

BMJ Open Promoting compassionate and respectful maternity care during facility-based delivery in Ethiopia: perspectives of clients and midwives

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ABSTRACT

Objective The purpose of this qualitative study was to explore clients' and midwives' perceptions of compassionate and respectful care during facility-based delivery in Bishoftu District, the regional state of Oromia, Ethiopia.

Setting Public health facilities (two health centres and one district hospital).

Study design A qualitative exploratory descriptive research design was used.

Study participants The research population included purposely sampled women who had given birth in a health facility in the previous 2 weeks and midwifery experts who provided maternity care in the health facility's labour and delivery wards. Data were gathered through an individual interview (with 10 midwives and 12 women in labour). Interviews were audio-recorded and transcribed immediately. For the research, thematic analysis was performed manually. Both a priori codes (from the query guide) and emerging inductive codes were used in the study. In the thematic data analysis, three inter-related stages were involved, namely data reduction, data display and data conclusion.

Results From the analysis of in-depth interviews with labouring women, three themes emerged, namely: dignified and respectful care, neglectful care and unqualified staff. Five main categories emerged from in-depth interviews with midwives: trusting relationships formed with labouring women, compassionate and respect-based behaviour, good communication skills and holistic care, intentional disrespect toward women, and barriers to compassionate and respectful maternity care due to structural factors. These themes were discovered to be a rich and detailed account of midwives' perspectives on compassionate and respectful maternity care.

Conclusion The majority of women who witnessed or suffered disrespect and violence during labour and childbirth were dissatisfied with their maternity care during labour and delivery. Despite midwives' accounts showing that they were aware of the importance of compassionate and respectful maternity care, clients face verbal abuse, neglect, and a lack of supportive treatment during labour and childbirth. Clients' human rights were violated by disrespectful or abusive acts, whether perpetrated or observed. It is essential to address structural problems such as provider workload, and all other initiatives aimed at improving midwives' interpersonal relationships with

Strengths and limitations of this study

- The researchers were self-conscious and aware of their immersion in the study process to ensure that it was as objective as possible.
- The findings may not be replicable or transferable since this was a study conducted in a specific location at a specific time.
- The information obtained from study participants could be subject to recall bias.
- The findings of this research were applied to a similar population in the study area.

women to provide compassionate and respectful client-centred maternity care.

BACKGROUND

Maternal health refers to a woman's well-being during pregnancy, childbirth, and the first few days and weeks after giving birth. According to the WHO, respectful maternity care (RMC) is 'care organised for and provided to all women in a manner that maintains their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and allows informed choice and continued support during labour and childbirth'.¹ Although motherhood is often a positive and fulfilling experience, far too many women associate it with suffering, sickness and even death.² RMC includes respect for women's fundamental human rights, such as autonomy, dignity, emotions, choices and desires, as well as companionship during maternity care.²⁻³ RMC stresses that high-quality, evidence-based, and informed services, procedures, and care are provided while taking into account the specific needs and preferences of women and babies.⁴ Disrespectful maternity care is a worldwide problem that affects how mothers are treated during pregnancy, birth and afterward. These experiences, on the other hand, are known

to discourage or delay maternal care in health institutions in low/middle-income countries (LMICs), such as Ethiopia.^{1 5-7} The seven forms of disrespect and violence described are physical violence, non-consented treatment, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities or demand for payment.^{2 8}

All pregnant women need high-quality antenatal care (ANC), professional labour and delivery care, and postpartum care and support. They often need access to fully operational emergency services in the event of complications. All births must be attended by qualified medical personnel who can provide competent life-saving procedures. The aim of interventions should be to improve the quality of treatment. RMC is an important component of high-quality care.^{2 9} Disrespect and exploitation of women during labour and childbirth are increasingly viewed as a violation of their rights and a barrier to using life-saving, facility-based labour and delivery services.^{1 0} Despite a recent dramatic national scale-up in the number of qualified providers and facilities, Ethiopian rates of professional birth attendance remain at just 28%.^{1 1} Maternal deaths are caused by a lack of facility-based deliveries, and delivery with a qualified birth attendant can substantially reduce maternal mortality. Women's perceptions of poor care quality and fear of mistreatment may play a role in their low utilisation, according to some experts.^{1 0}

Although some factors contribute to low healthcare utilisation, it is becoming clear that poor service quality and fears of provider mistreatment are among the reasons why many women are unable to access reproductive, maternal, neonatal and child health services. Several studies show that women's expectations of how they will be handled at health facilities may have a significant impact on where they want to give birth and discourage women from seeking care in a timely manner or not at all.^{1 0 1 2 1 3} According to research from high-income nations, healthcare workers (HCWs) may treat women of poor socioeconomic standing, such as migrants and refugees, with disrespect when it comes to maternity care.^{1 4 1 5} Poor communication between service customers and healthcare providers may contribute to healthcare providers' negative views due to language barriers and illiteracy among ethnic minority women. This is also true in sub-Saharan Africa (SSA), where new research from the perspective of healthcare providers relates providers' poor treatment of women to healthcare system constraints. In a qualitative study of Nigerian women, for example, it was shown that certain women's obstinacy during birth has been known to result in verbal abuse from attending staff.^{1 6} Patients are still being treated with disrespect and violence, especially during childbirth, across East Africa, including Ethiopia.^{1 0 1 2 1 7} According to a study, women who experience poor or disrespectful treatment during childbirth are much less likely to seek future facility-based maternity care, placing themselves and their newborns in danger. Women who have had negative experiences with facility-based care may discourage others from seeking it.⁷

Skilled attendants can prevent up to 75% of maternal deaths during labour, delivery and the early postpartum period.^{1 8 1 9} Despite this, just a few mothers in many poor countries attend at least one antenatal visit and even fewer receive skilled delivery care. Up to 74% of births in Ethiopia take place at home, mostly by family or untrained traditional birth attendants.^{1 1} Ethiopia's constitution and subsequent national policies, on the other hand, promote the promotion of women's rights and status by endorsing major United Nations General Assembly resolutions and other international accords that recognise childbearing women's right to dignified maternity care.^{3 1 0 2 0} Although population-based surveys have revealed valuable information about disrespect and abuse in healthcare facilities during childbirth in Ethiopia, they have been unable to capture client and provider explanations about compassionate and respectful maternity care (CRC). We conducted the current study to understand clients' and midwives' perspectives of CRC in the study setting to fill in the gaps from the previous population-based surveys in Ethiopia.

This research contributes to the literature on the experiences of women and midwives on compassionate and respectful treatment during facility-based delivery services. Understanding their viewpoints is crucial in directing healthcare professionals in developing women-centred practice recommendations that counter negative perceptions of healthcare delivery in facilities. Finally, improved positive experiences with delivery care could increase the use of facilities in the future, reducing the risk of direct obstetric complications and maternal death. Furthermore, the data produced as a result of this study will be useful as reference material for other researchers.

METHODS

Study design and period

An exploratory, descriptive, qualitative approach was used to obtain an in-depth understanding of midwifery experts' and women's perceptions of CRC during labour and delivery. The study was carried out between 1 May and 30 June 2020.

Setting of study

The research was conducted in the district of Bishoftu. It is located in the Eastern Shewa Zone of the regional state of Oromia, 47 km from Addis Ababa. The district has one general hospital and five health centres. The research was carried out at sampled three public health facilities, namely Bishoftu General Hospital, Bishoftu Health Center and Keta Health Center. The hospital serves as a referral centre for peripheral healthcare facilities.

Bishoftu General Hospital was founded in 1941. It has 171 inpatient beds and employs 255 health personnel to serve 1.2 million people in three towns and five districts. One gynaecologist, 2 emergency surgeons, and 18 midwives are working in the hospital's labour and delivery units. Three midwives provide maternity care in each of

the health centres in Bishoftu and Keta. Because of their high volume of clients, these health facilities were chosen for the study. The maternity ward gets four admissions per day on average, with 80% of the admissions being labour cases. According to the daily ward record book from 2020, the average number of deliveries each day was 4, with 70% of vaginal deliveries occurring spontaneously. The reproductive and child health unit offers antenatal, postnatal, family planning and child health services. The unit sees an average of 40 people each day, with postnatal visits accounting for 20% of all visits.

According to the Ethiopian Midwives Association Database, Ethiopia has an estimated 4725 midwives per 85 million people, or a ratio of 1:17989. The vast majority of them (95.6%) work as midwives at various hospitals and health centres, while the rest serve as managers, coordinators and lecturers. The government is the primary employer of midwives as it owns the majority of hospitals, health centres and training schools.²¹ In Ethiopia, the overall prevalence of newborn death was 16.3% (95% CI: 12.1% to 20.6%, $I^2=98.8\%$), with 18.8% in Oromia (95% CI: 11.9% to 49.4%).²²

Study population, sample and sampling

Women who had given birth in the past 2 weeks in health facilities and the midwifery experts who worked for at least 1 year as a midwife in the labour and delivery ward were the study population. Because of their ability to provide rich information about CRC, participants for the study were purposively selected. Women who met the eligibility criteria were approached by the midwives/nurses in charge of the maternity and child health units at the designated hospitals and health centres to discuss the study's aim, activities and request to participate. The researcher then approached all of the women who agreed to participate face-to-face and followed them into the communities where the health services were located. We contacted 20 women who were eligible for the interview and interviewed 12 of them. Eight of the women contacted were not interested in participating in the interviews, three because they had moved out of the study setting and five because they were too busy.

Eligibility criteria

Inclusion criteria for women

The study included women who met the following criteria: who had given birth by a midwife in the selected health facility during the past 2 weeks, women who had given birth in the previous 2 weeks in the selected health facilities, 18 years and above, and gave written consent to participate in the study.

Inclusion criteria for midwives

The research included midwives who met the following criteria: graduated with a diploma or BSc in midwifery, worked for at least 1 year as a midwife in the labour and delivery ward, and gave written consent to participate in the study.

Data collection

In-depth interviews with the women

Data were gathered through face-to-face individual interviews. The principal authors with two trained female research assistants conducted in-depth face-to-face interviews. The research assistants were sociologists with extensive qualitative research experience. An interview guide was used to outline the open-ended topics, which was then translated into Amharic (local language). The interview was conducted in Amharic with an Amharic interview guide. The interview guide used in this study was attached as online supplemental file 1.

The researchers piloted the schedule of the interview on two women who met the eligibility requirements set. However, the findings were not included in the main study as the aim was to test whether adequate answers were provided to the research questions. After the pilot study, the researchers were able to improve the interview guide. Certain improvements were made in response to issues raised during the pilot study. Some questions, for example, were rephrased and sequentially aligned. To ensure the study participants' confidentiality and privacy, the interviews were conducted in their homes. The interview guide questions concentrated on the aims of the study as follow-up questions were asked based on the response of the study participants. The assistant researchers audio-recorded the interviews with the verbal consent of the participants and took written notes during the interview to capture the original accounts of the responses of the participants and to check their explanations by going back to the original answers. Each interview session lasted 20–50 min. During each interview session, field notes were taken. The responses that were captured in audio were transcribed verbatim after the interview session each day, and the transcript was preserved in Microsoft Word format along with field notes.

On-the-spot member checking was done during the interviews in this study by repeating what the participants said and what was documented in the field notes to them and confirming that this was what they wanted to say. After member checking, the participants were given feedback. The study participants received no compensation other than reimbursement for travel expenses.

The researchers interviewed a total of 12 women. In-depth interviews were performed until saturation, which was achieved through early data analysis. Data were returned to participants individually for cross-checking and validating their responses after data analysis to ensure validity.

Lastly, the reporting of this study complied with the 32 requirements suggested by the Consolidated criteria for Reporting Qualitative research.²³

In-depth interviews with the midwives

The lead researchers conducted individual face-to-face interviews to collect the data. The researchers were assisted by two trained female research assistants who were sociologists with substantial qualitative research

experience. An interview guide was used to outline the open-ended topics, which were prepared in English. The interview was conducted in Amharic with an interview guide written in English. The interview guide used in this study was attached as online supplemental file 1. The researchers tested the interview schedule on two midwives who matched the eligibility criteria. The findings, however, were not included in the main study because the goal was to see if acceptable responses to the research questions were supplied. Following the pilot test, the researchers were able to improve the interview guide. Certain improvements were made in response to issues raised during the pilot study. Some questions were rewritten and reorganised more logically, for example. To protect their identities and privacy, the interviews were conducted in private rooms at their health facilities. The interview guide questions focused on the study's goals, with follow-up questions depending on the study participants' responses. With the participants' verbal consent, the assistant researchers audio-recorded the interviews and took written notes. Each interview lasted between 20 and 50 min. The audio responses were transcribed verbatim each day after the interview session, and the transcript was saved in Microsoft Word format alongside field notes. During the interviews, on-the-spot member checking was done by repeating what the participants stated and what was recorded in the field notes to them and confirming that this was what they wanted to say. Other than reimbursement for travel fees, the study participants received no compensation. A total of 10 midwives were interviewed by the researchers. In-depth interviews were conducted until saturation was reached; saturation was attained through early data analysis. Data were returned to participants individually for cross-checking and validating their responses after data analysis to ensure validity.

Data analysis

Descriptive statistics were used to summarise the sociodemographic characteristics of participants. Data from audio recorders were transcribed verbatim manually. One of the lead authors, EGS, chose the transcripts at random and created the first codebook by hand. The research assistants then used the codebook to code the remaining transcripts. HDJ then went over the data that had been coded and combined the main and subthemes. EGS compiled the final codebook after reading all of the codes. In using this scheme, a codebook was first established, discussed and accepted by the authors. Both a priori codes (from the query guide) and emerging inductive codes were used in the study. In the thematic data analysis, three inter-related stages were involved, namely data reduction, data display and data conclusion. The thematic method of analysis also included the construction of textual data, the description of data themes, the coding of the themes, and the interpretation of the structure and content of the themes.²⁴ Finally, the views shared by respondents were used as quotes to support the points made in the study.

The trustworthiness of the study

A pretest was conducted before the main study to test the trustworthiness and reliability of the instrument to correct and make the necessary changes before the study was carried out.

Various methods were followed to ensure the trustworthiness of the report, which included the use of the same interview guide during the entire study. To confirm the methods undertaken in the report, an audit trail was held for researchers. A thorough description of the study area, methodology and history of the sample was given to ensure the transferability of the research results to similar contexts. To ensure validity, data were returned to participants to cross-check and verify their responses. The researchers asserted a non-biased approach to the study and applied reflexivity, increasing the confirmability of the results. A dense description of the procedures and the review, and approval from the relevant scientific committees affiliated with the study increased the reliability of the research. Finally, the reporting of this study met the 32 standards proposed by the guidelines for unified qualitative research reporting.

The researchers ensured that their attitudes, thoughts, and experiences about the topic under investigation did not impact data collection and analysis by adopting bracketing. The researchers' backgrounds had no influence on the study's data collection and analytical procedures.

Patient and public involvement

Patients were not involved in this study.

Research findings

This paper's findings include perspectives from both service users and service providers on CRC.

Participants' sociodemographic characteristics

The study involved 12 women and 10 midwives. None of the participants contacted refused inclusion in the study. The mean age for the total women sampled was 31.6 years (\pm SD=5.2).

The educational characteristics of the participants indicate that the majority (7 out of 12) had primary education and that two-thirds of them had one to two children. All of these participants were married or in a stable relationship with their partners. During this study, all of them delivered their last child at a health facility (table 1). Likewise, of the midwives, there were six men and four women, ranging in age from 25 to 38 years with the mean age of 28.96 years (\pm SD=4.2). Eight of them held a Bachelor's degree in midwifery, and more than three-quarters had worked in the field for 5 years or more (table 2).

SERVICE USERS' PERSPECTIVES OF CRC

Our first research aim was to explore the experiences and viewpoints of women in labour and delivery care on CRC. From the analysis of in-depth interviews with labouring women, three themes emerged, namely: dignified and

Table 1 Sociodemographic characteristics (women)

Variable	Category	Frequency (n=12)	Percentage
Age (years)	20–25	2	16.6
	26–31	6	50
	32–37	3	25
	≥38	1	8.3
	Mean=31.6 years (±SD=5.2)		
Educational level	Primary	7	58.3
	Secondary	5	41.7
Occupation	Unemployed	6	50
	Private employee	2	16.7
	Daily labourer	4	33.3
Number of children	1–2	8	66.7
	≥3	20	62.5

respectful care, neglectful care and unqualified staff (table 3). These themes were discovered to be a rich and detailed account of women's and midwives' perspectives on CRC.

Dignified and respectful care

Some women also related the manner of communication of midwives to CRC practices and identified the care of midwives as dignified and respectful.

She [Midwife] treated me like a friend... I would say the midwife who took care of me was polite and dignified. (In-depth interview 12; 27-year-old woman)

That was my first time in a health facility delivering a child. There, I got a lot of support and constructive reinforcement from the midwife and I just delivered a normal baby vaginal. (In-depth interview 9; 33-year-old woman)

Neglectful care

Issues on verbal and physical assault, as well as psychological stress resulting from neglect and lack of supportive care, were discussed concerning forms of ill-treatment

during childbirth. Some women recalled stories of midwives yelling at them as they were about to bear down during the second stage of childbirth. During labour and childbirth, women's experiences revealed psychological stress as a consequence of neglect, lack of treatment and unresponsiveness of health workers to their needs.

I am not pleased with the provision of her care [Midwife]. There are some negligent workers, you know. We go there to get their help, but they talk and talk about their private issues. It's not advisable, therefore, to go there. (In-depth interview 4; 35-year-old woman)

I was in pain from bearing down and crying for support from the midwife who was speaking with her friends as I delivered my second baby at a health center. She had no compassion for me, and a doctor came and shouted at me as well. I propose that these individuals must value their customers in the first place and also recognize their professional roles and obligations. (In-depth interview 5; 28-year-old woman)

Table 2 Sociodemographic characteristics (midwives)

Variable	Category	Frequency (n=10)	Percentage
Age (years)	25–30	2	20
	31–35	6	60
	≥36	2	20
	28.96 years (±SD=4.2)		
Educational level	BSc	8	80
	Diploma	2	20
Gender	Male	6	60
	Female	4	40
Service year	1–4	2	20
	≥5	8	80

Table 3 Codes, categories, and themes of compassionate and respectful care

Codes	Categories	Themes
Women		
The midwife was polite and dignified; the midwife treated the client friendly, and the midwife provided support and constructive reinforcement during labor and delivery.	Dignified treatment, professionalism, demonstrating respect	Dignified and respectful care
I am not pleased with the provision of her care [Midwife]. There are some negligent workers, you know. We go there to get their help, but they talk and talk about their private issues. It's not advisable, therefore, to go there; the midwife ignored the woman and left her alone in labor. I was in pain from bearing down and crying for support from the midwife who was speaking with her friends as I delivered my second baby at a health center. She had no compassion for me, and a doctor came and shouted at me as well. All of them [midwives] is yelling at us... They don't like us in particular, if we're poor; a young woman in labor slapped...	Lack of supportive care, mistreatment, lack of respect and dignity, being poor/poor mothers are ignored, verbal abuse and uncompassionate care	Neglectful care
The midwife was unable to care for the baby and placenta; the midwife lacks the knowledge and competence needed to help women throughout labor and delivery; the midwife lacks a sufficient amount of training or experience.	Not knowledgeable, incompetent, lack of expertise or skills	Underqualified staff

Some women felt they were being neglected because they were poor. They felt despised in this situation because of their low socioeconomic status. In some cases, without the help of a healthcare provider, women gave birth in the hospital and believed that this was due to inadequate supervision and examination of women during the period of childbirth:

All of them [midwives] is yelling at us. They don't like us in particular, if we're poor. She [Midwife] left me alone, unattended... and I delivered my baby by myself. (In-depth interview 11; 31-year-old woman)

Because I am poor, I believe I was more likely to be subjected to verbal and physical abuse by healthcare professionals. I noticed how they [Health Workers] treated the wealthy and educated women. (In-depth interview 6; 30-year-old woman)

According to the findings of the study, women would not select facility-based delivery due to negative attitudes of healthcare providers and uncompassionate care at health facilities. Some women in this study claimed physical and verbal abuse from midwives, as well as a lack of respect and sympathy. The following sample responses reflected these findings:

Some of the midwives continue to beat and scream at you because they are impatient with you. They are intolerable, verbally violent, and uncaring. (In-depth interview 1; 28-year-old woman)

She [Midwife] showed no concern for me and even shouted at me when I asked for assistance. I'm not sure I'd deliver my next baby there. (In-depth interview 11; 31-year-old woman)

Underqualified staff

Women do not want to give birth in a health facility for a variety of reasons, including perceived provider incompetence, and a lack of knowledge and appropriate attitudes toward pregnant women's care during pregnancy and childbirth, according to the findings.

She [the midwife] had no idea how to deal with the baby and the placenta. She didn't seem to have undergone adequate training or experience. I may not come here in the future for childbirth. (In-depth interview 3; 36-year-old woman)

They [Providers] lack the necessary knowledge and expertise to assist women during labor and delivery. I guess it would be much better to deliver at home. (In-depth interview 5; 32-year-old woman)

SERVICE PROVIDERS' PERSPECTIVES OF CRC

Five main categories emerged from in-depth interviews with midwives: trusting relationships formed with labouring women, compassionate and respect-based behaviour, good communication skills and holistic care, intentional disrespect towards women and barriers to CRC due to structural factors (table 4). These themes were discovered to be a rich and detailed account of midwives' perspectives on CRC.

Trusting relationships formed with labouring women

Participants thought that by being in touch with her (women in labour) and establishing a connection, the midwife commonly interacts with the woman in the labour ward. Then, the midwife and the labouring women admirably bond with each other through interpersonal communication, honesty and respect, and then gradually

Table 4 Codes, categories, and themes of compassionate and respectful care (CRC)

Codes	Categories	Themes
Midwives		
The midwife developed a positive bond with labouring women; the client is treated as a human being by the midwife, who negotiates with her to suit her requests; to develop a trusting relationship, the midwife treats the client with respect and courtesy.	A trusting relationship, being treated respectfully, dignified care	Trusting relationships formed with labouring women
By covering the client's perineum, the midwife ensures her privacy; due to the presence of multiple students on the wards, we are unable to protect the privacy of our customers. Clients frequently feel humiliated when vaginal examinations are performed; the midwife encourages the mother to have the most positive childbirth experience possible; the woman in pain during the vaginal examination was reassured by the midwife, who told her she had to bear it.	Respectful actions, supportive care, positive childbirth experience	Compassionate and respect-based behaviour
The midwife extends a warm welcome to the client, introduces herself, and takes the time to explain what will happen next, as well as answer her questions and fulfil her needs; the client was encouraged by the midwife, who touched her and smiled at her; the midwife stayed with the woman and offered her with both physical and mental support even after her hours of service.	Communication abilities that are effective, holistic treatment, demonstrated professionalism	Good communication skills and holistic care
Midwives are purposefully shouting at women to save their lives and the lives of their unborn infants... but they are unaware of it; the woman has been harassed; yelling at women is not personal; disrespect towards women on purpose.	Physical and verbal abuse, mistreatment	Intentional disrespect towards women
There is less midwifery staff; there is not enough time to treat customers, CRC was not included in midwifery education; most midwives have reported low pay, lack of various compensation packages, restricted career growth, and abilities to exercise their midwifery profession to the standard.	Inadequate resources, low staffing, the incentive package, gaps in midwifery training	Barriers to CRC due to structural factors

develop a trusting relationship. The results of the individual interviews showed that some providers consider the provision of CRC to result in good health-seeking conduct because it builds a sense of confidence among women and midwives. In the following sample responses, these results were evident:

The midwife must be 'with the women' during labor and childbirth. A positive relationship with laboring women can certainly be constructed by staying in touch with her. (In-depth interview 3; 28-year-old midwife)

...occasionally [women] do not know the midwife in the labor ward who looks after them. But you do sometimes, you get to chat. You may establish quite a good relationship in a short time...

... Treating our clients with respect and dignity increases acceptance and builds a trusting relationship with them. Such clients often continue to use health services [Women in labor]. (In-depth interview 2; 26-year-old midwife)

Compassionate and respect-based behaviour

Participants addressed experiences in which the midwives demonstrated compassion and respect, mainly respect for privacy. Respect and compassion for the women were also expressed by the midwives, particularly when they underwent an invasive medical procedure or suffered labour pains. This strengthened the relationship between the midwife and the labouring woman and was described as an integral part of CRC. However, some midwives were conscious that having many students present on the wards threatened women's dignity and their right to consent at once, resulting in meagre care:

As a midwife, to respect her dignity, I should maintain her [woman in labor] privacy by covering her perineum. (In-depth interview 2; 29-year-old midwife)

We are vigilant to protect the privacy of a woman from the use of partitions and clothes by other women. (In-depth interview 1; 32-year-old midwife)

...When a midwife and team comes around a woman and empowers her to have the best birthing experience she will ever have, respect and compassionate care occurs. (In-depth interview 2; 29-year-old midwife)

The woman was crying because of the pain when I was doing the vaginal examination. I reassured her that pain is expected during the vaginal examination and that she must tolerate it. (In-depth interview 9; 34-year-old midwife)

As several students are on the wards, we cannot protect the clients' privacy. Clients often feel humiliated when conducting vaginal exams. (In-depth interview 5; 27-year-old midwife)

Good communication skills and holistic care

Communication abilities are reported as of primary importance and these include being a good listener and being able to express things. The importance of using meaningful, motivating words when communicating with women in labour and using non-verbal gestures such as facial expression, tone of voice and touch was stressed by participants. They also listed instances in which the midwife's presence offered the woman emotional and physical supports even at the end of her shift to continue the support.

I greet her warmly, introduce myself and take the time to explain what will happen next, and allow her to ask questions and address her needs. (In-depth interview 7; 34-year-old midwife)

If the client is listened to, encouraged by touching her, given a smiling gesture, her thoughts are noted, she will be very pleased... increases acceptance and builds a trustworthy relationship with them, and these clients don't hesitate to come to get health care services. (In-depth interview 5; 24-year-old midwife)

Until she delivered, even after my hours of service, I remained with the woman and provided her both physical and emotional supports. (In-depth interview 6; 35-year-old midwife)

Intentional disrespect towards women

Physical and verbal abuse, lack of respect and lack of sympathy at the hands of midwives were reported by some participants. In the following sample replies, these results were obvious:

...Women don't know why we scream sometimes. We're all shouting at them to save their lives and the unborn baby... but they don't understand us. I'd be mad at her if I told her something any time and didn't listen to me. (In-depth interview 8; 29-year-old midwife)

In the second stage of labor, when the vulva is wide open and the head is bulging, I usually ask her to push down. When she doesn't do that, it makes me angry and I may yell at her, but that's not personal. I may do it on purpose. (In-depth interview 10; 26-year-old midwife)

Barriers to CRC due to structural factors

The midwifery participants indicated that there were insufficient resources needed to provide quality treatment at healthcare facilities. According to the findings, there was a shortage of midwifery staff. A small number of midwives handle a large number of clients in numerous public health facilities, leading midwives to become exhausted and overburdened and compromising the standard of treatment.

In our department, there is less midwifery staff. When you attend follow-up and delivery room at the same time, this would compromise the quality of your work.... And you can't get enough time to treat your clients respectfully. (In-depth interview 10; 26-year-old midwife)

When looking after 2 or 3 clients at the same time, you will not provide compassionate and respectful care [CRC]. Our midwifery education did not include CRC, and most of us did not receive it as part of our in-service training. (In-depth interview 8; 29-year-old midwife)

In addition to employee shortages, most midwives have reported low pay, lack of various compensation packages,

and restricted career growth and abilities to exercise their midwifery profession to the standard. The lack of health insurance was also listed by the participants as one of the challenges. The following are sample quotes:

Our monthly payment and workload are not proportional; often this will annoy you because life is very costly and you can represent your anger on your customers.

Officials should recognize our positions and provide health insurance for us. Health care is a basic concern for all service providers. (In-depth interview 6; 35-year-old midwife)

The salary and the workload never fit. (In-depth interview 2; 29-year-old midwife)

No educational opportunity exists to advance our career and skills. (In-depth interview 1; 32-year-old midwife)

DISCUSSION

This article looked into the perspectives of both service users and providers on CRC.

Service users' perspectives of CRC

The women in this study reported many incidents of disrespectful and abusive treatment during delivery at a health facility. According to the findings, mistreatment, particularly in the form of verbal abuse and neglect and lack of supportive care, is common among labouring women who use healthcare facilities. A few women also witnessed physical and verbal abuse from midwives, as well as a lack of respect and sympathy. This finding is consistent with the results of previous studies.^{10 25-27} Bohren *et al* conducted a comprehensive study in 2015 that provided an evidence-based typology of what constitutes childbirth mistreatment, which included physical aggression (hitting, kicking, pinching), verbal harassment, stigma and prejudice, as well as systemic/structural problems in health facilities and procedures that contribute to poor care experiences.²⁸

Women do not want to give birth in a health facility for a variety of reasons, including perceived provider incompetence, and a lack of knowledge and appropriate attitudes toward pregnant women's care during pregnancy and childbirth, according to the findings. Several studies have found that women in health facilities are mistreated during childbirth, leading to the decision to give birth at home.²⁹⁻³¹ Disrespectful treatment, unskilled care and poor health provider-client interaction were all listed by the same authors as reasons why women chose to give birth at home.

Every woman has the right to the highest attainable level of health, which includes the right to dignified, respectful healthcare, according to a new WHO policy.^{3 32} Mistreatment of women during childbirth is a violation of their human rights and autonomy, and it can be a significant deterrent to accessing maternity care at a health

facility.²⁵ For instance, women may be afraid to give birth in health facilities in the future as a result of their maltreatment or hearing about another woman's abuse. Another qualitative study from Ghana reported that fear of mistreatment by healthcare providers may thus play a role in women's reluctance to give birth in health facilities.²⁵ Women would not favour facility-based delivery in the future, according to a previous qualitative study from Addis Ababa, Ethiopia, because of health professionals' perceived incompetence and negative behaviours, as well as insufficient treatment at health facilities.¹⁸ The present result is also in line with the multiple-level life-course system of facility-based delivery in LMICs proposed by Bohren *et al* according to which previous birth experiences can influence a woman's decision about where to deliver her baby.

Some women in the present study believed they were being ignored because they were poor. They felt hated in this case due to their low socioeconomic status. In other nations, low socioeconomic status has been linked to an increased risk of obstetric abuse. Poor and rural women in Burkina Faso, for example, stop attending healthcare facilities during pregnancy because they are abused.³³ Women with low economic status and women who are less educated are more likely to be abused in healthcare, according to a study conducted among women in South Africa. Providers know that women with low economic status and women who are less educated will tolerate whatever level of care they receive, even if it is limited.³⁴ A similar finding was also reported in Sri Lanka.³⁵

One of the most important facilitating factors for increasing access to professional maternity care is CRC, which needs attention from midwives all over the world. In reality, attempts to increase the use of facility-based maternity care in low-resource countries are unlikely to yield the desired results unless the standard of care is improved and the experience of women is prioritised.²⁷ It is, therefore, critical to advance CRC to enhance facility-based childbirth and ensure the successful implementation of women's rights in maternal health services.

Service providers' perspectives of CRC

The second objective of the study was to explore how midwives thought about CRC during childbirth. A majority of the midwives in this study sought to build and establish positive relationships with the women by engaging in conversational interactions and providing emotional support. Communication between the client and the midwife was part of the compassionate and respectful midwifery care. This finding is in line with previous research findings. Good interpersonal relationships between women and midwives were identified as common aspects of respectful childbirth care in previous studies.^{3 36–38} These relationships included greeting, talking gently and patiently, providing an environment where women can relax and feel relaxed, motivated women, and explaining about the labour process and treatment.

Labour support was seen as a cost-effective intervention that met a woman's basic emotional and physical needs during a painful and fragile stage of her reproductive journey—childbirth.³⁹ According to the current findings, a significant number of midwives attempted to consider women's rights, such as respecting women's privacy and providing information, as well as encouraging women to have the best birthing experience possible. The midwives in our study tended to be aware of aspects of RMC from the perspective of human rights, such as protecting confidentiality and privacy and providing information.³ Some midwives, on the other hand, were conscious that having so many students on the wards jeopardised women's dignity and right to immediate consent, resulting in substandard care. This result is consistent with previous studies.^{10 38 40}

The midwives in our current study described respectful and abusive treatment at various levels of maternity care. In this study, some participants also witnessed physical and verbal harassment, as well as a lack of respect and sympathy from midwives. They at times inferred such actions and behaviours, such as screaming at women in labour, as being carried out with good intentions to gain their support and ensure the women's safety during childbirth. The provider's ability to help women and their emphasis on safe childbirth were cited as motivating factors for participating in disrespectful and abusive practices. These results are comparable with previous study findings.^{10 38 41} According to their accounts, many of the rights outlined in the RMC Charter³ were reportedly abused in practice, including the right to know and informed consent, as well as respect for choices and wishes.

Disrespectful and abusive treatment of women in labour may result from healthcare system flaws, such as what HCWs learn in training and reinforce on the job, as well as various types of discrimination that persist in society.³⁵ Many obstetric providers' stressful and poor working conditions, and low payment, which is compounded by hospital overcrowding and staff shortages, exacerbate disrespect and bullying. As our research shows, obstetric violence is linked to a conflict of attitudes between clients and providers—for example, clients view being told how to act during labour as a form of violence, while providers consider such 'moral counselling' to be part of the task of successful midwifery practice. This finding is consistent with a previous study.³⁵ The health authorities have a responsibility to remedy the current condition of inadequate accountability for improper conduct in caregiver relationships. Internal problems such as low pay and a lack of CRC training can also give the impression that the procedures are disrespectful and uncaring. Maternity care facilities thus require a system for tracking how effectively patients are treated so that they can be treated with respect, consideration and professionalism. To attain this goal, staff attitudes toward patients and how patients are treated must be a major consideration in both hiring and retention, and abusers must be reported to the authorities



in the most serious cases. To ensure that all personnel understand and apply the principles of respectful care and gender responsiveness when dealing with patients, a reporting and response system must be established and implemented.⁷

Apart from what they studied in midwifery schools, the midwives in our study had not undergone any training on compassionate and respectful practices. This highlights the need for Ethiopian health authorities and stakeholders to take steps to ensure that healthcare providers are properly trained in respectful maternity practices, including elements of rapport building and counselling skills, as part of their midwifery curricula, as well as timely refresher training to address the issue. To ensure ethical conduct and patient safety in obstetric care, better supervision, training and policies are also needed.

Strength and limitations

This is one of the few studies that provides valuable information on midwives' actual childbirth activities and care of women during childbirth in urban Ethiopia. It should also be noted that the emerging themes were supported by local and international works. As a result, the results are useful to health agencies who want to boost CRC in healthcare facilities. As in every research project, there were some limitations. The findings may not be replicable or transferable since this was a study conducted in a specific location at a specific time. Similarly, qualitative designs must focus on definitions and interpretations, but the limited sample size limits the generalisability of the findings. The insights and experiences of policymakers in maternity care settings could be useful in future studies. More research is needed to understand culturally relevant techniques that can enhance RMC.

CONCLUSION

This article looked into the perspectives of both service users and providers on CRC during childbirth.

This is an important topic that continues to highlight the key issues faced by health systems in SSA that need to be addressed. The study also adds to the growing body of knowledge about how women are treated during ANC, delivery, labour and post partum.

The majority of women who witnessed or suffered disrespect and violence during labour and childbirth were dissatisfied with their maternity care during labour and delivery. Despite midwives' accounts showing that they were aware of the importance of CRC, clients face verbal abuse, neglect, and a lack of supportive treatment during labour and childbirth. Clients' human rights were violated by disrespectful or abusive acts, whether perpetrated or observed. Most abuse, on the other hand, is accidental, according to midwives, and stems from healthcare system flaws or medical needs. The government should hire an appropriate number of midwives for health facilities, resolve resource availability and provide midwives with a variety of benefits, including paying fair

wages, to enhance CRC and facilitate birth at health facilities. It is essential to address structural problems such as provider workload, and all other initiatives aimed at improving midwives' interpersonal relationships with women to provide compassionate and respectful client-centred maternity care. Cooperation and synchronisation between researchers, health organisations and the Ethiopian government are also required to provide preservice and in-service training, improve working conditions, and streamline various processes to promote respectful care of women during childbirth.

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