labor, the instrument serves well as a proxy for quality of care and patient satisfaction, because the items measure indicators for which there is evidence-based research as well as respectful treatment. The internal reliability (Cronbach’s alpha) was .90. It was pilot tested with 6 Dominican nurses prior to use, and several of the Chilean words were substituted to be aligned with Dominican usage.

Because women receive postpartum care on large wards with many women and their families, the decision was made to conduct the well-being survey face-to-face with women in their homes, to ensure confidentiality and to increase the likelihood that answers would not be influenced by the presence of the health personnel who cared for them. The disadvantage of this strategy was that not all 84 participants could be interviewed within the time frame of the study because the women from the rural areas lived at quite a distance from the hospital. Thus, of the 84 women for whom there are data from the Intrapartum Data Set, there are completed well-being survey data on 55 of them.

Continuous variables were described as means, and categorical variables as proportions, both with their respective confidence intervals. A spreadsheet was created, and data were analyzed for descriptive statistics. The scoring of the well-being scale used the same scoring and interpretation as in the other Latin American countries. The maximum possible score is 210, with an optimal score (>172), adequate score (152–172), and minimal score (<152).

Qualitative Data Collection and Analysis

To add more nuance and explanatory detail about the perceptions of the quality of care, 7 focus group discussions were conducted among a total of 40 participants (Table 1). The purpose of this qualitative arm of the study was to discover if there was alignment or discrepancy between the perceptions of women and their providers of care. An interview guide was used, which was reviewed by 2 nursing faculty at the Autonomous University of Santo Domingo for content and comprehensibility.

Three focus groups were conducted among health care providers (nurses, auxiliary nurses, and family medicine residents). The obstetricians were invited but declined to participate. Group I consisted of 8 baccalaureate-trained nurses. Licensed baccalaureate nurses have formal university training, similar to baccalaureate-level nurses in the United States. Group II consisted of 12 family medicine residents. The family medicine residents are physicians who have completed medical school, as well as a one-year (usually rural) primary health center internship. This one-year internship is a required service to the government, because medical education in the public universities is subsidized and thus very low cost (several hundred dollars per semester). Group III consisted of 6 auxiliary nurses. Auxiliary nurses function much like licensed practical nurses in the United States. They have a one-year training period that requires high school completion prior to entry. Inclusion criteria for the nurses and auxiliaries were employment in the labor and delivery wards for at least 3 years. The discussions for all the health care providers were held in a classroom within the hospital.

Four focus group discussions were conducted with a subset of postpartum women who had completed the well-being scale. Women who lived in the urban environment were divided into 2 groups: one group who had given birth vaginally and one group who had a cesarean birth. These group discussions were held in the hospital classroom. Women from rural areas were similarly divided into 2 groups, and the discussions were held in a community center in the town closest to most participants.

The facilitators were 2 US research assistants, the in-country director of the study, and one Dominican research assistant. Two of the facilitators had prior research experience in the Dominican Republic, and at least one of them was present at every focus group conducted. The group of physicians, nurses, and auxiliary nurses were facilitated by the first author, as well as the Dominican research assistant. The facilitators for the community focus groups were
Table 1. Numbers of Focus Groups and Characteristics of Participants (N = 40)

<table>
<thead>
<tr>
<th>Numbers of Focus Groups and Characteristics of Participants</th>
<th>Health Care Providers at Regional Hospital (n = 26)</th>
<th>Women Who Gave Birth at Regional Hospital (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of focus groups</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Focus group participants by group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses (Group I)</td>
<td>8</td>
<td>—</td>
</tr>
<tr>
<td>Family medicine residents (Group II)</td>
<td>12</td>
<td>—</td>
</tr>
<tr>
<td>Auxiliary nurses (Group III)</td>
<td>6</td>
<td>—</td>
</tr>
<tr>
<td>Rural women vaginal birth (Group IV)</td>
<td>—</td>
<td>4</td>
</tr>
<tr>
<td>Urban women vaginal birth (Group V)</td>
<td>—</td>
<td>3</td>
</tr>
<tr>
<td>Rural women cesarean birth (Group VI)</td>
<td>—</td>
<td>3</td>
</tr>
<tr>
<td>Urban women cesarean birth (Group VII)</td>
<td>—</td>
<td>4</td>
</tr>
</tbody>
</table>

2 US research assistants as well as a Dominican research assistant.

Initially, the research plan for the health care provider focus group discussions was to discuss the challenges providers encountered to adhering to the published standards for care in the maternity setting. These standards are published by the Secretariat of Public Health and Social Assistance. Surprisingly, no one on the maternity unit could locate the published standards, so they were unable to address the question. Thus, the facilitators of the focus group discussions asked the physicians and nurses to describe their understanding of quality care and then discuss some of the challenges they faced to achieve it. Additional qualitative data were obtained by field notes obtained while observing on the labor and delivery unit in order to be sure that no births were missed during the research period. These observations were a valuable additional source of information to triangulate with the data from the focus group discussions.

Qualitative Data Analysis

We took a qualitative descriptive approach to the focus group discussions, using content analysis, replicating the design of the Chilean study. The qualitative analysis team members included the first and last authors, who are both fluent in Spanish; one is a doctoral student with many years of volunteer experience in the Dominican Republic, and the other is a nursing faculty with more than 12 years of program and qualitative research participation in this site, including conducting previous qualitative research related to the quality of maternity care.

The focus groups were audiotaped verbatim in Spanish, transcribed in Spanish, and read and coded in Spanish. The codes were categorized, and categories were reviewed across groups of health care providers and groups of women for recurring patterns of responses. The data were examined for alignment, or discrepancy, between nurses’ views, physicians’ views, and women’s views. Also, responses were compared across women’s residential locations (urban or rural). The trustworthiness of the data and the credibility of the findings were fortified by the last author’s 12 years of experience of field observations, including participant observations, in the hospital unit from 2004 to the present. Also, the comments of some of the women participants aligned with previous literature related to quality of maternal care in the Dominican Republic. The idea that women were not listened to was a repeated iteration from previous qualitative work in this site.

Once the preliminary analysis was completed, an initial draft was written in English, and all authors reviewed the draft to modify, confirm, or augment the analysis. The English language manuscript was interpreted to the Spanish-speaking research team by a Dominican medical student who speaks English but was not involved in the study.

RESULTS

Of the 84 women in the sample, 46 (54%) were attended by nurses, and 38 (46%) were attended by obstetricians and/or family medicine residents. Women in both nurse and physician groups were homogeneous with respect to age, and the newborns were homogenous with respect to gestational age, birth weight, and Apgar scores (Table 2). Nurses and physicians had similar rates of episiotomy (22%–23%), with women attended by the nurses having lower prevalence of lacerations (32% vs 38%). The newborns born to women with only nurses in attendance had higher rates of immediate skin-to-skin contact (91% vs 79%) and higher rates of breastfeeding within the first hour of life (67% vs 24%).

Table 2. Maternal Age and Newborn Outcomes by Provider Type (N = 84)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Births Attended Solely by Nurses (n = 46)</th>
<th>Births Attended by Physicians (n = 38)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of mother, mean (SD), y</td>
<td>21.13 (4.70)</td>
<td>20.92 (5.41)</td>
</tr>
<tr>
<td>Apgar 1 min, mean (SD)</td>
<td>6.96 (1.19)</td>
<td>7.54 (0.69)</td>
</tr>
<tr>
<td>Apgar 5 min, mean (SD)</td>
<td>8.07 (1.16)</td>
<td>8.81 (0.84)</td>
</tr>
<tr>
<td>Newborn weight, mean (SD), g</td>
<td>3040.87 (491.85)</td>
<td>3080.89 (484.78)</td>
</tr>
<tr>
<td>Gestational age, mean (SD), wk</td>
<td>38.88 (1.99)</td>
<td>39.01 (1.26)</td>
</tr>
</tbody>
</table>
Table 3. Intrapartum Care Processes Stratified by Attending Provider During Childbirth (N = 84)

<table>
<thead>
<tr>
<th>Intrapartum Care Processes</th>
<th>Births Attended Solely by Nurses (n = 46)</th>
<th>Births Attended by Physicians (n = 38)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth type, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal</td>
<td>46 (78)</td>
<td>13 (22)</td>
</tr>
<tr>
<td>Cesarean</td>
<td>0 (0)</td>
<td>25 (100)</td>
</tr>
<tr>
<td>Episiotomy, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>10 (21.7)</td>
<td>3 (23.1)</td>
</tr>
<tr>
<td>No</td>
<td>36 (78.3)</td>
<td>10 (76.9)</td>
</tr>
<tr>
<td>Vaginal lacerations, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15 (32.6)</td>
<td>5 (38.6)</td>
</tr>
<tr>
<td>No</td>
<td>31 (67.4)</td>
<td>8 (61.5)</td>
</tr>
<tr>
<td>Type of induction, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>31 (68.9)</td>
<td>23 (63.9)</td>
</tr>
<tr>
<td>Pitocin</td>
<td>6 (13.3)</td>
<td>7 (19.4)</td>
</tr>
<tr>
<td>Artificial rupture of membranes</td>
<td>1 (2.2)</td>
<td>1 (2.8)</td>
</tr>
<tr>
<td>Both methods</td>
<td>7 (15.6)</td>
<td>5 (13.9)</td>
</tr>
<tr>
<td>Skin-to-skin contact, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42 (91.3)</td>
<td>11 (78.6)</td>
</tr>
<tr>
<td>No</td>
<td>4 (8.7)</td>
<td>3 (21.4)</td>
</tr>
<tr>
<td>Breastfeeding within one hour postpartum, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>30 (66.7)</td>
<td>9 (24.3)</td>
</tr>
<tr>
<td>No</td>
<td>9 (75)</td>
<td>3 (25)</td>
</tr>
</tbody>
</table>

None of the women received pain medication for labor or birth. None of the women had a companion in the labor and delivery area (Table 3).

Responses to the well-being scale indicated that most women felt care was adequate or better. This was true whether they were attended by a nurse or by a physician. Women who lived in the urban area, however, were more likely to assess their well-being in labor as adequate or excellent, in comparison to women from rural areas. Two-thirds of women who rated well-being as poor were from rural areas within the region of the referral hospital. Also, women who felt their well-being was excellent were more than twice as likely to have received discharge instructions than women who rated their care as poor, and women attended by nurses had a higher prevalence of receiving discharge instructions in comparison those attended by physicians (57% vs 41%) (Table 4).

Qualitative Findings

There were 3 overarching themes from the qualitative analysis: resources, respectful treatment, and woman-centered care. Resources included the physical structure and availability of equipment and medications on the labor and delivery unit. Both nurses and physicians cited the poor physical structure of the hospital, with a lack of continuous running water, the inability for patients to have privacy, and a shortage of beds, essential medications, and disposable supplies as serious concerns about quality. They also complained that too many family members clogged the limited space, there was not enough security, and that they were challenged by the inability to communicate with the Haitian patients who spoke Kreyol only. There was strong concordance between women and provider groups about the shortage of beds, the lack of clean sheets, and the poor sanitation and lack of running water in the bathrooms. One woman explained: “The bathrooms were in very bad condition, and so were some of the beds, and some of the sheets were very ugly, and also, sometimes cockroaches would appear.”

The second theme was respectful care. Affirmations of respectful care were aligned between provider groups but were not aligned with all the women. Nurses and physicians spoke eloquently about the importance of high-quality care and the need for humanism and attentiveness to patients’ emotional needs, along with the ways they did the best for the patient. Despite the limited resources of the hospital, they felt they gave good care.

The physician group noted that birth outcomes in the hospital were good, and people left the hospital feeling well treated. Slightly higher levels of complications at the hospital were due to the fact that the hospital was a referral hospital from other provinces, and thus they received some patients in a deteriorated condition.

The findings of some of the women’s focus groups contradicted the health care providers’ self-assessments regarding respectful treatment. There were contrasting experiences recounted in the urban women’s focus group discussions and the rural women’s focus group discussions as well. In general, women from urban areas were very pleased with the care and treatment that they received. As noted by one participant: “They treated me well, well, well; because one should
Table 4. Maternal Satisfaction With Care During Childbirth per Mode of Birth, Type of Provider, Geographic Location, and Receipt of Discharge Instructions (N = 55)

<table>
<thead>
<tr>
<th>Maternal Satisfaction With Care</th>
<th>Optimala (n = 19)</th>
<th>Adequateb (n = 24)</th>
<th>Minimalc (n = 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of birth, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal</td>
<td>10 (52.63)</td>
<td>19 (79.2)</td>
<td>6 (50)</td>
</tr>
<tr>
<td>Cesarean</td>
<td>9 (47.37)</td>
<td>5 (30.8)</td>
<td>6 (50)</td>
</tr>
<tr>
<td>Episiotomy, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2 (20)</td>
<td>7 (36.8)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>No</td>
<td>8 (80)</td>
<td>12 (63.2)</td>
<td>6 (100)</td>
</tr>
<tr>
<td>Type of provider, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>6 (33.3)</td>
<td>15 (62.5)</td>
<td>5 (41.6)</td>
</tr>
<tr>
<td>Physician</td>
<td>12 (66.7)</td>
<td>9 (37.5)</td>
<td>7 (58.3)</td>
</tr>
<tr>
<td>Geographic location, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>10 (52.6)</td>
<td>12 (50)</td>
<td>4 (33.3)</td>
</tr>
<tr>
<td>Rural</td>
<td>9 (47.4)</td>
<td>12 (50)</td>
<td>8 (66.7)</td>
</tr>
<tr>
<td>Received discharge instructions, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11 (57.9)</td>
<td>10 (41.7)</td>
<td>3 (25)</td>
</tr>
<tr>
<td>No</td>
<td>8 (42.1)</td>
<td>14 (58.3)</td>
<td>9 (75)</td>
</tr>
</tbody>
</table>

a Descriptors are from the Well-Being Scale, a 42-item 5-point Likert scale. The maximum possible score is 210, with an optimal score >172.
b Adequate score is 152-172.
c Minimal score is <152.

say things how they are, and if they had treated me badly, I would say so.”

The discussions by the women from rural areas, however, produced a third theme, woman-centered care. This theme is related to respectful care, but it stands apart, because it subsumes an important concept, reported in previous research in this setting. The concept, no me hace caso is a Dominican saying that refers to not being listened to, having opinions discounted or ignored.10 In this study, women felt there were long periods of time that would pass before providers attended to them. There were frequent complaints that providers differed in assessing cervical dilatation, which would result in inconsistent appraisals of, and thus delays in attention to, their labor progress. Several spoke about a serious lack of attentiveness to their needs by the nursing and medical staff. As one woman said:

… when I gave birth there was a girl next to me, and her hour of giving birth had arrived, and her mother, who was with her, left [the room] and began to call them, and no one appeared until the end, after the girl had already given birth. When they finally appeared, they said no one had called them. That bothered me a lot, because what happened to her could have happened to me.

Observations by the research team in this study also corroborated the lack of attentiveness of medical and nursing staff articulated by these women.

DISCUSSION

As one of 6 situation analyses of maternity care in Latin America and the Caribbean, this study assessed the processes of care, and women’s perceptions of well-being with that care, in one public, tertiary hospital in the Dominican Republic. The results comparing all 6 participating countries have been reported elsewhere.18 There are several features that make the Dominican Republic an outlier from the other countries. As noted previously, the Dominican Republic neither educates nor employs professionally trained midwives, but some of the nurses received midwifery education from 2004 to 2007 from US midwives.12 In this setting, when nurses managed the labor and birth, their care was comparable to physicians. Moreover, women were more likely to receive evidence-based newborn care, including skin-to-skin contact and immediate breastfeeding. Also, women who gave birth with nurses in attendance were more likely to be given discharge instructions. It is not known from this study whether the evidence-based practices nurses provided were related to the midwifery education some of the nurses received from 2004 to 2007.

What is known from the qualitative part of this study is that there persists a discrepancy between providers’ self-assessment of their behavior toward their patients and rural women’s assessment of their providers’ behavior. Both women and providers were united about the lack of physical resources. Some women felt respected by providers; others did not. The most salient finding from the women in the focus groups is that some women felt that they were not listened to, that their concerns were not heard. The best example is the patient report of a family member calling out for help with her loved one about to give birth, and no one responding. The patient noted that the staff claimed no one had called them.

In 2014, the cesarean rate in the hospital under study surpassed 50% of all births. Vaginal birth after cesarean is not offered in the hospital (Lic. Rosa Burgos, MA, written communication, November 2015). Two notable results from the quantitative data are that no women in labor are
offered pain medication or continuous emotional support. It is highly plausible that lack of pain relief and denial of a companion with women during labor and birth may provoke requests for planned cesareans from women who know these comfort measures are not available. For the WHO vision for quality care for pregnant women to be realized in this setting, the next step is for all providers to heed their patients’ call to be listened to and plan collaborative activities with a time frame to account for their progress toward that goal.

**Study Limitations**

It is likely that the cross-cultural research team may have not have fully comprehended some of the sociocultural distinctions between women from urban and rural communities that might have influenced the negative perceptions of quality from rural women. The cross-sectional nature and the limited time to conduct the study were limitations. Time and budgetary constraints precluded a larger sample size overall, as well as completion of the well-being survey on the entire sample of women for whom the intrapartum data were collected.

**CLINICAL IMPLICATIONS**

A situation analysis is an essential first step in the quality improvement cycle to advance women’s and newborns’ health care in every maternity site around the globe. This study in a public hospital in the Dominican Republic indicated that while most women perceived their care was adequate or better, there was a discrepancy between the health care providers’ perception of the quality of care they provided and some women’s perceptions of their care by providers. Reflective practice and frequent communication with patients about their experience of care should be a part of every practitioner’s toolkit, wherever that care is provided.

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**CONFLICT OF INTEREST**

The authors have no conflicts of interest to disclose.

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