

RESPECTFUL MATERNITY CARE: A QUALITATIVE STUDY ON THE EXPERIENCE OF HEALTH PROVIDERS IN PUBLIC HEALTH FACILITIES OF NORTH SHEWA ZONE, OROMIA, ETHIOPIA

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ABSTRACT

BACKGROUND: Emerging evidence indicates that women face humiliating and undignified conditions in health facilities in developing countries like Ethiopia. This negative aspect of maternity care can influence women's decision not to make use of health facilities. It is, therefore, crucial to examine the experiences of health providers on the provision of respectful maternity care and to identify the forms of disrespect and abuse that exist, and better meet women's needs as part of broader efforts to provide better quality care.

METHODS: A qualitative study employing a phenomenological research design was carried out from August to September 2017 in six woredas/districts of North Shewa Zone, Oromia, Ethiopia. A total of 20 key informant interview was done. The key informants were selected by purposive sampling techniques considering their experience in Maternal, Neonatal and Child Health (MNCH) service delivery in the selected public health facilities. The data were collected using a semi-structured key informant interview guide. All interviews were transcribed and translated verbatim into English. Data analysis was initiated alongside data collection using a thematic approach based on a priori identified themes and those emerged during the analysis.

RESULT: The health providers' experiences indicated the existence of different categories of disrespect and abuse to women in the study area. Non-consented care, physical abuse, non-confidential care, non-dignified care were the areas identified. Furthermore, painful procedures such as episiotomy were performed without anesthesia, women may also stay for a long time without getting the service and they were restricted to have a companion of their choice in the birthing area. The discrimination of women because of personal attributes such as income level, being rural versus urban, and HIV status was also revealed in the present study. However, detention wasn't reported by any of the respondents.

CONCLUSION: To promote quality maternal health service, the government in partnership with other stakeholders should address the challenges faced by women in the health facilities. Providers should also be capacitated with the required knowledge, attitude and skill and further effort should be made to equip health facilities with the necessary material and human resource. Enforcing policies on respectful maternity care is also important.

KEY WORDS: Respectful Maternity Care, Health Providers Experience, Qualitative Study, Ethiopia
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BACKGROUND

Delivery with a skilled birth attendant significantly decreases maternal mortality^{1,2}. While multiple factors explain low health service utilization, there is increasing recognition that many women are reluctant to use maternal health services because of poor service quality and fears of provider mistreatment^{2,3}. Different studies demonstrate that women's perceptions of how they will be treated at health facilities can strongly influence their choice about where to deliver, and deter women from accessing services in a timely manner, or at all^{3,4}. Unfortunately, disrespect and abuse of women during childbirth is common in East Africa^{3,5}.

Emerging evidence indicates that women face humiliating and undignified conditions in health facilities. These negative patient experiences contribute to poor health outcomes and reinforce mistrust of institutional care. Additionally, women and families may delay or avoid seeking care in health facilities; which may increase the risk to her own health and that of her newborn⁶.

Over the past decade, disrespect and abuse of women during childbirth has become an increasingly recognized phenomenon^{7,8}. Respectful Maternity Care (RMC) is an approach that focuses on the interpersonal aspect of maternity care. That is an attitude that permeates each word, action, thought, and non-verbal communication involved in the care of women during pregnancy, childbirth, and the postnatal period⁷.

In 2010, Bowser and Hill, by using a comprehensive review of the evidence, identified seven categories of disrespect and abuse during childbirth: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes abandonment of care, and detention in facilities⁶.

In Ethiopia, perceptions of poor quality of care such as lack of privacy and lack of psychosocial support, are significant factors in a woman deciding whether or not to give birth at a health facility^{9,11}. Furthermore, a recent evidence of disrespect and abuse was reported in Ethiopian health facilities¹²⁻¹⁵. For example, result from women and health providers in health facilities

in two regions revealed that 21% of post-partum women surveyed reported disrespect and abuse, non-consented care (17.7%), lack of privacy (15.2%), and non-confidential care; and 82% of providers cited occurrences of disrespect and abuse in their facilities¹⁵. The Ethiopian Ministry of Health is highly committed to increasing the rate of skilled birth attendant assisted deliveries in health facilities; the health sector transformation plan (HSTP) has a target of 90% skilled birth attendance rate and elimination of all preventable maternal deaths (Reduce to 199/1000000 live births, expected annual rate of reduction is 11% per year) by 2020¹⁶. Ethiopia's Ministry of Health acknowledges, however, that provision of RMC is also a key intervention to bring unreached women to health facilities for maternity care services and thus, an important component in achieving their 2020 goals.

This important negative aspect of maternity care can influence women's decision not to make use of health facilities in their present or subsequent deliveries^{17,18} thus contributing to the number of births assisted by non-skilled personnel. It is, therefore, crucial to assess the experience of health providers on the provision of respectful maternity care and to identify what forms of disrespect and abuse exist, and better meet women's emotional, physical, socio-cultural and psychological needs as part of broader efforts to provide better quality care. Therefore, the objective of the study was to examine the experiences of health providers on the provision of respectful maternity care in public facilities of North Shewa zone, Oromia Ethiopia.

METHODS AND MATERIALS

Study setting and study design

The study was conducted in six woredas of North Shewa zone, Oromia, Ethiopia. According to the Central Statistics Agency population projection, the total population of the six woredas/districts included in the present study, account for 43% (648,835) of the total population of North Shewa Zone. There were 26 health centers, 97 health posts/kebeles and two hospitals in these woredas included. A qualitative study employing a

phenomenological research design was carried out from August to September 2017.

Study population and data collection procedure.

The study populations were health professionals who were working on MNCH service delivery points of selected North Shewa Zone public health facilities, in the study period. By using purposive sampling method twenty key informant interview (KII) respondents (11 females and 09 males) were contacted. Among these, twelve KII respondents were selected from 6 health centers and eight KII respondents were selected from 2 Hospitals. To better understand and examine the health professionals experience on RMC, study participants were selected based on their experiences of MNCH service. The health professionals were identified based on the recommendation of the hospital managers and health center Out Patient Department (OPD) coordinators.

To assess health providers thought and experience regarding respectful maternity care, three facilitators/ data collectors, having masters degree in public health and well experienced in qualitative data collection and transcription conducted the interview

The data were collected using semi structured KII guide and field notes and tape recording.

After giving consent, all interviews were conducted in Amharic language with each key informant in a private room at the health facility. Each session lasted between 45 and 60 minutes. The facilitators acted as a guide for the participants helping to maintain the flow of ideas when relevant through probes. All roles of the facilitators were disclosed and vacant prior to beginning fieldwork so as to guarantee the interview and data was not overly compromised or prejudiced.

Ethical approval for the study was obtained from IRB of Saint Paul's Hospital Millennium Medical College and written support letter was also obtained from North Shewa Zone Health office. A written informed consent from all the participants was obtained. Confidentiality of the information was maintained throughout the study by excluding names as identification in the data. We assured all the information gathered during the

course of the study was kept completely confidential. All the information was coded for anonymity. Only the investigators have access to the collected data.

Data processing and analysis

Groundwork data analyses were done alongside with study procedures to lead iterative revisions of the interview guide and decide theoretical saturation. After interviewing the 20th participants, the lead investigator decided that the responses to interview questions were becoming decidedly recurring and that no new data were likely to come into view. Thus, a twenty-participant sample size was finalized based on theoretical saturation. Interview were transcribed and then translated in to English. Data analysis was initiated alongside data collection. This helped in identifying emerging themes for consideration in subsequent interviews. Final data analysis was done manually using a thematic approach based on identified themes a priori and those emerged during the analysis.

RESULTS

Background Characteristics of the Respondents

Twenty KIIs respondents (11 females and 09 males) have participated in the study. Among these, the majority of respondents (14) were between age 25 to 30 years and twelve KII respondents were recruited from the Health Center. Fifteen KII respondents were Midwives by their profession and nine of them had work experience level of fewer than 5 years (Table 1).

Table 1; Background characteristics of KII Respondents in North Shewa Zone Public Health Facilities, 2017

Back ground variable		Frequency
Sex	Male	09
	Female	11
Age	< 25 Years	02
	25 to 30 Years	14
	>30 Years	04
Facility Type	Health Center	12
	Hospital	08
Position	MCH Head	05
	Service Provider	14
	Labor Ward Coordinator	01
Profession	Midwifery	15
	Nurse	03
	Health Officer	02
Work experience	< 5 Years	09
	5 to 10 Years	08
	>10 Years	03

The present study found that health facilities in the study area were rendering almost similar maternity care services and some forms of disrespect and medical malpractices have been happening to the women. The identified practices of disrespects and medical malpractices were reported based on the seven categories of disrespect and abuse in childbirth that are drawn from human rights and ethics principles by Bowser and Hill. The manifestations of disrespect and abuse often fall into more than one category that are not intended to be mutually exclusive. Rather categories should be seen to be overlapping along a continuum⁶.

Physical Abuse and Medical Malpractices

Most health workers in the study area reported the practices of physical abuse. These include; hitting the women while providing various maternity care services. “When we are doing an episiotomy, the mother may want to stand and try to leave the room, in such cases, we may kick the women by scissor...” (Male Midwife with 6 Years Work Experiences)

In almost all health facilities, vaginal examinations have been carried out every four hours using a partograph. Most of the health providers well understood that; repeated vaginal examination could result in infection/sepsis to the women and they also know the importance

of doing vaginal examination only when it is indicated for the individual women. However, some of the health providers uncovered the practices of repeated vaginal examination for different reasons. Women with precipitated labor and having multiple pregnancies were among the reasons behind repeated vaginal examination before four hours schedules interval.

“Regarding vaginal examination, we are working as per the standard (every four hours), as we are using partograph. However, for the women having multiple pregnancies, we may repeat the examination even before four hours.” (Male Midwife with 2 Years Experiences)

Regarding the episiotomy procedure, all of the health providers have been providing episiotomy care by considering its indication for individual women and most of them have been using a local anesthesia for the procedure. However, few health providers have been still providing episiotomy care without anesthesia particularly while cutting the vulva.

“I cannot say that we all use anesthesia during episiotomy procedure. This is due to the fact that some of the health workers believe that women do not feel the pain of episiotomy during labor. However, these health providers use anesthesia while suturing the area.” (Female Midwife with 10 Years Experiences)

In the study area, nearly none of the health care providers has been practicing fundal pressure. These providers recognized that the practice of applying fundal pressure could be risky for women as it potentially causes ruptured uterus. However, very few health providers are still practicing fundal pressure considering as if it facilitates/increases poor uterine contraction.

“... Some of the nurses are practicing fundal pressure assuming as if it facilitates labor. They are often saying that applying fundal pressure is like augmenting laboring mothers.” (Female Midwives with 5 Years Work Experiences)

Non-Consented Care

Health care providers working in the study area have varying perception regarding the importance of obtaining women's consent before undertaking any medical procedures such as vaginal exam, catheterization, and IV-line opening. Some of the health providers clearly reported that all women should be asked for consent although it is practically difficult for implementation in their routine medical practice. However, there are still providers questioning the importance of having the women's consent for medical procedures despite the scientific recommendation.

“... To be honest we are not always asking for consent before examinations or medical procedures. I don't think that taking consent for every medical procedure is helpful despite the scientific recommendation.” (Male Health Officer with 16 Years Work Experiences)

The study found out that most of the health providers does not usually ask women for their consent. Instead, they usually inform the women about the procedure they are going to do and even there are situations where some health providers directly proceed to the procedure without informing the women about the procedure.

“... In practice, for example I do not usually ask the women for consent, rather I simply inform them. When I am very busy, I may proceed to the procedure without even informing the women about the procedure.” (Male Midwife with 2 Years Work Experiences)

Some providers may even enforce women while doing various maternity care procedures.

“For example, when we want to check the progress of the labor, some women may not be cooperative for vaginal examination; we may, therefore, enforce them for the examination.” (Male Midwife with 2 Years Work Experiences)

Non-Confidential Care

Almost all health providers agree on the importance of maintaining the privacy of women while providing various maternal health services. In nearly all of the health facilities, different efforts such as providing the service in separate closed room, limiting the entrance of others including health providers and attendants, covering the women's private parts and the use of screen have been undertaken to maintain client's privacy. However, some health providers mentioned the practice of exposing the private parts of the women and the provision of maternity care with other health providers whose presence may not be essential as the existing malpractice with the potential of compromising the right of a woman to privacy and confidentiality. In a few health facilities, there were a shortage of screen, room, and space, the windows were transparent for an external view and lack curtain allowing other clients to look at what is happening inside.

“Our windows and doors are made of glass with no curtains. As you can realize, everyone can see what is happening inside.” (Male BSc Nurse with 14 Years Work Experiences)

Non-Dignified Care

In the study area, most health workers reported the practice of insult: particularly using harsh tone or shout while providing various maternity health care services.

“Due to our culture some women may not allow us for vaginal examination; in this case, we may remove our glove and shout on her to leave the room. This is happening in our facility, and I think it is common in any hospital as well. (Male Midwife with 2 Years Work Experiences)

“For example, when the women ask repeated questions or if they say I am not clear to the given instructions/information, some health workers could not be happy and usually say I told you already using harsh tone and

may shout on the women. This is a common problem in our facility.” (Female Midwife with 5 Years Work Experiences)

Discrimination Based on Specific Patient Attributes

In this study, most of the health providers reported that mistreatment was not happening to women because of their personal attributes. Health providers have been serving the community without considering religious orientation, educational level, marital status, income, ethnicity, and other personal attributes. However, very few health providers reported the existence of mistreatment because of some personal attributes such as income level, being rural vs. urban, and HIV status.

“... For example, a poor and rural woman may not be treated like those who are rich and come from urban areas. Some health workers give priority to rich and urban women. In another scenario, some health workers may not equally serve HIV positive women as those who are HIV negatives because of the fear of infection.” (Male Clinical Nurse with 9 Years Work Experiences)

Abandonment of Care and Not Allowing a Companion of Choice

In this study, leaving women alone or unattended for a long time was not a common problem in the health facilities. However, some of the health providers reported that women might stay for a long time in the health facility without getting the required medical service. In addition, there were also situations where the women may be unnecessarily appointed for another day or referrals to other facilities.

“... Sometimes, women may not be getting our service on time due to the staff work overload and related issues. They may even return back home without getting the service which is especially common for those women requiring laboratory service that may not be available due to the frequent power interruption.” (Female Midwife with 2 Years Work Experiences)

Currently, most health care providers have been allowing a woman to have a companion of her choice such as a family member with her throughout labor and birth to provide support in her stay at the facility. Some health workers, however, do not allow women to bring a companion into the birthing area.

“... We may not allow family members to be with the women. This is because some family members may not understand the situation very well. Sometimes they are not even allowing us to care for other laboring women. Every time when the woman shouts, they think that she is sicker than others are and consider as if we are not offering her the required care, which occasionally leads to inappropriate conversations.” (Female Midwife with 6 Years Work Experiences)

Detention in Facilities

In this study, there were no reported detentions of women in health facilities in relation to the inability to pay for the services. Right after the diagnosis of pregnancy, all services related to pregnancy and labor were delivered free of charge in the study area.

“I am truly speaking that the all services given to the mothers is free...” (Female Nurse with 4 Years Work Experiences)

DISCUSSION

In this study, we explored the various categories of disrespect happening to women in Public Health Facilities of North Shewa Zone, Oromia Regional State of Ethiopia. It was found that some form of mistreatments has been happening to the women. To mention some of the mistreatments; providers may shout on women, providers do not usually ask for women’s consent, the women may stay longer without getting the health services, and medical malpractice such as episiotomy care without anesthesia were also there in the public health facilities.

All physical contact with pregnant women should be as gentle, comforting, and reassuring as possible. Even though freedom from physical abuse is the right of each patient, many stories of physical abuse during childbirth have been reported globally¹⁹. The present study found out that there were the practices of physical abuse including hitting the women by health care providers. In the study conducted through direct observation of RMC in five countries of East and Southern Africa including Ethiopia, the incidents of slapping or hitting the client was also reported²⁰. In the Addis Ababa City

of Ethiopia, mothers reported the providers' practice of slapping/hitting patients in maternity care provision¹². Another systematic review also reported a similar finding of physical abuse by nurses, midwives, and doctors²¹. Moreover, every woman seeking care is a person of value and has the right to be treated with respect and consideration¹⁹. It was however found out that, the providers in the study area practiced verbal abuse particularly using harsh tone or shout. A systematic review also reported that verbal abuse of women by the use of harsh or rude language as the common practice across all regions and countries around the globe²¹.

The health providers further reported the practice of episiotomy care without using anesthesia particularly while cutting the vulva and for small episiotomies. Based on the qualitative study conducted in Debre Markos Town, midwives and midwifery students mentioned the practices of stitching episiotomies without anesthesia²². Another observational study conducted in East and Southern Africa found out the practice of routine episiotomy and the lack of anesthesia for episiotomies or suturing of tears²⁰. A similar finding was also reported from a systematic review conducted in Nigeria²³. Two reasons were commonly mentioned behind the practice; the first reason arises from the perception that the women could not feel the pain of the episiotomy since they are already suffering from the more advanced labor pain. These health providers, however, have been using anesthesia while suturing the episiotomy cuts. The second reason behind not giving anesthesia during episiotomy care lies in the fact that providers thought that anesthesia could cause a delay in the healing process. The health providers also reported the shortage of anesthesia in the health facilities as a reason behind providing episiotomy care without anesthesia.

In principle, all patients need a careful explanation of proposed procedures in a language and at a level, they can understand so they can knowingly consent to or refuse a procedure¹⁹. However, there is evidence of a widespread absence of informed consent for common procedures around the time of childbirth in many settings⁶. The

present study also revealed that most of the health providers did not usually ask women for their consent. Instead, they usually inform the women. Even there are situations where some providers enforced women for medical procedures. A similar finding was reported from studies conducted in Debre Markos Town²². According to a study undertaken in Addis Ababa City, 43.4% and 48.0% of mothers reported that the provider did not explain the procedure and obtain consent respectively. In another study, it was noted that clients in Ethiopia received a prior explanation of the procedure and about their findings of the initial examination from providers least often²⁰. The perceived high workload of the health providers was stated as the reason for not taking consent in the routine medical practice. The background of the women and the associated resistance to medical procedures and tests such as HIV test were another reported reason behind not taking consent.

Healthcare providers must do everything possible to protect the privacy and confidentiality of patients and their information¹⁹. However, there have been reports on the lack of privacy and confidentiality for many women around the world^{6,22}. However, the present study found out encouraging practice in the provision of confidential care. It was revealed out that most of the problems challenging the provision of confidential care arise from the shortage of the materials, and space in the health facilities.

All women are equal and must be treated with respectful care regardless of their ethnic background, culture, social standing, educational level, or economic status¹⁹. The practice of discriminating women because of personal attributes such as income level, being rural vs. urban, and HIV status was not a common problem in the study area. Unlike the finding of a systematic review, the present study did not find discrimination based on ethnicity, race, religion and age of the women. However, we found similar finding in areas where very few health providers offer substandard care for women with lower socioeconomic status and positive HIV status²¹.

At health facilities, women should be able to have a companion of their choice with them throughout labor and birth to provide continuous support¹⁹. However, this study found that some health workers did not allow women to bring a companion into the birthing area. The most common reason mentioned was; family members may not understand the process of labor and delivery. When the women shout and cry as the labor advances, worried family members sometimes considered this as if the problem of the health providers and start complaining and sometimes insist the health providers to look after their clients only which, causes inappropriate conflict in the birthing area.

Long waiting time, unnecessary appointments and referrals were also among the issues affecting the right of a woman to the highest attainable level of health in the study area. The finding of a systematic review also reported that women frequently referred and suffered from long delays, feeling alone, ignored, and abandoned during their stay at the facility²¹. Lack of promptness of care and time wasting was also reported from Nigeria as per the report of a systematic review²³. In the present study the shortage human resource, the shortage of resources/equipment particularly the lack reagents for laboratory services, the frequent electric power interruption, lack of services integrity and the shortage of trained staffs in different units were also mentioned as a reason for the observed long waiting time, unnecessary appointments and referrals.

Some health facilities have been known to detain or prevent women from leaving with their babies because they cannot pay their bills¹⁹. In this study, there were no reported detentions of women in health facilities in relation to the inability to pay for the services. A similar finding was reported from a study conducted in Ethiopia where no reports of detention for non-payment²². In contrast, a systematic review reported that women of lower socioeconomic status believed that they received poorer treatment because they were unable to pay for services or to pay bribes²¹. In Nigeria, 22% of women reported detention in facilities for failure to pay their bills and that of their babies²³. The observed variation

may be explained by the fact that all maternal health care services in Ethiopia have been provided free of charge.

CONCLUSION AND RECOMMENDATIONS

The study examined health providers' experience on the provision of RMC. Accordingly; it was found out that various mistreatment to a woman has been happening in the study area. Among others, health providers may hit the women, use harsh tone and shout during providing care, health providers do not usually ask consent prior to medical procedures, and there was a situation where women may not be informed about the findings of examinations and painful procedures such as episiotomy may be performed without anesthesia. Although it was not common, the study disclosed the discrimination of women because of personal attributes such as income level, being rural vs. urban, and HIV status.

However, good medical practices were also observed in the study where health providers reported the practices that should be encouraged such as providing confidential care. There was also no detention of mothers in health facilities because the inability to pay for the services and no reported discrimination was reported based on the ethnicity, religion, and age of the women. Abandonment of care and not allowing a woman to have a companion of her choice such as a family member was not also a common problem in the study area. Furthermore, most of the health providers did not also report the discrimination of women based on personal attributes and the detentions of women in health facilities because of their inability to pay for the services.

The study reported the experience of health providers regarding the care they have been providing to the women in public health facilities. The potential introduction of the information bias should be taken into account while interpreting the finding of the study.

In recommendation, all concerned stakeholders should boldly strengthen RMC provision as the first step to attract more women to health facilities, to promote quality health service in the health facilities and to

subsequently improving the maternal health services. Interventions directed toward RMC should focus on capacitating the health providers on the required knowledge, attitude, and skill supported with effective interpersonal communication approaches. Motivating health providers, continuous supportive supervisions and feedbacks mechanisms should also be there. Effort should be made to equip the health facilities with the necessary infrastructures, resources, equipment, and human power. Finally, health facility managers and health providers should demonstrate commitment, work ethics and closely collaborate with the community to promote RMC.

ABBREVIATIONS AND ACRONYMS

HSTP- Health Sector Transformation Plan; KII- Key Informant Interview; MNCH- Maternal, Neonatal and Child health; RMC-Respectful Maternity Care

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COMPETING INTEREST

The authors declare that they have no competing interests.

AUTHORS' CONTRIBUTIONS

AG, NW, and TB participated in the coordination of the study, and performed the analyses. DW, TT, FA and AW drafted the manuscript and participated in the design and data analysis of the study. All authors read and approved the final manuscript.

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