Scientific Research Publishing

Open Journal of Obstetrics and Gynecology, 2025, 15(9), 1447-1461
https://www.scirp.org/journal/ojog
ISSN Online: 2160-8806
ISSN Print: 2160-8792

Healthcare Providers' Attitudes toward Standardizing Clinical Handover: A Multi-Site Study in Referral Maternity Hospitals in Burkina Faso

Marguetou Compaore[1*], Félicité W. Nana[1], Nestor Bationo[1,2], Souleymane Sidibe[1], Patrice Ngangue[3], Romaric Toe[4], Blandine Thieba[1], Maxime K. Drabo[5]

[1]Université Joseph Ki Zerbo, Ouagadougou, Burkina Faso
[2]Université Saint Dominique d'Afrique de l'Ouest, Kombissiri, Burkina Faso
[3]Faculté des Sciences Infirmières, Université Laval, Québec, Canada
[4]Hôpital Militaire Capitaine Halassane COULIBALY, Ouagadougou, Burkina Faso
[5]Institut de Recherche en Science de la Santé, CNRST, Ouagadougou, Burkina Faso
Email: *mariettoe12@gmail.com, nestorbationo72@gmail.com, patrice-alain-gerard.ngangue.1@ulaval.ca, romatoe19@gmail.com, m_drabok@yahoo.fr

How to cite this paper: Compaore, M., Nana, F.W., Bationo, N., Sidibe, S., Ngangue, P., Toe, R., Thieba, B. and Drabo, M.K. (2025) Healthcare Providers' Attitudes toward Standardizing Clinical Handover: A Multi-Site Study in Referral Maternity Hospitals in Burkina Faso. *Open Journal of Obstetrics and Gynecology*, **15**, 1447-1461.
https://doi.org/10.4236/ojog.2025.159121

Received: August 12, 2025
Accepted: September 9, 2025
Published: September 12, 2025

Abstract

Background/Objectives: Poor communication between healthcare providers is a leading contributor to adverse events, particularly during clinical handovers. These moments are critical junctures for transferring information essential to patient care. In Burkina Faso, limited evidence exists on healthcare providers' perceptions of handover practices. This study aimed to explore the attitudes of key maternity care personnel toward the standardization of clinical handovers in referral hospitals. Methods: A qualitative, descriptive, cross-sectional study was conducted between August 7 and November 22, 2023, in three referral maternity hospitals. Semi-structured interviews were carried out with purposively selected healthcare providers. Transcripts were analyzed thematically using Nvivo to identify key themes. Results: A total of 29 participants were interviewed. All respondents acknowledged the importance of clinical handovers for patient safety but reported that handover practices were inconsistently applied, especially during shift changes. Most participants supported the idea of standardizing handovers and expressed openness to implementing a structured model. However, anticipated barriers included resistance to change, lack of formal guidelines, and insufficient training on effective handover procedures. Conclusions: Maternity care providers in referral hospitals demonstrated positive attitudes toward the standardization of clinical handovers. These findings provide a foundation for developing and implementing stand-

ardized handover protocols aimed at reducing adverse events and improving maternal and neonatal care quality in Burkina Faso.

Keywords

Clinical Handover, Healthcare Provider, Attitudes, Standardization, Maternity Care, Burkina Faso

1. Introduction

Effective communication among healthcare providers is a cornerstone of high-quality care and a critical determinant of patient safety. Among the various forms of clinical communication, clinical handover is defined as the transfer of professional responsibility and essential patient information from one caregiver or team to another. It represents a particularly high-risk but pivotal moment in the care continuum [1]. These handovers, especially during shift changes, require the rapid, accurate, and coordinated exchange of information to ensure continuity and safety in patient care.

The importance of standardized clinical handover has been extensively highlighted in the international literature. Studies have shown that structured handover protocols can significantly reduce errors and improve care coordination [2]-[4]. Conversely, communication failures during handovers are recognized as leading causes of preventable adverse events in hospitals. In the United States, reports from the Joint Commission indicate that communication breakdowns contribute to wrong-site surgeries, delayed treatments, medication errors, and falls [5].

In obstetric care specifically, approximately one-third of malpractice claims are linked to communication errors, with failures in information transfer during labor and delivery being particularly frequent [6].

A structured communication tool can significantly enhance the effective exchange of patient information, minimize adverse events, promote patient safety, elevate the quality of care, and improve healthcare provider satisfaction [7].

In 2007, the Joint Commission International (JCI) and the World Health Organization recommended the adoption of a standardized approach to handover communication through the use of the SBAR technique—an acronym for Situation, Background, Assessment, and Recommendation [8].

In Burkina Faso, the Ministry of Health has introduced a national guideline on managing adverse events associated with care, which acknowledges communication as a key human factor in patient safety. This guide seeks to establish a harmonized framework for managing risks within the healthcare sector. The standardization of procedures has been recognized as an effective strategy for reducing the likelihood of errors and enhancing the delivery of care. However, there is still no standardized model or national protocol to guide clinical handover practices [9]. This gap is particularly concerning in maternity care, where delays and miscommunication can lead to severe maternal and neonatal outcomes [10]. Despite

the recognized importance of clinical handover, little empirical research has examined how this practice is implemented or perceived by healthcare providers in Burkina Faso.

Given this context, it is critical to explore how frontline maternity care providers, including unit coordinators, team leaders, and supervisors, perceive the potential for standardizing clinical handovers in referral hospitals. Understanding their attitudes, readiness, and perceived barriers is essential for informing national strategies aimed at improving communication and enhancing the quality and safety of maternal and newborn care.

This study aims to explore the attitudes of key maternity care personnel toward the standardization of clinical handovers in three referral hospitals in Burkina Faso.

2. Materials and Methods

2.1. Study Design and Period

This study employed a descriptive qualitative design, conducted between August 7 and November 22, 2023, in three tertiary referral maternity hospitals in Ouagadougou, Burkina Faso.

2.2. Study Setting and Population

The study was conducted in the maternity units of the following university hospitals: Yalgado Ouédraogo (YGD), Bogodogo (BGDG), and Tengandogo (TGDG). These facilities serve as national referral centers with high patient volumes and represent different organizational levels within the health system. The study targeted unit coordinators (UC), care unit supervisors (CUS), and team leaders (TL)—key personnel responsible for organizing care delivery, supervising clinical teams, and mentoring frontline providers in obstetric and neonatal services.

2.3. Sampling Strategy

A purposive sampling approach was used to select study sites and participants. The three hospitals were chosen based on their status as national referral centers with structured maternity units. Participants were selected non-randomly based on their roles in team management, care coordination, and oversight of handover processes. Eligible participants were required to: (1) be actively serving as a UC, CUS, or TL in the maternity unit; (2) have at least one year of experience in the department; (3) be present during the study period; and (4) provide informed consent to participate. Participants were recruited within the hospitals following a presentation of the study's objectives, emphasizing anonymity, voluntary participation, confidentiality, and informed consent. Ethical approval was presented prior to recruitment. Interviews were scheduled based on the availability of respondents to ensure minimal disruption to their clinical responsibilities. In total, 33 healthcare providers meeting these criteria were recruited.

2.4. Data Collection

Data were collected using semi-structured individual interviews, guided by a tool organized around eight core themes: perceptions, opinions, beliefs, judgments, motivations, persuasions, intentions, and overall attitudes toward clinical handover practices. Interviews were conducted in person by three trained medical students, following prior orientation on qualitative interviewing techniques and ethical considerations.

Interviews were audio-recorded using digital voice recorders after obtaining verbal and written consent from participants. Data collection continued until thematic saturation was reached—defined as the point at which no new themes or insights emerged from successive interviews.

2.5. Data Analysis

Interview recordings were transcribed verbatim and analyzed manually using thematic content analysis. Initial coding was carried out to identify meaning units, which were then grouped using axial coding to generate broader themes. Interpretation of themes was iterative and grounded in the study objectives.

To enhance credibility and trustworthiness, findings were returned to selected participants for member checking, allowing them to validate the accuracy of their responses and suggest clarifications if needed. Rigorous documentation of the coding process and transparent reporting of analytic decisions supported the confirmability and dependability of the results, in line with qualitative research standards [11].

2.6. Ethical Considerations

The study received ethical approval from the National Ethics Committee for Health Research in Burkina Faso under protocol number No. 2023-03-065. Authorization to conduct the study was also obtained from the general management of all participating hospitals. All participants provided informed consent before the interviews, and confidentiality and anonymity were strictly maintained throughout the research process.

3. Results

3.1. Socio-Demographic Characteristics of Participants

A total of 29 healthcare providers participated in the study, yielding a participation rate of 87.9%, based on the saturation of information. Among the respondents, 51.7% were team leaders, and the majority were midwives (including both male and female practitioners). The mean age of participants was 44.6 years, with most having over 10 years of professional experience in obstetric care (see **Table 1**). The sex ratio (male to female) was 0.31, indicating a predominance of female participants, consistent with gender distribution trends in the maternity care workforce.

Table 1. Distribution of CUS/SUS/CE in the teaching hospitals of Ouagadougou by socio-demographic categories n = 29.

Variables	Number of Participants (n)	Percentage of participants (%)
Age		
30 - 39 years	2	6.89%
40 - 49 years	23	79.31%
50 years and older	4	13.79%
Professional Experience		
3 - 5 years	0	0%
5 - 9 years	0	0%
10 years or more	29	100%
Gender		
Men	7	24.13%
Women	22	75.86%
Professional Category		
Specialist Nurses	4	13.79%
Midwives	17	58.62%
Specialist midwives	8	27.58%
Responsibility		
Team Leaders	15	51.72%
Unit Supervisors	11	37.93%
Unit Coordinators	3	10.34%

3.2. Attitudes of Unit Coordinators, Care Unit Supervisors, and Team Leaders (UC/CUS/TL) Toward Clinical Handover

As key actors in the organization and supervision of maternity care, care unit coordinators, supervisors, and team leaders (UC/CUS/TL) are well positioned to influence the quality and consistency of clinical handover (CH) practices. Their attitudes toward CH are crucial for understanding the feasibility and acceptability of implementing a standardized handover model. This section explores their perceptions, motivations, and concerns, providing insight into both the enablers and barriers to improving communication during care transitions.

3.2.1. Perceived Role of Clinical Handover in Enhancing Care Quality and Patient Safety

All respondents consistently recognized clinical handover (CH) as a critical component in improving the quality of care and ensuring patient safety in maternity wards. Shift handovers were identified as key transition points during which essential information about patient status, ongoing care, and potential risks must be

communicated clearly to avoid errors and ensure continuity.

Participants emphasized that clinical handovers during job rotation periods were crucial for sharing up-to-date information on women in labor or those receiving postpartum care. Given the continuous nature of maternity services—where patient needs may evolve rapidly depending on the stage of labor or complications—respondents considered clinical transmission to be an indispensable tool for coordination between outgoing and incoming teams.

One respondent articulated this importance as follows:

"In clinical settings such as maternity wards, continuity of care is mandatory for patients to receive quality care. Since our services operate continuously with shift rotations, there must be transmission between the outgoing and incoming teams. [...] It is a very relevant and essential aspect to prevent errors such as duplication or omission in patient management, or even a complete break in the continuity of care." (BGDG 1)

Overall, participants viewed clinical handover not simply as a routine task, but as a strategic safety mechanism that contributes to better clinical decision-making, risk reduction, and improved outcomes for mothers and newborns.

3.2.2. Assessment of the Implementation of Clinical Handover in Maternity Services

Across all three referral maternity hospitals, the conduct of clinical handover (CH) was widely perceived as unsatisfactory by the respondents. Several factors were cited to explain this situation, including inadequate communication within care teams, the absence of a shared understanding of the importance of CH, and the lack of formal guidance or standard operating procedures.

While CH practices had been partially implemented—notably at the University Hospital Center of Tengandogo since its opening—interviewees reported that these efforts have faced significant operational challenges. Chief among these were frequent staff turnover, a decline in adherence to protocol, and the absence of institutional directives to reinforce handover practices over time.

In contrast, at the Yalgado Ouédraogo and Bogodogo university hospitals, the conduct of CH was described as inconsistent and largely informal. The handover process lacked standardization, and overlap periods between outgoing and incoming teams were often not respected, leading to fragmented or delayed information transfer.

One respondent from Tengandogo highlighted how CH was once systematically integrated but gradually eroded:

"At our hospital, clinical handover used to be part of our routine. It was included in our protocols, and we had a clear outline of the information that needed to be shared during handover. But as staff have changed, the practice has declined. Today, it is not well-respected." (TGDG 01)

This decline in adherence to clinical handover protocols, especially in high-risk units such as maternity care, was a recurring concern among participants. Respondents emphasized the need for a formalized, institutionally supported model

to restore the quality and consistency of clinical transmission across maternity units.

3.2.3. Gaps in Practice and Perception of Clinical Handover

Respondents noted that the need for effective clinical transmission is not fully recognized by all providers, particularly during shift changes. In many instances, there is minimal to no direct interaction between the outgoing and incoming teams, resulting in fragmented communication. Instead of structured verbal handovers, information is often conveyed through written notes or logs, which may omit critical clinical details or nuances.

Only exceptional or complex cases were typically discussed in person with the incoming team, while routine patient care information was left undocumented or transmitted superficially. This practice, according to participants, increases the risk of omissions, misunderstandings, and compromised continuity of care.

Many respondents stressed that the physical presentation of patients during handovers—*i.e.*, allowing the incoming team to see and assess patients themselves—was essential to ensure safe and holistic care. The lack of such interactions was identified as a systemic weakness in current handover practices.

One team leader described the issue as follows:

"It often happens that an outgoing provider gives instructions without presenting the patient to the incoming team. According to best practices, the new team should be informed not only about the patient's health status, but should also see the patient directly to ensure proper care. Too often, we simply mention the patient's name and introduce treatments without the incoming team ever seeing the patient. And this is done amidst constant interruptions—responding to requests or managing emergencies in the ward." (BGDG 03)

This lack of direct engagement at the point of handover was seen by several participants as undermining both clinical accountability and quality of care, particularly in the fast-paced and high-stakes environment of maternity services.

3.2.4. Fragmented Team Practices and Lack of Standardized Procedures

Respondents highlighted a major gap in clinical handover practices: the absence of coordinated multidisciplinary communication during shift changes. The principle of the effective presence of all healthcare team members—including physicians, midwives, and trainees—during handovers is rarely applied in practice. Instead, clinical responsibilities and updates are often discussed within siloed professional groups, with gynecologists and medical trainees conducting separate briefings from midwives and other care providers.

This fragmented approach results in incomplete or delayed transmission of information, as patient care plans are not consistently shared across all team members. Furthermore, respondents emphasized the absence of standardized protocols guiding these exchanges, leading to wide variation in handover practices—not only across services but even within the same team, depending on individual preferences and experience.

One participant described this separation of roles and the resulting communication gap:

"Gynecologists do their work separately with medical students and residents, and midwives also work among themselves. Often, there isn't even direct contact between gynecologists and midwives during the handover." (YLG 08)

Another respondent emphasized the lack of coordination and procedural oversight:

"Service briefings are held separately. Gynecologists meet with interns and residents, and we [midwives] try to do the same. But there is no established procedure or supervision. It is only when urgent cases arise that we attempt to share the file with the midwife team going on duty. Often, there is no contact at all with the doctors." (YLG 13)

These findings reveal a critical disconnect in interprofessional collaboration during handovers, which not only undermines the effectiveness of clinical transmission but may also jeopardize patient safety. The lack of interdisciplinary communication protocols and oversight mechanisms further exacerbates this challenge, reinforcing the need for a standardized, team-based model of clinical handover.

3.2.5. Perceptions toward the Formalization and Standardization of Clinical Handover

Respondents expressed strong support for the formalization and standardization of clinical handover (CH) within maternity services. Many emphasized the need for a harmonized model to be embedded in national or institutional quality of care frameworks. According to participants, formalizing CH would promote a shared understanding, ensure consistency across services, and reinforce the perception of handover as an institutional priority rather than an optional task.

A participant illustrated this perspective:

"Harmonization is necessary so that each department works the same way, which will make patient care more seamless. If it's formalized, then everyone understands that it's official and institutional—we'll have the same understanding, the same tools. Acceptance will be greater and adherence more satisfactory." (BGDG 02)

Respondents viewed standardization as not only a technical adjustment but also a cultural shift in how communication is valued within the healthcare system. A consistent, system-wide approach was seen as essential to overcoming current variability in practice and to institutionalizing safe handover procedures.

3.2.6. Motivating and Enabling Factors for Effective Clinical Transmission

Several key enablers for the successful implementation of standardized CH practices were identified. These included: awareness-raising campaigns to highlight the risks of inadequate communication and the benefits of structured handovers; staff training on CH principles, protocols, and tools; regular follow-up and supportive supervision to reinforce adherence; improved interprofessional commu-

nication, especially between physicians and midwives; the existence of written procedures or job aids to guide practice.

Respondents emphasized that training should not only target knowledge acquisition but also aim to foster a culture of accountability and appreciation for teamwork. The lack of oversight was cited as a major barrier to sustainability, with some participants noting that practices tend to erode when no one monitors compliance.

One participant explained:

"It all must start with staff training and the existence of procedures. That will help people understand why communication is important during shift assignments. [...] Also, we need monitoring to make sure these guidelines are being followed. Right now, no one checks what you do. Since people are often in a rush to end their shift, they just give a quick summary and leave." (YLG 01)

These findings point to the need for a multi-level implementation strategy, combining policy formalization, capacity-building, supervision, and behavioral reinforcement to embed clinical transmission as a standard, team-based practice in maternity care.

3.2.7. Strategies to Promote Adherence to a Standardized Clinical Transmission Model

In addition to formal training and procedural standardization, several respondents emphasized the importance of motivational strategies to encourage healthcare providers to adopt and maintain standardized clinical handover (CH) practices. These strategies were seen as essential for building a shared culture of accountability and safety in maternity wards, where effective communication is critical to safeguarding both maternal and neonatal health.

Participants suggested that awareness campaigns could help highlight the clinical and legal risks associated with communication failures during shift changes. They believed that reinforcing the serious consequences of errors—both in terms of patient harm and potential professional liability—would enhance provider engagement and compliance.

One respondent articulated this clearly:

"We need to raise awareness among colleagues about the risks that come with poor communication between healthcare teams. People need to know that mistakes are no longer tolerated, and legal action can be taken. [...] To protect ourselves, we must follow national protocols and comply. After all, it's two lives at stake. Handover procedures must be done properly to avoid errors and ensure quality care in our maternity services." (TGDG 05)

Respondents also linked standardized CH with professional ethics, suggesting that quality communication reflects not only adherence to institutional rules but also respect for patients' rights and safety. Encouraging a sense of collective responsibility and framing CH as a non-negotiable aspect of safe clinical practice were proposed as effective avenues to foster long-term behavioral change.

These insights underscore the importance of combining technical interventions

(e.g., procedures, checklists) with relational and normative strategies (e.g., awareness, peer engagement, supervision) to create a supportive environment for implementation.

3.2.8. Barriers to the Implementation of a Standardized Clinical Handover Model

Respondents identified several barriers—political, institutional, and individual—that could hinder the effective implementation of a standardized model for CH in maternity services.

At the institutional and policy level, participants cited the absence of formal reference tools and national guidelines to support standardized CH practices. Without an endorsed model or procedural framework, healthcare providers are left to rely on informal or inconsistent practices, which undermines sustainability and quality. The lack of integration of clinical transmission into pre-service and in-service training programs was also flagged as a critical gap, limiting providers' awareness and competence in conducting structured handovers.

On an individual level, resistance to change was described as a common obstacle—particularly when staff perceive new procedures as additional burdens rather than tools to improve safety and workflow. Some respondents also raised concerns about professionalism and engagement, noting that not all providers consistently prioritize communication or quality of care.

As one respondent explained:

"At first, when people don't understand the purpose, they'll see it as just one more task or tool to deal with. But it's meant to make work easier. [...] Those who don't like to work professionally will always find it to be a problem." (TGDG 03)

Another participant underscored the lack of training in clinical handover as a structural limitation:

"Providers don't have any information on how to do a proper transmission. We were never taught that in school. [...] If we ask someone to do something they've never learned, it's going to be difficult." (YLG 05)

Overall, these findings point to the need for a comprehensive, multi-level strategy that addresses not only technical and procedural barriers but also cultural and educational gaps. Without addressing these factors, the introduction of a standardized model risks limited uptake, inconsistent application, and resistance among frontline staff.

4. Discussion

This study explored the attitudes of unit coordinators, care unit supervisors, and team leaders (UC/CUS/TL) toward clinical handover (CH) in maternity wards of three university hospitals in Burkina Faso. The findings reveal an overall favorable disposition toward the formalization and standardization of clinical handover procedures. However, the actual conduct of CH was described as inconsistent, unstructured, and poorly supported by institutional mechanisms, exposing critical gaps between attitudes and practice.

All participants acknowledged that clinical transmission is essential for improving patient safety and ensuring continuity of care in maternity services. This aligns with the definition of attitudes as psychological predispositions that influence individuals' evaluations of practices or objects in their environment [12]. The favorable attitudes observed in this study suggest a readiness among healthcare leaders to adopt structured CH processes, which is a critical condition for successful implementation.

Similar attitudes have been documented in other settings. Wimalagunarathne *et al.* (2024) [13] found that positive perceptions of handover practices were significantly associated with their actual application. Kilic *et al.* (2017) and Suryani & Said (2020) [12] [13] further confirmed that the attitudes of healthcare providers strongly influence the uptake of clinical handover models, particularly in resource-constrained environments.

Despite favorable attitudes, respondents expressed dissatisfaction with the current state of CH in their services. Commonly reported issues included a lack of formal procedures, inconsistent practices across teams, and poor communication between professional groups, especially between physicians and midwives. The lack of team-based handovers and the disregard for designated overlap times indicate non-compliance with the principles of Clinical Handover (CH), further undermining the quality of information transfer. To mitigate adverse events associated with patient care, it is recommended to formalize an overlap period, implement the use of a CH logbook, and ensure the active presence of all care team members during shift transitions.

These shortcomings are consistent with findings from Egypt, where more than three-quarters of participants reported being unsatisfied with existing handover processes due to information gaps and lack of standardization [14]. Similarly, studies in other LMIC settings have shown that unstructured communication during shift changes contributes to errors, omissions, and preventable adverse events [15] [16].

Participants in this study unanimously supported the adoption of a standardized and harmonized model of clinical transmission, integrated within institutional protocols and quality-of-care guidelines. These findings echo previous research highlighting that the use of structured tools—such as SBAR (Situation, Background, Assessment, Recommendation)—improves the accuracy, consistency, and safety of handovers [17]-[19].

Given the complexity of maternity care and the high frequency of shift rotations, a standardized CH process is essential to minimize clinical risk and optimize patient outcomes. Structured communication helps ensure that essential patient data are shared efficiently, enables evaluation of care resources, and fosters shared clinical responsibility among staff.

The motivation of healthcare providers emerged as a key determinant of successful implementation. Motivation, defined as the energy and direction given to work behavior [20], was reinforced by several enabling factors cited by respondents. These included staff training, supportive supervision, clearly defined proce-

dures, and improved interprofessional collaboration. The emphasis on harmonizing practices across teams was also seen as crucial for building a culture of safety and accountability.

Despite strong interest in standardization, participants identified significant institutional, organizational, and individual-level barriers. At the system level, the lack of reference tools, absence of national guidelines, and exclusion of CH from health professional training curricula hindered adoption. Organizationally, weak oversight and poor scheduling practices further undermined implementation efforts.

On an individual level, some providers perceived standardized handovers as an additional workload, especially in the absence of proper orientation or support. Resistance to change, especially among staff not accustomed to formal procedures, was a recurring concern.

Interruptions during CH were also reported as a major operational challenge. As noted in other studies, such disruptions often stem from inadequate planning and poorly chosen handover environments [19] [20]. Conducting bedside handovers has been proposed as an effective solution to reduce interruptions and enhance patient involvement [21]-[23].

1. Implications for Practice and Policy

To bridge the gap between intention and action, healthcare institutions in Burkina Faso should develop and implement nationally endorsed CH protocols, grounded in evidence-based practices. These protocols should be complemented by training programs, performance monitoring, and regular feedback loops to support behavior change. Several mnemonics have been tested and adopted as part of efforts to standardize healthcare practices. Among the most widely implemented are SBAR and ISBAR [3]. However, there is no conclusive evidence that one mnemonic is superior to another in terms of effectiveness in promoting patient safety [24]. For optimal impact, mnemonics should be tailored to the local healthcare context. The SBAR model, recognized as an international benchmark, has been endorsed by the French National Authority for Health. This model has already been adapted into French through the mnemonic SEAD (Situation, Antécédents, Évaluation, Demande), and could be considered for implementation [25].

Furthermore, the integration of CH into pre-service and continuing professional education is essential to ensure that future healthcare providers acquire the skills and mindset necessary to prioritize effective communication.

2. Study Limitations

This study presents some limitations. First, it focused exclusively on the attitudes of UC/CUS/TL, excluding the broader perspectives of physicians, nurses, and other staff involved in maternity care. This limits the generalizability of the findings across the entire care team. Second, the sampling strategy was purposive and limited to three hospitals in Ouagadougou, which may not reflect conditions in other regions or rural facilities. Third, the study did not assess actual handover practices or the congruence between reported attitudes and observed behaviors.

Despite these limitations, the study offers important insights into the readiness for and challenges of implementing standardized CH in referral maternity services, and it provides actionable recommendations for health system strengthening in similar contexts.

5. Conclusion

This study offers valuable insights into the attitudes of key maternity care personnel—care unit coordinators, supervisors, and team leaders—toward standardizing clinical handover (CH) in three referral hospitals in Burkina Faso. Findings highlight their strong readiness and positive perceptions of CH, recognizing its vital role in enhancing care quality and patient safety. Dissatisfaction with current fragmented practices reinforces their support for formalization. Despite institutional and behavioral challenges, participants proposed practical solutions such as staff training, awareness campaigns, and improved supervision. Their engagement signals potential for institutional change when frontline leaders champion quality and safety. Implementing a standardized CH model—backed by national guidelines, capacity building, and monitoring—could reduce adverse events, foster interdisciplinary collaboration, and improve maternal and perinatal outcomes. These findings provide a foundation for policy dialogue and health system reform in similar low- and middle-income settings.

Acknowledgements

We would like to thank all the healthcare professionals at the referral maternity units who kindly agreed to participate in this study. We would also like to thank the three investigators who collected the data, which made this study possible. We are also grateful to the directors of the three university hospitals who granted us permission to collect data in their institutions, without whom this research would not have been possible.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] Bismilla, Z., Wong, B., Gleicher, J., McLaughlin, T., *et al.* (2018) Handover Toolkit: A Resource to Help Teach, Assess and Implement a Handover Improvement Program. Royal College of Physicians and Surgeons of Canada, Ottawa. https://www.royalcollege.ca/content/dam/documents/standards-and-accreditation/canmeds-handover-toolkit-e.pdf

[2] The American College of Obstetricians and Gynecologists (2012) Communication Strategies for Patient Handoffs.

[3] National Clinical Effectiveness Committee (2014) Communication (Clinical Handover) in Maternity Services.

[4] Ferorelli, D., Giandola, T.P., Laterza, M., *et al.* (2017) Handover Checklist: Testing a

Standardization Process in an Italian Hospital. *Risk Management and Healthcare Policy*, **10**, 87-93. https://doi.org/10.2147/RMHP.S129652

[5] The Joint Commission (2017) A Complimentary Publication of the Joint Commission Issue 58, September. Sentinel Event Alert.

[6] A Division of the Risk Management Foundation of the Harvard Medical Institutions Incorporated (2015) Malpractice Risks in Communication Failures.

[7] Shahid, S. and Thomas, S. (2018) Situation, Background, Assessment, Recommendation (SBAR) Communication Tool for Handoff in Health Care—A Narrative Review. *Safety in Health*, **4**, Article No. 7. https://doi.org/10.1186/s40886-018-0073-1

[8] WHO Collaborating Centre for Patient Safety Solutions (2007) Communication-During-Patient-Handovers.

[9] Ministère de la santé (2021) Guide de gestion des EI au Burkina Faso.

[10] Rickard, F., Lu, F., Gustafsson, L., MacArthur, C., Cummins, C., Coker, I., *et al.* (2022) Clinical Handover Communication at Maternity Shift Changes and Women's Safety in Banjul, the Gambia: A Mixed-Methods Study. *BMC Pregnancy Childbirth*, **22**, Article No. 784. https://doi.org/10.1186/s12884-022-05052-9

[11] Drapeau, M. (2004) Les critères de scientificité en recherche qualitative. *Pratiques Psychologiques*, **10**, 79-86. https://doi.org/10.1016/j.prps.2004.01.004

[12] Girandola, F. and Joule, R.V. (2013) Attitude,changement d'attitude et comportement. https://www.researchgate.net/publication/283350004

[13] Wimalagunarathne, K.W.R., Chaminda, U.G.G. and Withanachchi, K. (2024) Assessment to Improve the Knowledge, Attitude and Practices of Nursing Officers on Shift Handover at Neonatal Intensive Care Unit, Teaching Hospital, Karapitiya. *Sri Lankan Journal of Medical Administration*, **24**, 99-106. https://doi.org/10.4038/sljma.v24i2.5432

[14] Kilic, S.P., Ovayolu, N., Ovayolu, O., *et al.* (2017) The Approaches and Attitudes of Nurses on Clinical Handover. *International Journal of Caring Sciences*, **10**, 136-145.

[15] Suryani, L. and Said, F.B.M. (2020) Empowering the Implementation of Patient Handover with Increasing Nurse Knowledge and Attitude at X General Hospital Indonesia. *Malaysian Journal of Medicine and Health Sciences*, **16**, 63-66. https://pesquisa.bvsalud.org/gim/resource/pt/wpr-877040

[16] Dorgahm, S.R. and Obied, H.K. (2021) Factors Affecting Nurses' Experiences Related to the Current Handover Process between the Emergency Department and In-Patient Units. *Tanta Scientific Nursing Journal*, **20**, 182-200. https://doi.org/10.21608/tsnj.2021.171327

[17] Huth, K., Stack, A.M., Chi, G., Shields, R., Jorina, M., West, D.C., *et al.* (2018) Developing Standardized "Receiver-Driven" Handoffs between Referring Providers and the Emergency Department: Results of a Multidisciplinary Needs Assessment. *The Joint Commission Journal on Quality and Patient Safety*, **44**, 719-730. https://doi.org/10.1016/j.jcjq.2018.05.003

[18] Allah, N.A. (2022) Effectiveness of Educational Program on Nurses' Knowledge and Performance Regarding Shift Change Handoff and Its Effect on Continuity of Patient Care. *International Egyptian Journal of Nursing Sciences and Research*, **3**, 192-205. https://doi.org/10.21608/ejnsr.2022.130812.1165

[19] Nagammal, S., Nashwan, A.J., Nair, S.L. and Susmitha, A. (2016) Nurses' Perceptions Regarding Using the SBAR Tool for Handoff Communication in a Tertiary Cancer Center in Qatar. *Journal of Nursing Education and Practice*, **7**, 103-110. https://doi.org/10.5430/jnep.v7n4p103

[20] Forest, J., Crevier-Braud, B.L. and Gagné, M. (2009) Mieux comprendre la motivation au travail. *Effectif*. 12, 23-27.

[21] Fealy, G., Donnelly, S., Doyle, G., Brenner, M., Hughes, M., Mylotte, E., *et al.* (2018) Clinical Handover Practices among Healthcare Practitioners in Acute Care Services: A Qualitative Study. *Journal of Clinical Nursing*, **28**, 80-88. https://doi.org/10.1111/jocn.14643

[22] Siemsen, I.M.D., Madsen, M.D., Pedersen, L.F., Michaelsen, L., Pedersen, A.V., Andersen, H.B., *et al.* (2012) Factors That Impact on the Safety of Patient Handovers: An Interview Study. *Scandinavian Journal of Public Health*, **40**, 439-448. https://doi.org/10.1177/1403494812453889

[23] Kerr, D., Lu, S. and McKinlay, L. (2013) Bedside Handover Enhances Completion of Nursing Care and Documentation. *Journal of Nursing Care Quality*, **28**, 217-225. https://doi.org/10.1097/NCQ.0b013e31828aa6e0

[24] Australian Commission on Safety and Quality in Health Care (2010) OSSIE Guide to Clinical Handover Improvement.

[25] Haute autorité de santé (2014) Securité du patient: Un guide pour faciliter la communication entre professionnels de santé. HAS, Saint-Denis. https://www.has-sante.fr/jcms/c_1777725/fr/saed-un-guide-pour-faciliter-la-communication-entre-professionnels-de-sante