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Leapfrog to Value

# What matters to mothers

## Survey on mothers' values in Value-Based Care (VBC)

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# Abstract

This is a survey of what 360 South African mothers valued across the entire maternal episode. The questionnaire focused on what mattered to women during pre-natal appointments, labour and delivery and in postpartum appointments with respect to their interactions with healthcare providers. The survey investigated quantitative indicators of what different mothers valued alongside qualitative insights that mother's themselves provided.

Mothers were sampled through the Facebook groups of SideBySide and Sister Lilian Centre: two organisations that share messaging and advice to women about maternal and child health.

How mothers felt during their interactions (feeling listened to, treated with care, respect, and understanding) and whether they were offered information that could help them take charge of their own health and the health of their new-borns were the two most prominent quantitative findings. However, in the qualitative section where women could express themselves in their own words, they reflected more on the relationship with their healthcare providers. Here we found that women expected healthcare workers to perform basic competencies (being checked regularly, being offered pain relief) and to treat patients compassionately and appropriately, based on pre-existing and emergent health needs, so that they could be reassured by and trust in the care they received.

# Acknowledgements

Appreciation to SideBySide and Sister Lilian Centre for making this report possible by making their platforms available for data collection, and to all the women who completed our survey.

Thanks to Leapfrog to Value (L2V). L2V works to produce knowledge products and collaborate with regional affiliates to promote VBC.

Gratitude to Mustafa Omar on Unsplash.com for making this cover image available for use.

# Contents

# Lists of tables and figures

## List of figures



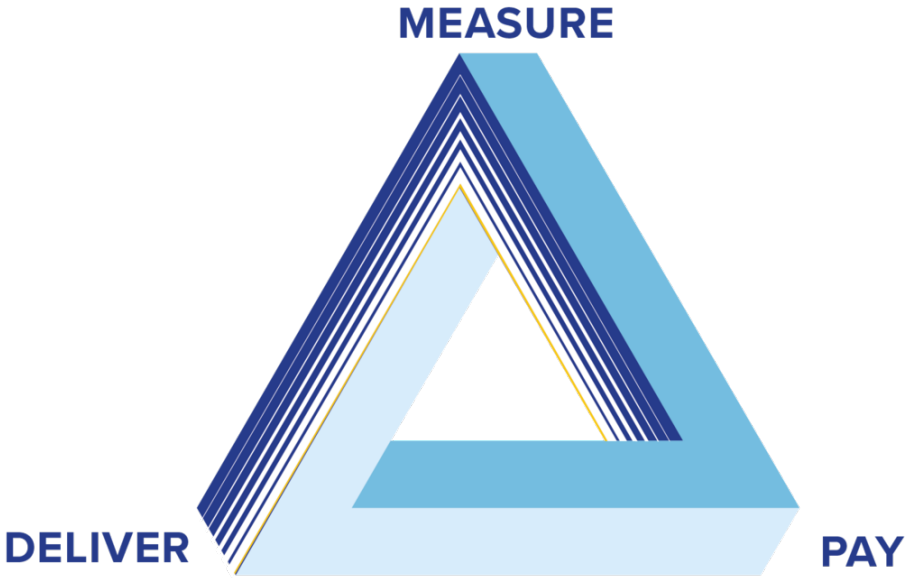
## List of tables

# 1. The role of mothers' values in value-based maternal care

Value-based care (VBC) focuses on achieving outcomes that matter to patients while optimising costs. A central tenet of VBC is that centring care delivery around the patient not only improves health outcomes for health-seekers but is also a better buy. The providers deliver the highest-value interventions (whether biomedical, social, behavioural, or environmental) using payment models that reward value, rather than volume.

Practically VBC is provided through iterating measurement of outcomes patients care about, paying for the outcome achieved, and adapting future care delivery to better achieve these outcomes. This cyclical model of care provision is illustrated in **Figure 1**.

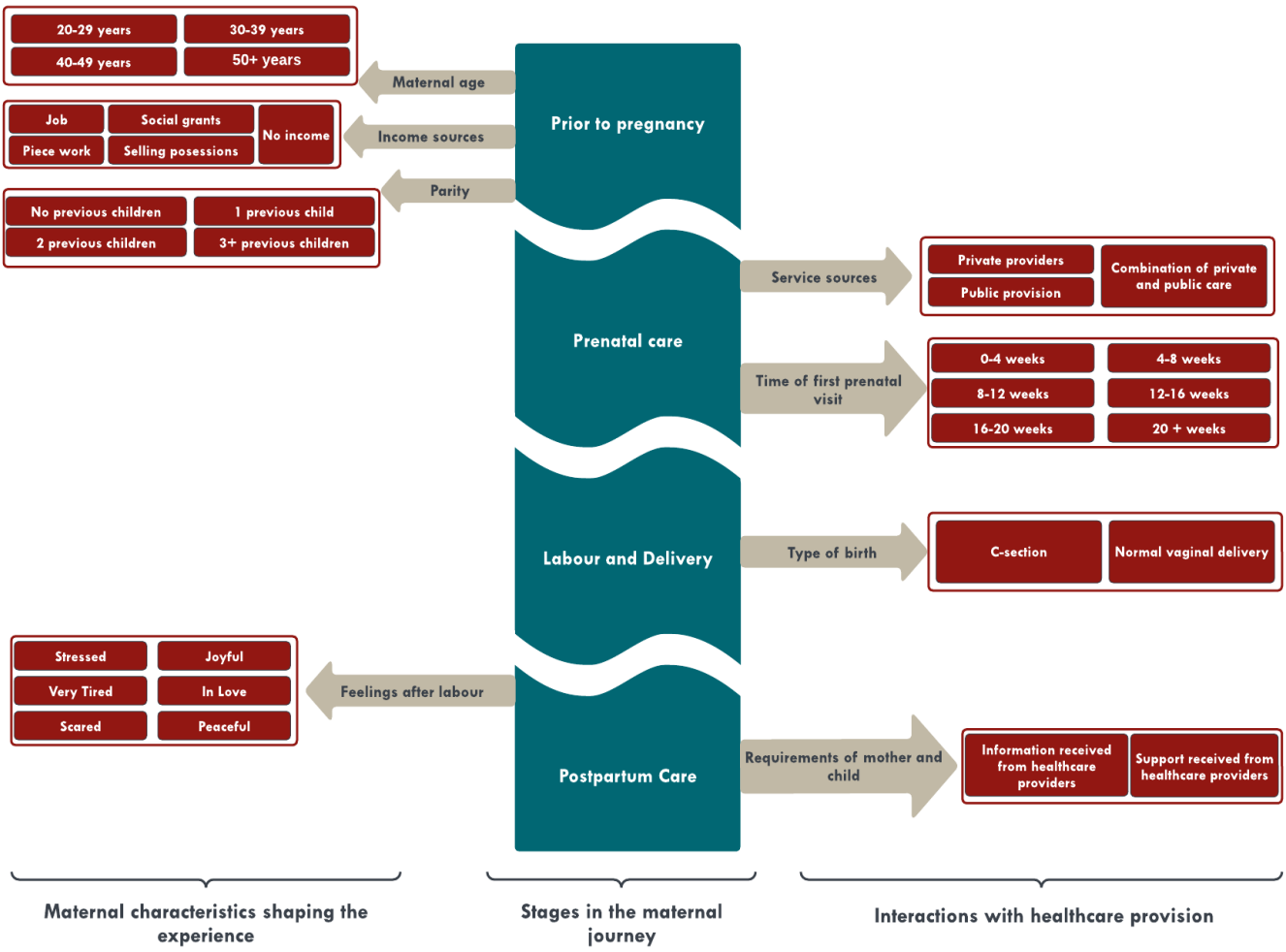
**Figure 1: VBC provision cycle**




Building a framework for VBC, and more generally human-centred care in maternity starts with understanding what outcomes matter to women and mothers as they interact with the healthcare system on their maternal journey. Once we understand what outcomes are valued, we can design measurement tools to assess these outcomes and then build payment and delivery systems around optimising them. If this is successful it can lead to improvements in care utilisation and engagement, shift power to those whom the health system is meant to serve and reduce health complications.

**Figure 2** shows the stages of the maternal care pathway, from prenatal to postnatal care. These stages of the maternal pathways were used to understand the care mothers receive and structure the questions we asked mothers. In a preliminary survey of 360 mothers, all of whom gave birth in South Africa, were asked questions about their value along this maternal pathway. On the left of the diagram below are some of the maternal characteristics that we assumed might shape their values, preferences, and interactions with healthcare, including their age, parity, and emotional state postpartum. On the right of the diagram are the utilisation questions asked in the survey. The rest of the questionnaire was focused on what mattered to women at each stage of pregnancy with respect to their interactions with health providers.

## Figure 2: The maternal journey



# 2. Reaching mothers

Despite global findings from The White Ribbon Alliance on 'what women want'[1] South African women's voices were not included in the campaign. As such, we needed local, country specific evidence that could establish what matters to South African women and mothers. We developed and distributed a survey to women who had given birth in the public sector or private sector within the past five years in South Africa.

## 2.1 Survey delivery

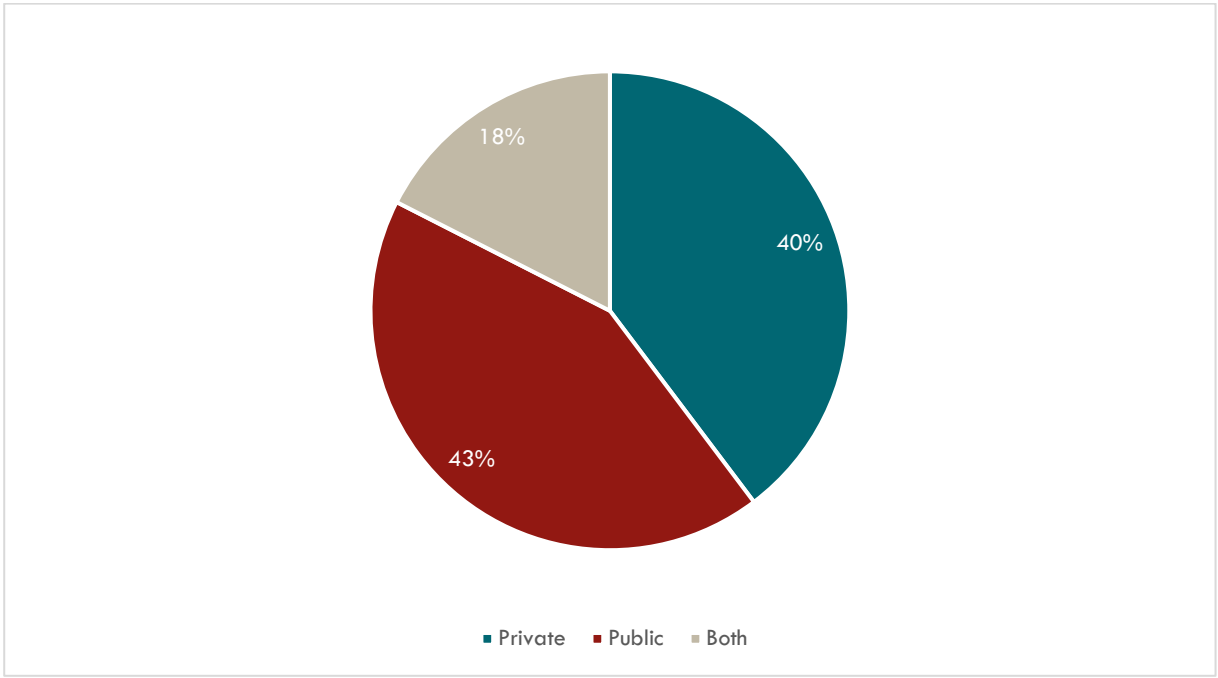
The survey consisted of 35 questions and was distributed through the Facebook groups of two organisations. The first organisation was SideBySide, the government's primary Early Childhood Development (ECD) and maternal health communication platform. SideBySide uses radio, posters, pamphlets, and Facebook to share messaging related to ECD and maternal health. SideBySide primarily reaches mothers who make use of public sector resources. The second organisation was the Sister Lilian Centre. The Centre also offers advice and advocacy for parents of young children. The Centre's communications are frequented by mothers from both the public and private sector.

## 2.2 Who were the women responding?

360 mothers responded to the survey. The sample consisted of a diverse group of mothers in terms of parity, age, and healthcare provision.

Of the respondents, 43% used the public sector exclusively, 40% used the private sector exclusively, and 18% made use of healthcare services in both the public and private sector (as shown in **Figure 3**).

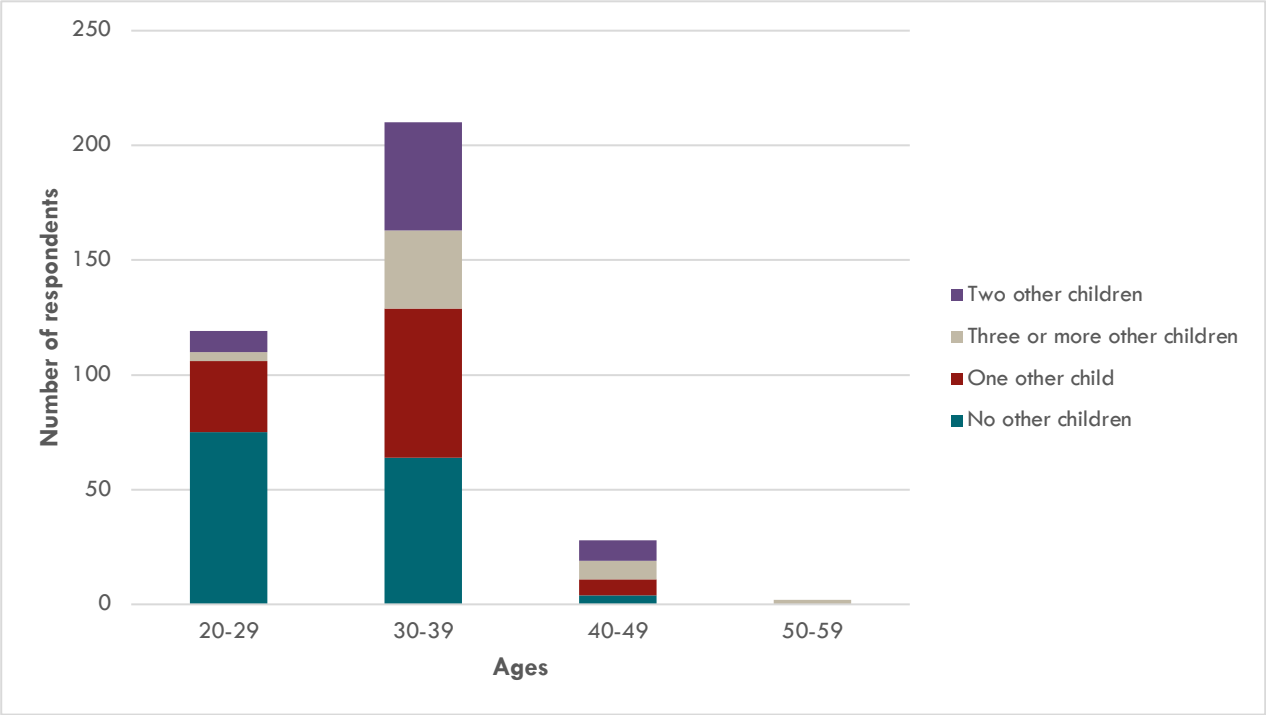
**Figure 3: Healthcare providers used**




While this cannot be considered representative of the South African population (where only around 18% of the population make use of private healthcare[2]) it does provide samples of sufficient size from each sector. Importantly, it also shows that a significant proportion use both sectors at once, which requires that we think about needs as not necessarily arising from a public private binary but as situated across a continuum. The respondents' ages and numbers of previous children were also distributed as expected, offering sufficient

sample sizes for mothers of different ages and parities. The range of mothers by age, and sub-grouped by parities, is shown in **Figure 4**.

**Figure 4: Mothers' ages and parities**




It should be noted that no mothers were below the age of 20 when responding to the survey. This would indicate that the results of this survey are not necessarily representative of younger mothers, who are an important population at risk of both poor health outcomes and poor experiences of healthcare. However, it was revealed through the qualitative survey questions that at the time of giving birth several mothers were below the age of 20, with at least two mothers being in high school and as young as 16 when giving birth. There is likely to be some representation of younger mothers even though it is difficult to quantify. There were limited respondents over the age of 50, but this poses a less noteworthy limitation to the applicability of the results as births are lower at these high ages. Respondents' ages and numbers of previous children were also distributed as expected, offering sufficient sample sizes for mothers of different ages and parities.

# 3. Investigating what mothers value

The survey's main aim was to establish what mothers value at different stages in the maternal journey. There were three questions focused particularly on what matters to mothers, each with multiple possible responses, of which survey participants could select two. The questions and available responses are shown below in **Table 1**.

**Table 1: Survey questions on what matters to mothers**

| What was most important at prenatal clinic visits | What was most important during labour and delivery | What was most important during postnatal clinic visits |
|---|---|---|
| That my health worker had all my health information, so that I didn't have to tell them my whole story | I wanted to be treated with care and respect | That health workers listen to me and understand my challenges |
| That I could meet other pregnant women | I wanted to be sure that my health workers had the training and knowledge to take care of me and my baby | That I don't spend too long in line |
| That I could ask as many questions as I needed to | I wanted to be with the same health workers I knew from my pregnancy, not new ones | That I leave with information that helps me |
| That I didn't spend too long at the clinic | Even if my birth was easy and uncomplicated, I wanted a doctor to be there | That I don't have to come back to the clinic again |
| That I felt listened to by the staff | While I was in labour, I wanted to be updated on how my baby was doing | That health workers treat me with kindness |
| That I left with information that helped me take charge of my own health | I wanted privacy from other patients | That the care I get is private |

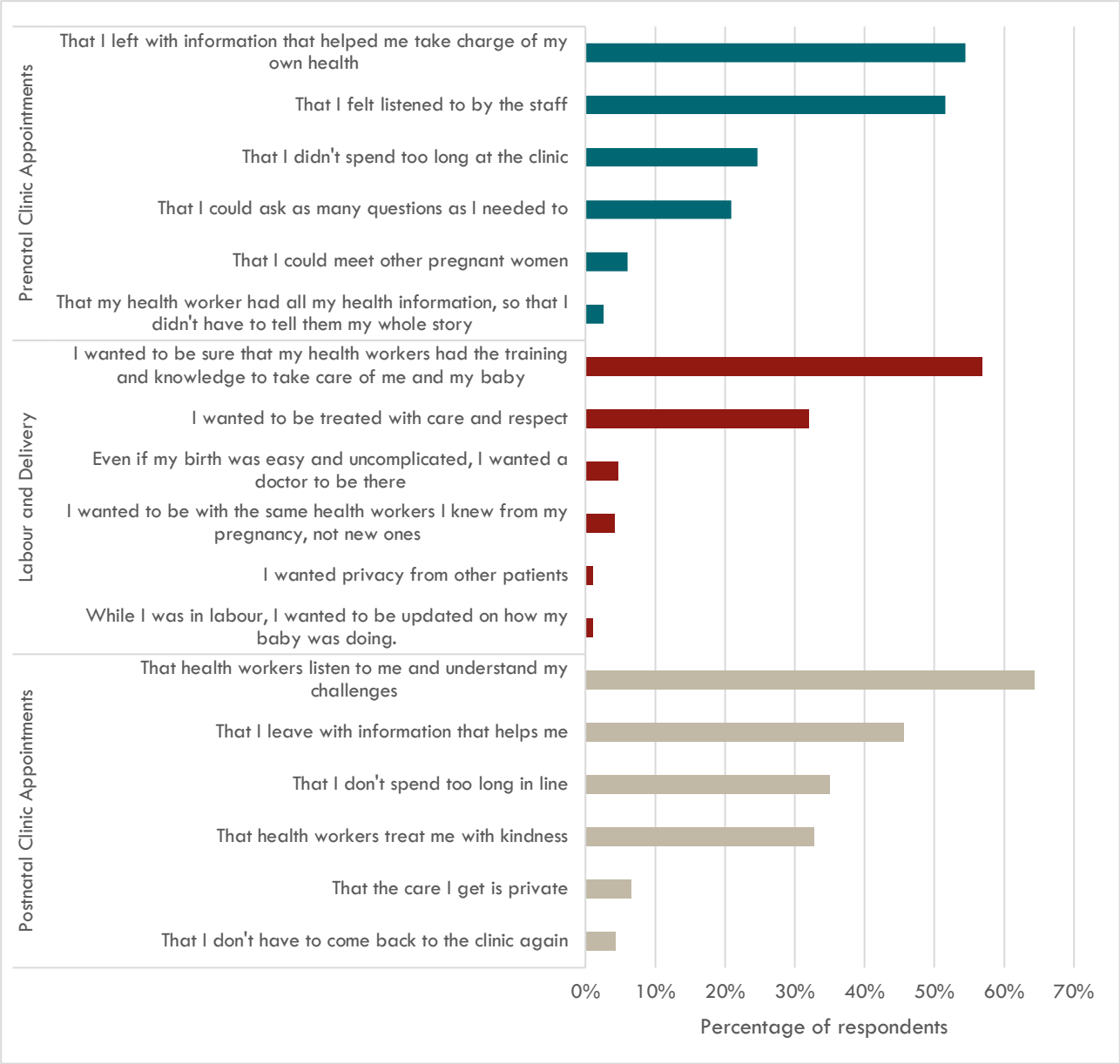
## 3.1 Quantitative analysis of responses

As explained at the beginning of this section, the key data points collected related to what mothers value during prenatal appointments, labour and delivery, and postpartum appointments. **Figure 5** shows responses reflecting what matters to mothers in terms of the percentage of mothers that selected certain options.

Mothers were allowed to select the two options that most mattered to them. Responses were then analysed by assessing which percentage of respondents selected a given option. As the respondents could select several options, the percentages in **Figure 5** adds up to more than 100%.

At each of the different stages, certain options stood out significantly. In general, how mothers felt during their interactions (feeling listened to, being treated with care and respect, being understood) and how informed they were, outweighed concerns about their health workers (such as interacting with the same health workers or having health workers with certain qualifications). However, it still mattered to mothers whether their healthcare workers have sufficient training and knowledge to provide them and their babies with appropriate medical care.

**Figure 5: Responses of what matters to mothers**




### 3.1.1 What different mothers' value

To assess whether different aspects of healthcare provision were important to mothers of different ages, parities, and healthcare sectors, a statistical analysis was performed.

The responses to the questions presented in Table 1 were transformed into a binary variable recording 1 if a participant selected it, and 0 if a participant did not select it. For example, to represent what was most important at prenatal visits, six variables were created each corresponding to one of the answer options.

These binary outcome variables were then modelled using logistic regression. The outcomes variables considered were what mattered at prenatal and postnatal clinic appointments, and what mattered during labour and delivery. The explanatory variables considered were age, parity, and healthcare provision source.

At the 95$^{th}$ percentile, the modelling only indicated three statistically significant differences:

1. Mothers who used private or public sector health services were respectively 55% and 70% less likely to value spending less time at prenatal appointments than women who used both the private and public sector services. This suggests that women who access maternity services across sectors might be doing

so, in part, because it helps them reduce waiting times. Depending on the type of service being sought, service might be slower or faster in the public vs private sector.

2. Mothers using private sector healthcare were 92% less likely to value meeting other mothers at prenatal appointments than those traversing both sectors or the public sector only. Mothers using the public sector were 22% more likely to value meeting other mothers at prenatal appointments. This suggests that mothers restricted to public sector services may experience, and seek out, a level of solidarity in this experience.
3. During labour, women using public sector healthcare services were 98% more likely to value being updated on how their baby was doing, while being 81% less likely to value their own privacy. This shows that pregnant women in the public sector may be particularly concerned about their baby's health outcomes, perhaps given rates of infant mortality in the public sector. Having been granted little to no privacy when accessing public sector healthcare services, their expectations for privacy may be low.

Additionally, at the 90th percentile, those in the public sector where less likely to value their healthcare worker already having all their information during prenatal visits than those in other sectors.

Given that the sample size for this survey was relatively small, the limited statistical significance is perhaps unsurprising. It is almost certainly the case that women who use the public sector, for example, will have very different experiences of healthcare and of mothering from those who use the private sector. But the lack of statistically significant results may also point toward an important convergence in what mothers *value* in healthcare provision, despite having very different experiences of these values being met.

## 3.2 Qualitative insights into what mothers value

Included in the survey were three qualitative questions. Below, we provide interpretation of what women want, based on their own words. It covers prenatal care, labour and delivery, and feeling powerful as a mother.

### 3.2.1 Prenatal care

The first qualitative question related to prenatal care and was designed to glean more information about whether women felt it was important that their supporter was welcome and included in clinic visits. Four main themes emerged: **help and support; reassurance; moral support; sharing in the process and counteracting loneliness; father involvement.**

65% percent of respondents indicated that their most important support person during their pregnancy was their partner, speaking to the latter theme of 'father involvement'. This theme included aspects of 'sharing in the process' and 'help and support' but was also both wider and more specific than those. It included aspects of the obligation or duty a father has with respect to caring for their child. In other words, participants drew a link between the father's participation in pregnancy and birth and greater participation in the child's life later on.

Marriages are becoming less common in South Africa. Civil marriages declined from 167, 264 in 2011 to 89, 338 which is almost half, in 2020.[3] In addition, The 2018 General Household Survey revealed that 63% of registered births had no information on fathers.[4] What we can ascertain from that is many women will not only be giving birth outside of wedlock but may have little connection to the father of their children. This makes the question of men's participation in birth and in the life of their child an important one to consider.

The finding that women felt fathers' participation in birth acted as a catalyst for future father involvement in a child's life is one we cannot ignore.

*For example: (participant 21) "In addition my partner needed to be present so that our son can learn responsibility from both parents at a young age". (Respondent 29) "they just as important as the mother." (Respondent 72) "it is important to involve him from conception to birth as this fosters a good bond for a mother father baby". (Respondent 51) "so he can… get informed as well, see his baby's growth and just feel included in everything as the father".*

Overall, father involvement was understood to make maternity care more inclusive of men's experiences and

facilitate participation in pregnancy, birth, in the child's life after the birth and in family life generally. This suggests that in order to be more attentive to what matters to women, prenatal and birthing services should be inclusive of men. The health and wellbeing of mother and child are intertwined with the quality of caring relationships in their lives and the various forms of support from which they can draw.

### 3.2.2 Labour and delivery

The second question related to labour and delivery and enquired specifically about was what else (other than the quantitative categories provided above), was important for mothers. Of the three qualitative questions, this one was the most nuanced, and should occupy a greater proportion of any further qualitative interviews.

Many answers had several codes attached, and the codes had different dimensions to them. For example (*respondent 195) "I knew I was in good hands, so I never worried about anything except coming out of theatre alive" was coded as: 1.* ***safety*** *(the affective dimension – I feel safe) 2.* ***experience in relation to mode of birth*** *(surgical birth) 3.* ***I am alive, healthy and cared for appropriately*** *(this had two dimensions – healthcare worker competency and my life and health are safeguarded).*

The code that was most frequently referenced was: **healthcare worker treatment of me and my baby**. This is unsurprising given both the focus of our survey and what we know from the literature. It has been shown that women remember with accurate precision the nature (including the sensate, felt nature as well as medical nature) of their experiences with healthcare workers up to 30 years after birth.[5],[6]

The different dimensions of this code included: **bedside manner; being checked regularly; healthcare worker competency; provides help with pain management; compassionately and appropriately cares for me and my baby**. The final three dimensions were the most complex and had different elements to each dimension: **communicates with me** (included: listens to me; involves me in decision-making; explains what they are doing and why; reassures me; prepares me in advance); **treats me with respect** (included: has respect for my birth companion; treats me fairly & without discrimination; not left alone); **respects my bodily autonomy** (included: seeks permission; privacy; freedom of movement).

**Healthcare worker treatment of me and my baby** required basic competencies such as being checked regularly, being offered pain relief, and being treated compassionately and appropriately based on previous and present health issues. The expectation was that healthcare workers would have an acceptable bedside manner that would help women cope with labour and beyond. Most women seemed to trust the information received from their healthcare worker and relied on this for their own navigation and decision-making around birth and what is best for baby.

This code most frequently dealt with issues of *healthcare workers' communication*. Women wanted to be kept abreast of what was happening to them, have things explained to them, have the repercussions of specific procedures explained so that they could prepare in advance and most importantly, they wanted *to be listened to and included in decision-making*.

This means that healthcare providers need to take seriously that they are in service to the birthing mother who oversees her own health and that of her baby. The more the healthcare worker can empower women with knowledge and information, and treat them with respect and care, the more likely it is that women's caring priorities will be met. This in turn is likely to have a positive effect on whether these women seek out care in future and the quality of care they are able to provide for their newborns.

Which brings us to the last two dimensions. It was expected that healthcare workers would not discriminate and would treat patients fairly, treat their chosen supporter with respect and not leave them on their own. While these are basic traits of healthcare providers, it seems not all women were afforded these basic dignities. This fits with the growing awareness of obstetric violence in labour wards, an important dimension of which is neglect during birth.

Women wanted to be treated with dignity, which required that healthcare workers respect their **bodily autonomy, offer them privacy, freedom of movement and request permission** before they perform any procedures. Humane treatment from healthcare workers is important to women, and to any person seeking healthcare. We need to ensure that healthcare facilities, medical institutions, and governing structures themselves contribute to and promote birthing people's dignity.

### 3.2.3 Feeling powerful as a mother after birth

Mothers were also asked to recall a time when they felt particularly powerful as a mother. The most frequent theme here was **breastfeeding**. The ability to juggle work, breastfeeding, and childcare was a common source of feelings of empowerment for mothers. However, the risk of not breastfeeding successfully was conversely shown to make mothers feel disempowered and unconfident and to doubt their mothering abilities. Hence breastfeeding is a tricky issue and one that needs to be dealt with sensitively and individually.

Being a mother was recognised as a demanding job that simultaneously filled women with meaning, joy, and purpose. It is important to emphasise that this doesn't mean mothering comes easily or intuitively. Some women mentioned "every day is a struggle" and not remembering a time when they felt confident or powerful.

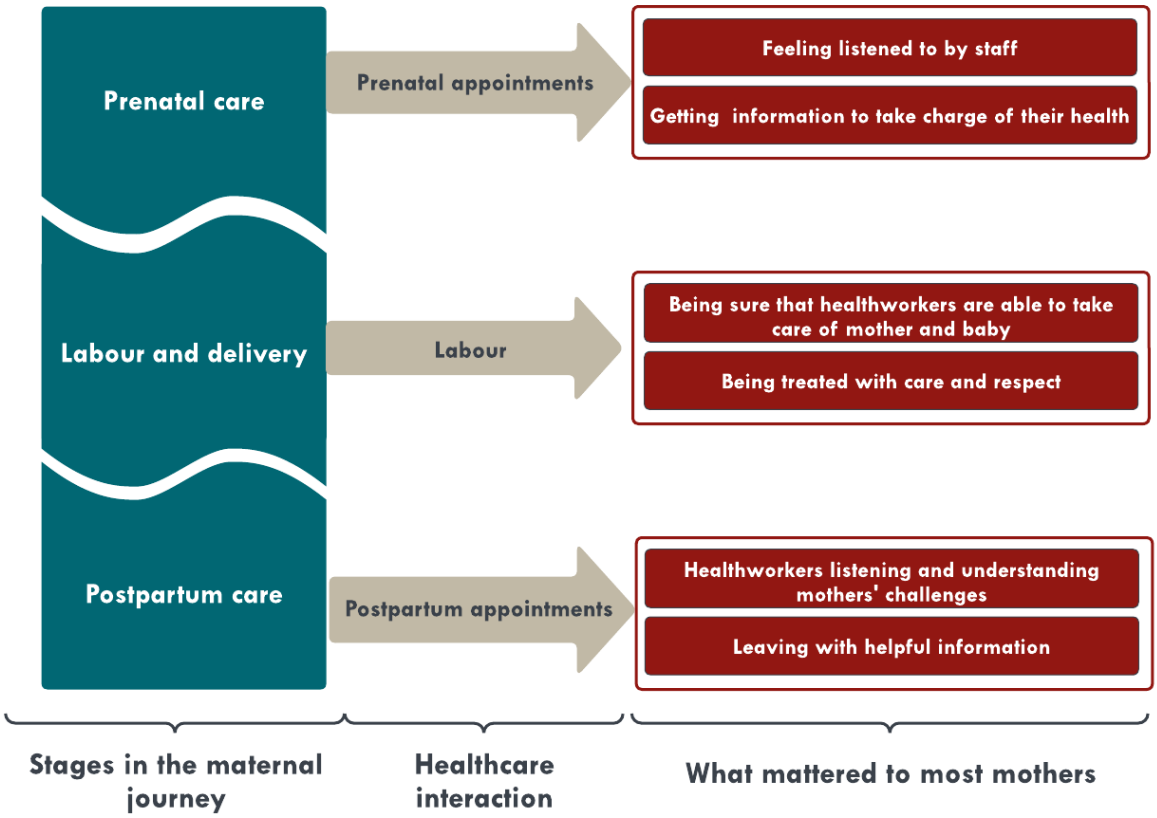
Many respondents had severe stress and anxiety when their children were sick and didn't know what to do to help them. A few sadly recalled losing their baby to illness. Helping them recover was a source of confidence for them. Hence, the ability to successfully care for and advocate for their sick children so that they may receive timely, life-saving care from healthcare institutions was an important skill. One which mothers who give birth in the public sector, may find themselves less able to do.

Overall, women had to come to trust their instincts – and this process was not linear. For many, confidence emerged when their children surpassed a particular milestone – when they reached maturity, or a certain age – or when mothers themselves had other children or successfully navigated a particular challenging period. Support for mothers should not end with the birth, but should extend across the full first 1000 days of a child's life.

# 4. Summary of mothers' values

Our survey found that what matters most to women and mothers took different forms across the different stages of care offered during pregnancy, childbirth, and during the postpartum period. Nuanced in this way, our survey adds to the existing empirical evidence on what women want, by disaggregating those demands according to specific healthcare provider interactions across the maternity journey. **Figure 6** shows the key points valued by mothers during their interactions with the healthcare system at different points in the maternal journey. In their prenatal interactions with healthcare providers, women valued being listened to and getting accurate information to take charge of their health. During labour and delivery, they valued being treated with care and respect and having certainty that the healthcare providers and institutions attending them were adequately trained and properly equipped to handle their baby and themselves, especially in case of an emergency. Finally, after the birth it was important that healthcare workers were attentive and understanding of mothers' challenges and offered them helpful information about the care of their babies when they left the hospital.

**Figure 6: What matters to mothers throughout the maternity journey**




This high-level understanding of what matters to mothers can form the basis for developing VBC solutions in maternal care. Using these results, both providers and funders of care can be involved in a conversation about what outcomes to systematically measure and pay for. This process, as discussed in 'The role of mothers' values in value-based maternal care' section is the first step in bringing about improvements in care utilisation and engagement, shifting power to those whom the health system is meant to serve and a reduction in health complications.

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