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Anthropological Insights about a Tool for Improving Quality of Obstetric Care: The Experience of Case Review Audits in Burkina Faso

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ABSTRACT: The ratio of maternal morbidity and mortality in developing countries is high. The World Health Organization (WHO) and public health specialists promote case review audits as a means of improving quality of obstetric care. This reflects the need for high reactivity in health personnel's management of obstetric complications. Within an action-research programme in Burkina Faso, a trial of case review audits was implemented in a maternity ward. This was designed to help health personnel better align their practice with clinical standards and to enable more consideration of pregnant women's needs. Social anthropologists were involved in these case review audits in order to collect data about pregnant women's lifestyles and circumstances. They also worked to train health personnel to conduct interviews. Although it is important to take account of women's circumstances within audit sessions, conducting interviews in 'anthropological ways' (at women's homes, with observations) is time consuming and may sometimes be better replaced with interviews in hospital contexts. Anthropologically informed interviews may pinpoint socio-economic situations as key reasons for problems in healthcare, but health personnel are usually powerless to address these. However, anthropology contributes an awareness of the relevance of these issues for broader healthcare planning.

KEYWORDS: audit, Burkina Faso, health personnel, interviews at home, limits of anthropological approach, maternity care, obstetric care

Introduction

Today, social anthropologists are often invited to collaborate with public health specialists. Social anthropologists are required to make beneficiaries' voices and behaviours audible and understandable. In this regard, anthropological information could make public health programmes more suitable for the contexts where they are implemented and may help

health providers to make their practices more patient-centred. In addition, anthropology may also explore organization of health services: when it is 'used to analyse the organisational context for 'adverse events' in the health services it proved a powerful analytical device which made it possible to find new ways of looking at old problems' (Hart 2006: 160).

If anthropology is often attractive for public health programmes, is its approach always ap-

appropriate when applied within a framework of action-research? We will discuss this point through the example of social anthropologists' involvement in an 'audit' project that aimed to improve the quality of care in a maternity ward in Burkina Faso.¹ Public health specialists, social anthropologists and specialists of community-based approaches for social mobilization were involved in the project. Social anthropologists were asked to help health personnel understand women's economic and social constraints and to improve quality of care by helping them to emphasize interpersonal relationships. We will start by presenting the challenge of case review audits in the context of maternal morbidity and mortality; then we will present how the audit tool was set up and the limits of anthropology in this situation.

Case Review Audits for Improving Quality of Care for Delivery

One of the best indicators to measure the health gap between developing and developed countries is the maternal mortality ratio. For instance, in Western Europe the mean is 7 maternal deaths for 100,000 live births; in West Africa the ratio is 629 maternal deaths for 100,000 live births (Hogan et al. 2010). This is a particular challenge when we consider that the main causes of maternal mortality and morbidity (MMM) are well known, linked to substandard care, and mostly avoidable (WHO 2005). Improvement of practices by skilled staff in maternity wards during delivery can reduce MMM, and clinical audits of obstetric complications or maternal deaths could be one of the tools for better practices (WHO 2004). However, as improvement necessitates social as well as technical interventions (Penn-Kekana et al. 2007), reflexive, complex and dynamic responses of health workers and community members to policies and programmes are of potential importance.

Clinical audit can be defined as 'the systematic and critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient' (Department of Health, 1989). It is possible that tools of audit could contribute to the reduction of MMM, but there is no evidence that scaling it up may have such an impact. Audit methods postulate that solutions for the care improvements, using available technical resources, could be identified and implemented by the health team itself. This approach suggests that a health team's adherence to good practice recommendations is likely to be strengthened if that team (here, the maternity ward staff) is committed in finding out what can be avoidable or improved in caring for a critical case (maternal mortality, stillbirth, eclampsia, haemorrhage, etc.).

In the Burkina maternity ward at stake, audit sessions were organized as follows (Richard et al. 2008). Cases to be audited were selected by midwives and doctors during staff meetings. These were women transferred from peripheral health centres to the maternity ward with severe maternal complications or cases of fresh stillbirths.² During an audit session, a midwife first read out a clinical summary of the selected case supplemented by a presentation of the woman's experience, which was a synthesis of information gathered during home and ward interviews with an anthropologist. All stages of the case (referral, admission, diagnosis, treatment and discharge) were reviewed and compared with the standard of care. The group then analysed the causes of deficiencies and selected the most urgent of the identified incidents to deal with. Each session resulted in three or four recommendations, and staff members were selected to follow these up. The sessions were held once a month; attendance was not mandatory and was not linked to any financial reward. Although not mandatory, staff were expected to take part and to follow instructions to implement the audit tool as

part of an international project. This may have made it hard for staff to refuse attendance at the audit sessions. Between February 2004 and June 2005, 16 audit sessions were organized with an average of 17 participants at each session. Interviews with women at home began at the eighth audit session. Overall findings from audits included problems in case management, lack of equipment, drug shortages, poor adherence to clinical standards, and communication problems (both between health staff members and with the women and their families).

Usually, audits use hospital records as the main source of data. Sometimes, in developing countries, like in our experience in Burkina Faso, women and their families are interviewed on their feelings (including pain), conditions of transfer from peripheral centres to the maternity ward, opinions about quality of care and the behaviour of staff (see Richard et al. 2003; Filippi et al. 2009). In the programme described here, interviews were first conducted at women's homes, then in the maternity ward. To develop more patient-centred approaches, an objective of interviews was to emphasize individual and socio-economic constraints in addition to medical issues. A similar approach has also been attempted in Benin, but with interviews taking place in hospital rather than at home (Béhague et al. 2008). Béhague and colleagues report the impact of women's opportunity to talk:

[R]esults show that the audit feedback interviews gave some women ... the opportunity to actively redress social conflicts and injustices imbedded in their health-care experiences When patients and their families embark on such practices, they are in effect actively modifying social hierarchies, countering feelings of social marginalisation and stigmatisation, and seeking to establish the social and medical legitimacy of their demands. (Béhague et al. 2008: 506, 508)

According to the authors, the experience in Benin showed that their approach empowered women within attempts to improve a global quality of care in addition to purely

biomedical intervention. Thus, taking an anthropological approach that makes women's voices audible to health staff may complement established processes of clinical audit. The type of information that anthropologists can collect seems useful, but the authors of the Benin project do not reflect on the usefulness of anthropologists' involvement in the process. In our experience within Burkina Faso, it was not always easy to help health personnel to collect and/or to use this kind of anthropological data during audit sessions. We will discuss this in more detail below, but first we will clarify the challenges of setting up audits.

How to Set up the Audit Session: Practical Tips

When and How to Set up the Audit Sessions

Audit sessions were time consuming and, when health personnel attended them, they were not present in the ward for their expected activities as nurses or midwives. To prevent any claim for monetary compensation, and as attendance to the sessions was neither officially mandatory nor rewarded, we chose to set up sessions during normal working hours. The sessions were generally organized at the end of the morning, when all the routine medical activities were completed. To motivate staff to attend, a drink was provided after the session, but some staff members considered a drink not to be enough of a reward. Moreover, in selecting who could attend the session, we had to take account of the recovery time for some personnel after a night on duty. Therefore, it was not easy to ensure that all staff members were present at least at one session, and some, because of the schedule and the lack of payment, were reluctant to attend.

With Whom to Set up the Audit Sessions

One of the aims of an audit session is to lead health personnel into auto-reflexivity, that is

to lead them to evaluate their practice. However, it is important to define who should attend the sessions. For the first sessions, we chose to limit attendance solely to nurses and midwives:

The intention of the midwives was to re-establish ownership of the care and responsibility of their work by doing their own evaluation in their own specific field and also familiarizing themselves with evidence-based medicine. Once they were used to presenting a case and discussing the observed deficiencies among themselves, the audit was widened ... to include other hospital personnel, as had been initially intended: medical doctors, laboratory technicians, pharmacist and administrators. (Richard et al. 2008: 2)

As audit sessions aim to pinpoint possible dysfunction in care management, some problems may be linked to the practices of a number of staff.

Restricting attendance only to nurses and midwives may have provided the advantage that they felt able to talk without fear, as they may have been afraid to speak freely in front of a physician or a gynaecologist. However, the role of other staff had the potential to influence care. For instance, cashiers played a role as they waited for a woman's family to gather the required sum expected for a medical intervention, and ambulance drivers' availability could be an issue. Staff in peripheral facilities also had their parts to play, for instance in making decisions about when to transfer a woman for a caesarean section. In such instances, we therefore invited health personnel working in peripheral facilities to attend audit sessions.

By corollary, in order to inform decisions about who to involve in the audit process, it is important to ask for whom the improvement of care is an issue. If improvement is only a concern for the medical staff of the maternity ward, then the gynaecology–obstetric practices in the referral hospital are the focus. If the specific hospital organization is concerned about improvement, then administrative as well as technical staff can be involved. If the

whole network of care is the focus for improvement, then personnel of the peripheral facilities could be involved. Even more widely, the whole management team, at the health district level, and representatives of the community, as suggested by Filippi and colleagues (2009), may consider the necessity for reporting problems arising at the peripheral level as crucial to understanding issues such as delay before reaching a maternity ward. Finally, if a husband or family has had a part to play in decisions about care, then questions arise about whether they should be invited to be involved in the audit sessions.

To address these issues, we chose to work first at the clinical level with nurses, midwives, doctors, laboratory technicians and pharmacists. Second, we worked at the administrative level, in order to deal with questions of admittance and payment for emergency cases. Of course, considering the people attending the session, discussions varied from acute medical point to general organization of care. The question here is to know whether areas identified for improvement addressed specific medical practices in the ward or, on the other hand, global governance of the local health system.

Which Cases to Be Audited

Every case with complications is, theoretically, suitable for an audit. In practice, especially in settings where there are numerous cases of complications and so much maternal mortality and morbidity, this may be impossible in practice. In our experience, everyone working as health staff in Burkina Faso witnessed a maternal death at least once in his or her working life. For everyone, a death during delivery is a dramatic event: feelings about a maternal death are acute, and health personnel know that such a death could be due to a professional error which could be reported.³ Therefore it is very difficult to discuss a case of maternal death: the temptation to find a culprit is high, participants can find such discussions stressful and

attempts to identify future preventive solutions may fail as a result. As conducting audit sessions for cases of maternal death may lead to these challenging consequences, we chose only to audit cases of non-fatal complications.

How to Ensure Confidentiality

Discussions within audit sessions take place in conditions of absolute confidentiality. This is because sessions can highlight mistakes, dysfunctions, bad practices or errors. It is highly sensitive to criticize professional practices in collective sessions, sometimes in the presence of external personnel (e.g. an anthropologist or public health expert). We noticed that the personnel involved in the care of the audited case were present during the first sessions. As the programme progressed, some became reluctant to attend. Health workers expressed dissatisfaction with the way that audits were held, feeling that the attitude of those in charge was too repressive ('why do they speak loudly to us if they want to improve quality?'). They also felt that audit sessions highlighted only the negative aspects of case management, that staff anonymity was not respected, and they felt it unfair that medical doctors' case notes were not audited ('It's not fair – only cases of midwives are audited, they have never chosen cases of the bosses. They do errors too.') (cf. Richard et al. 2008).

Before starting an audit session, we reminded the participants that the session was not a court, and no information discussed would go beyond the room's walls. This is because some errors discussed in the sessions may constitute staff negligence. Absolute confidentiality prevents any risk to staff: for instance, for a nurse to be prosecuted by a woman's family if a nurse's error was identified during an audit. Even with safety procedures and confidentiality recommendations, the sessions had the potential to be seen like tribunals, especially for the personnel involved in the care of the audited case. Therefore, some-

times only staff members who had nothing to do with the audited case were present.

To conclude this section, we want to emphasize the limits of the audit tool itself, but also some challenges faced by health personnel in their attendance of audit sessions. In general, it is not easy for any professional to be publically criticized by peers, and professionals may be reluctant to admit errors (Richard et al. 2005). Auto-reflexivity induced by an audit is a real challenge, especially in audited cases with substantial ramifications for patients. Within obstetric care, impacts are often life changing for women and their families, and include infertility, infection and stillbirth. It is within this serious context that the anthropologists were involved in developing case studies and feedback of women's experiences.

Doing Women's Interviews for Audits

As previously mentioned, the first interviews to collect information about women's perception were carried out at home: 'The interview included the management of previous pregnancies and deliveries, the outcome and follow up of the present delivery, the cost of transport and hospitalisation, the preceding knowledge about this hospital, the perception of the care and caregivers, the care received and suggestions for improvements' (Richard et al. 2008: 2). Interviews were also conducted by some health personnel. This was to help personnel feel ownership of the new audit tool and to make them conscious of the complexity of interviews and of women's lifestyles and circumstances. During interviews health personnel were also able to help women understand medical information and to address any fear of intervention, for instance about caesarean sections.⁴ Interviews were initially conducted at women's homes because the context of the hospital seemed to constrain women's ability to talk freely about their experiences of delivery. Moreover, conducting interviews at home

allowed us to appreciate a woman's lifestyle, to collect complementary information from other members of her family and to assess her difficulty in accessing a health facility. However, this procedure was too time consuming for health personnel to implement it as a routine procedure, considering the project's agenda, the schedule for audit sessions, and the health workers' availability.

Our first difficulty was finding and reaching women's homes. Sometimes women who had transferred to the ward had travelled a long distance, and we had no time to go so far. We therefore limited our interviews to women living in the town where the hospital was located. But even for these women, it was often challenging to find their homes. We spent much time trying to look for women's homes, sometimes without success. This was for a range of reasons: women gave us imprecise or incomplete addresses; on the outskirts of town there were sometimes no street names, especially in irregular settlements; or women gave the temporary address where they stayed at the end of their pregnancy to be closer to the hospital, which they then left after delivery; finally, mobile phone numbers were sometimes incorrectly recorded or had no credits, which made it impossible to locate women by mobile phone.

When a case was selected to be audited, failing to find the woman altered the session. Staff reported clinical data, but it lacked the feedback of the woman's experience. We were especially disappointed because of the time and money committed to the engagement of an anthropologist and the health personnel. Our initial plan to conduct interviews at home was in part to provide good information for minimal outlay. However, we found that interviews at women's homes were not an easily achievable element of case review audit processes.

The alternative was to collect information from women once they had recovered from delivery but were still on the ward. With this option, the issue of finding women for inter-

views was removed (even for those living in remote areas). It was also easier and less risky to involve health personnel in conducting interviews: if interviews happened in the personnel's workplace then there was no insurance problem, which can be an issue when personnel are out of their health centre during opening hours; and it was cheaper (regarding time spent for each interview, and maintaining staff on site). Useful information can still be collected through interviews conducted in hospital. For the women, taking part in an interview in hospital may be the first time that they are listened to, which can make the hospital appear as a 'humanized' institution that listens to patients. We must also emphasise that good anthropology may be done in hospitals. However, it is worth noting that the hospital context may limit women from talking freely, especially when health personnel are conducting the interviews. Moreover, a situation of hospitalization just after delivery may not be the best time for interviews because women wanted to leave as soon as they can. The 'norm of passivity' may also come into play, in which patients declare their satisfaction even in the face of negative experience. Above all, with interviews in hospital you cannot, of course, add observations to words. For instance, it is not possible to observe transportation difficulties; nor to understand elements of the women's lifestyles when you do not see where they live; nor to record opposing points of view by questioning other members of their family at home, which might explain in part the delayed decision to seek a medical facility.

Once again, the question is: what specific objectives are we trying to achieve when we try to complement the clinical data with women's feedback of their experience? According to Freidson (1972), patient-provider relationships may be characterized more by conflict than agreement. Harsh attitudes from health personnel in African contexts are well documented (see Jewkes et al. 1998; Richard et al. 2003; Walker and Gilson 2004). In which case,

is the objective to ‘humanize’ patient–provider relationships and to make empathy an element of care quality? Is another objective to identify poor caring practices that are not included in clinical reports and to foster more patient-centred relationships as interview feedback provides health personnel with the chance to hear about women’s pain and problems? It must be borne in mind that if interviews in hospital wards engender the ‘norm of passivity’, then these goals may not always be reached. Our project highlighted the challenges of using anthropological standards of information collection at participants’ homes, although those standards aim to gather information that is as complete as possible by employing observation alongside interviews. We could therefore wonder whether the method of hospital interviews used in the project, as a means for including women’s perceptions in the audit sessions, is really related to anthropological approaches. In other words, even if interviews conducted at hospital level provided some important information that was missing from medical case notes, we have to consider whether the method has anything to do with anthropological approaches.

The Acceptability of Hearing Women’s Voices

Whether hospital-based interviews are anthropological or not, reporting information collected from them serves to emphasize women’s life contexts, especially regarding accessibility of health facilities. As already mentioned, interviews provide evidence about the women’s experience of pain (an element seldom taken into account), and women may make suggestions about quality of care (e.g. reception, advice received, staff consideration). Are health personnel always open to women’s perspectives though? Put differently: how useful is the information about women’s lifestyles and circumstances to audit sessions?

Occasionally, in audited cases, medical care seems adequate regarding the available equipment and nurses’ technical competence, but a woman’s experience brings to light much pain and a real dissatisfaction. This includes reports of suffering during delivery that health personnel did not take into account; lack of availability of personnel; lack of a bednet in a malaria endemic area; and medical assistants asking for reward before providing help to women. Sometimes, these issues can be addressed, but there is a risk that revealing such bad experiences may increase personnel’s negative feelings towards the women. Some staff suspect that patients do not ‘tell the truth’, and do not understand advice because ‘they are illiterate’, especially when the care seems to be adequate according to the clinical report.

Sometimes, ethnographic data may highlight issues in care before or after delivery that medical data and notes do not reveal (e.g. corruption, verbal violence, lack of care after delivery, irrelevant information to women by her entourage or health personnel). In some cases, the critical events are essentially bound to a woman’s socio-economic status (i.e. poverty), which is difficult to deal with in this context, whatever the quality of medical care. Thus it is possible that an anthropologist’s work may point out some problems which are not related to clinical care provided by the staff of the maternity ward.

Health personnel may see anthropologists as advocates for women and as failing to take staff work conditions into account. For instance, anthropologists may be accused of pinpointing only what is not working and of paying attention to rumours and lies: ‘Women are lying and anthropologists are listening to them!’ some personnel said. Anthropologists may expose very specific data about women’s lives, which influence quality of care but for which health personnel cannot be held responsible. They may be suspected of inappropriately merging questions of medical care with socio-economic problems. This might mean that an-

thropological intervention confirms staff members' feeling that audit sessions are 'courts' where health personnel stand trial. Therefore, anthropologists' interventions in audit processes may have the opposite effect than the intended one: anthropologists' provision of information might irritate health personnel. Once this occurs, there is a risk that health personnel may no longer wish to hear recommendations for modifying their own practice and for finding solutions for improving quality of care, namely to reach the goals expected through audit sessions. Moreover, when the whole medical staff is involved in a global dynamic of improving care, with good results, and with reciprocal confidence arising between the staff members, then the 'trial' set up by anthropologists could demotivate personnel.

Conclusion

Generally speaking, implementing and sustaining an audit is a complex intervention that requires careful planning and consideration. It is important to consider both the content and the context in which the audit takes place when developing strategies for sustainability (Hutchinson et al. 2010). Training health workers to conduct interviews with women and to deal with qualitative data could help health workers to understand their circumstances, such as lack of transport, insecurity or lack of money. This may help personnel to achieve a fuller appreciation of the decisions that women face when accessing healthcare. But the question remains whether anthropologists are best placed to train and support health personnel to conduct interviews. Furthermore, while anthropologists collect ethnographic information and analyse social, economic and political dynamics within relationships between people involved in the 'delivery arena' (e.g. women and their parents, drivers, health personnel and administrators, medical district officers, international experts), their conclusions from

this work may not be palatable or easily remedied by the healthcare system. Should anthropologists therefore learn to be silent in order not to hamper the global project?

Audit case review presents challenges in its set-up, the time commitment required and need for health personnel to engage with its processes. However, it is a useful tool for improving quality of clinical care (Richard et al. 2008). If used with sensitivity, women's views on their personal experiences of accessing health facilities and their views about the attitudes of health personnel may be rewarding. These views sometimes allow identification of critical elements of care that are not always reported in medical records (medical folders may be near to empty, because health personnel do not or cannot take time to write, and some stages of care can be reconstructed in part with the woman's narrative).

Campo (2006) writes that collecting information about patients' experiences may provide information needed to modify healthcare. We are not sure if information collected by health personnel during interviews conducted in hospital can be described as an 'anthropological approach'. But our objective was not to train nurses, midwives or gynaecologists as professional anthropologists. Instead, by taking women's narratives into account within audit sessions, the ultimate objective was to sharpen health personnel's awareness that women sometimes have good reasons for not doing what the staff expect. Anthropologists can take part in enterprises to teach health workers or other professionals (social workers, medical district officers, etc.) how to carry out interviews (hospital or home interviews) and how to identify the main issues within these interviews. This material could be used within clinical audit processes to ensure that patients' voices are represented, while mitigating the potential for resistance to external professionals in the audit process.

In addition to highlighting the importance of women's voices, anthropologists may identify

important micro-political considerations for the delivery of care, such as social, economic or political dynamics. Although these issues may be hard for health personnel to address in their practice, making them visible has wider implications for the design of a healthcare system as a whole. Through involvement in case review audits and by making the connection between micro- and macro-level processes, anthropology can contribute to broader debates about the design and delivery of healthcare.

Case review audits, like many other evaluation and feedback methods, is not only a technical device. Some have considered these tools as underscored by specific moral and social values, or by ideologies (Strathern 2000). It is worthwhile to analyse and re-politicize technical devices of audit and evaluation (Pels 2000). Complementing clinical audits with information collected through interviews is a way to re-politicize the use of a technical tool, especially when such information-gathering is conducted by social anthropologists. When politics is added to the use of a technical tool such as an audit, then debates, reluctance and conflict can be expected to arise. Here, anthropological perspectives are important.

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Notes

1. This initiative was a part of a more global multidisciplinary project dealing with the improvement of quality and accessibility of emergency obstetric care, founded by the French Ministry of Foreign Affairs (2004–2006) and implemented in several African countries (Burkina Faso, Cameroon, Senegal, for the audits).
2. This term refers to births where the baby is likely to have died during or close to the time of labour, rather than earlier.
3. It is well known that maternal deaths in hospitals are under-reported, and it was not always easy to document when and where the death happened: at home, on the way from home to the nearest health centre, during the transfer from peripheral to referral health facilities, when the woman just arrived at the emergency ward, etc. There are many situations explaining why a health facility does not count a maternal death in its statistics. This could also be illustrated by the huge discomfort of health personnel to declare a maternal death.
4. Regarding the main objective of the project about obstetrical complications, women's declarations are generally related to medical interventions and their fear that 'if you have a caesarean section for your first baby, afterwards you will always have a caesarean section for the next babies'.

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