Delivering Respectful Maternity Care: Midwives’ and Patients’ Perspectives on Disrespect and Abuse

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Project Background

This pilot project collected qualitative data on the knowledge, attitudes, and practices of patients and midwives related to patient’s rights and the delivery of women-centered midwifery services in Debre Markos, Ethiopia.

Ethiopia has one of the world’s higher rates of maternal mortality: 676 women die for every 100,000 live births and maternal deaths constitute 21% of all deaths to women ages 15-49 (Central Statistical Agency & International, 2012). Midwives are at the center of Ethiopia’s initiative to decrease maternal and child mortality by drastically scaling up the population coverage of health care workers at public facilities in underserved areas. While only 980 midwives were trained between 1980 and 2005 (Gaym, Worku, Getaneh, Berhe, & Tiruneh, 2008), their numbers have almost quadrupled between 2008 and 2012. A distinctive feature of this expansion is the high and growing proportion of male midwives (22%) due to new exam-based selection criteria (EMA, 2012).

A relatively understudied challenge of this scale-up has been ensuring the quality of these new services and understanding women’s readiness to avail themselves of them. Although the health system’s national coverage has increased dramatically in the past decade, currently only 15% of women receive skilled health care services at delivery (Central Statistical Agency, 2014). There is broad consensus that delivery with a skilled birth attendant can significantly reduce maternal mortality (Thaddeus & Maine, 1994; Campbell, 2006; AbouZahr, 1998). At the same time, it has long been appreciated that women’s perceptions of how they will be treated at health care facilities strongly influence their choice about where to deliver, and that fear of abuse and disrespect are significant factors in keeping women away from reproductive health services (Kruk, Paczkowski, Mbaruku, de Pinho, & Galea, 2009; Leonard, 2014). It has also been widely reported that disrespect and abuse of patients, particularly during childbirth, persists broadly throughout East Africa (and is
likely not limited to this region) and that instances of abuse (e.g., hitting and verbally abusing patients or delivering non-consented services) are not limited to a few individuals or institutions but rather are reflective of deep, systemic attitudes and beliefs (Freedman & Kruk, 2014). Previous research has found it challenging to measure disrespect both because of difficulties in acknowledging and/or recognizing the behavior, and has found a combination of qualitative and quantitative methods to be useful. Making care at health facilities more women-centered and responsive is, therefore, a crucial component of improving the utilization of maternal health services generally and delivery services in particular, and thus of reducing maternal mortality.

Research Questions
The project’s aim is to pilot the collection of data on the level of accountability and patient-responsiveness of midwifery care in Debre Markos. The specific questions explored in the pilot were:

1) What are women's experiences of treatment during labor and delivery?
2) What factors are associated with women’s perception of receiving quality care?
3) Are there differences in patient’s perceived quality of care by gender of midwives?
4) What are midwifery students’ awareness of and attitudes about responsiveness and accountability to patients in the provision of care and about approaches to accomplishing this?
5) How do midwifery students define abuse and disrespect to the patients and to what extent do they consider patient abuse to be a problem?

Methodology
This project took place in the town of Debre Markos, Ethiopia, a peri-urban hub in a predominantly rural area, located in Amhara Region, five hours to the northwest of the nation’s capital. A joint team of researchers from Debre Markos University’s (DMU) Department of Public Health, Touro University California’s Public Health program and the Bixby Center, University of California, Berkeley, conducted this research. Data collection took place at the DMU campus in the School of Midwifery, three public Debre Markos health centers, and the Debre Markos Referral Hospital in February and March 2015.

A convenience sample of 25 women over the age of 21, who had given birth in the past year attended by a midwife, was recruited from local health centers to take part in an open-ended
interview. Three women who had given birth at home were included in this sample. The study also conducted in-depth interviews with 16 randomly selected third-year bachelor’s degree midwifery students from DMU and 3 practicing midwives from local health facilities. Both the provider and patient samples were stratified by the gender of the midwife provider.

### Interviewee Information

<table>
<thead>
<tr>
<th>Interviewees</th>
<th>Number</th>
<th>Training</th>
<th>Gender</th>
<th>Age range</th>
<th>Interview Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwifery students</td>
<td>16</td>
<td>Bachelor’s Degree midwives (3rd year)</td>
<td>10 female; 6 male</td>
<td>19-23</td>
<td>Debre Markos University campus</td>
</tr>
<tr>
<td>Practicing Midwives</td>
<td>3</td>
<td>Diploma and Accelerated midwives*</td>
<td>All female</td>
<td>23-29</td>
<td>3 Health Centers</td>
</tr>
<tr>
<td>Women who delivered at a health facility</td>
<td>22</td>
<td>N/A</td>
<td>Female</td>
<td>21-45</td>
<td>Health Center or Hospital</td>
</tr>
<tr>
<td>Women who did not deliver at a health facility</td>
<td>3</td>
<td>N/A</td>
<td>Female</td>
<td>25-28</td>
<td>Debre Markos HC</td>
</tr>
</tbody>
</table>

*Bachelor’s Degree Midwives have four years of post-secondary training; Diploma Midwives have ten years of primary and secondary education and three years of specialized midwifery training; and Accelerated Midwives have ten years of primary and secondary education, three years of nursing training and one year of Midwifery training.

All interview guides contained questions on respondent demographics and socio-economic characteristics. Midwifery students and practicing midwives were asked questions on the coverage of patient’s rights in midwifery training, their knowledge of patient’s rights, their experiences of provider-patient interactions, and their observation and/or awareness of patient mistreatment. Midwives and midwifery students were also questioned on their knowledge and comfort with service provision in three clinical scenarios about patients in situations prone to disrespect and abuse. In addition, midwifery students also responded to a short written survey on their knowledge of patients’ rights.

Patients were asked about the quality and content of their care during pregnancy and labor and delivery, the quality of their interactions with health care providers, their satisfaction with the care they received, and whether they had heard stories about other women being mistreated during labor and delivery. They were also asked directly about common forms of mistreatment that might not be seen as abuse, such as the denial of food and drink, refusal of accompaniment and not being able to give birth in their desired position.
Data from the provider interviews and surveys are triangulated with data from the interviews with women who have recently given birth.

Interviews were conducted in Amharic and audio-recorded. They were translated into English and transcribed simultaneously. The project investigators developed a coding scheme based upon on research questions as well as themes emerging from the data. Investigators coded and analyzed the interviews using HyperResearch qualitative data analysis software.

**Preliminary Results**

Preliminary analysis suggests there is limited coursework on patient’s rights, primarily patient confidentiality and privacy.

Most women reported satisfaction with their care. Women were aware that health facilities offer life-saving care and grateful for access to them, particularly because they are free and cover interventions such as prevention of post-partum hemorrhage that cannot be provided at home. Women shopped for care, going out of their way to attend facilities with a reputation for providing quality care. The quality of care offered at the facility was also a factor in the choice of home rather than facility birth. Women defined good care as care that was warm, empathetic, and reassuring. Providing a traditional coffee ceremony and porridge, which is common in home births, was mentioned by almost all women as an example of good care and as a factor in women choosing a health facility for delivery.

Verbal abuse was reported by almost half of midwives and midwifery students (43%) and of women (48%). Women reported that providers often shouted at them and spoke to them in harsh or mocking tones. They also mentioned neglect and mistreatment due to health systems weakness, e.g., rushed care, long waiting periods, crowding, and long periods of being left alone.

None of the women interviewed reported being physically abused, although several mentioned hearing reports of abuse or witnessing physical abuse. In contrast, approximately a third of students report observing physical abuse of patients. The most common type of physical abuse witnessed was slapping patients on the legs in order to get women to comply with midwives’ instructions for vaginal exams or for positioning for labor.
Practicing midwives and students also mentioned practices such as stitching episiotomies without anesthesia, performing procedures without informing the patient, and refusing follow-up care to patients who had previously refused other care. Most women were not allowed to give birth in their desired position and some were not permitted to have family members or friends accompany them during delivery.

Providers described abuse as being the unintentional result of overwork due to very high patient loads. Women also saw stress and workload as a driver of abuse but said that that providers should try to temper their behavior because their professional and ethical commitments. Other drivers of abuse identified were communication difficulties due to the patient and provider not speaking the same language and having to care for rural, poorly educated women who might not familiar with health facilities. Several midwifery student respondents recommended the need for midwives to devote more effort to building rapport with the patient and to strengthen counseling training as ways to improve the quality of care they provide.

All students and providers saw respecting clients’ rights as a fundamental factor in developing a positive relationship between clients and providers; many providers viewed respect for rights instrumentally as a way to increase skilled birth attendance. Further, the awareness of both the women and the providers of some of the behaviors that constitute rights violations was high (some midwives’ mistaken belief that women do not have the right to choose their birthing position was an exception). Patient’s rights are only partially covered in the midwifery curriculum. Training around rights is done in the context of professional ethics training, and focuses on protecting patient confidentiality and privacy rather than on providing respectful care.

We found high acceptability of male midwives among patients. The majority of women interviewed either expressed no gender preference or preferred male midwives, citing their professionalism and competence. Patients who had male midwives were not more likely to report negative labor and delivery experiences than those seen by female midwives.

In conclusion, we find that abuse of patients during labor and delivery –particularly verbal abuse-- is relatively common and that this abuse has the potential to reduce patient demand for services. We find that training in patient’s rights in midwifery curriculum is uneven and that students would be responsive to additional training on this topic. However, addressing structural issues around provider workload should complement any such initiatives. The preliminary study results are consistent with
the findings from recent meta-analyses and systematic reviews of patient mistreatment in maternal services (Mannava, Durrant, Fisher, Chersich, & Luchters, 2015; Bohren et al., 2015). However this study is one of the few to examine both practicing and student providers and also patients and to ask questions about both the prevalence of abuse and provider knowledge of patient’s rights.

Further analysis of the data, including an examination of the discrepancies between provider and patient responses, the demographic factors associated with abuse and the relationship between low provider knowledge of patient’s rights and level of comfort with clinical scenarios is ongoing.
References